IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

ATTACHMENT JA-21 TO STATEMENT OF JUDITH DORENE ABBOTT

Date of document: 14 July 2015
Filed on behalf of: State of Victoria
Prepared by:
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This is the attachment marked "**JA-21**" produced and shown to **JUDITH DORENE ABBOTT** at the time of signing her Statement on 14 July 2015.

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An Australian Legal Practitioner within the meaning of the Legal Profession Uniform Law (Victoria)

CLINICAL TREATMENT GUIDELINES
FOR ALCOHOL AND DRUG CLINICIANS

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Turning Point
Alcohol & Drug Centre

WORKING WITH FAMILIES

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Turning Point
Alcohol & Drug Centre

WORKING WITH FAMILIES

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Published by Turning Point Alcohol and Drug Centre under funding provided by the Drug Treatment Services Unit, Department of Human Services Victoria. The views expressed in this material are not necessarily those of the Victorian Government.

The correct citation for this publication is:
Patterson, J., & Clapp, C. (2004). *Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 11: Working with Families.* Fitzroy, Victoria: Turning Point Alcohol and Drug Centre Inc.

ISBN: 1 74001 098 1

OVERVIEW

Working with Families is part of the *Clinical Treatment Guidelines* series developed by Turning Point Alcohol and Drug Centre.

Family inclusive practice describes a model of service delivery that values the importance of the family and includes families within the scope of clinical practice, even where the main focus of intervention may be on the individual. These guidelines utilise a broad definition of 'family' and recognise many different types of family involvement with the client. While family therapy is one model of family inclusive service delivery, there are also a number of approaches that can be taken by workers with a variety of experience and qualifications.

In developing family inclusive practice, it is recognised that most alcohol and drug services are primarily focused on the treatment of individual clients. Family inclusive practice aims to inform and empower families in utilising their own expertise and resources to cope with drug use and support the client in treatment.

Working with Families outlines a range of family inclusive practice models available to alcohol and drug services. It provides practice guidelines and strategies for engaging families, addresses principles and standards of application, and discusses professional practice issues. A continuum of family inclusive practice and stages of service development are provided to assist organisations to determine the level of family inclusive practice they have the resources and skills to undertake. Clinical resources are provided for use in delivering family inclusive services.

While *Working with Families* is a valuable resource in its own right, current drug treatment practice utilises multiple interventions. As a result, and reflecting the holistic approach to working with people with drug problems, these guidelines should be used in conjunction with other publications in the *Clinical Treatment Guidelines* series.

Other publications in the series to date are:

1. Key Principles and Practices
2. Motivational Interviewing
3. Relapse Prevention
4. Reducing Harm for Clients Who Continue to Use Drugs
5. Controlled Drug Use Interventions
6. Effective Weed Control: Working with cannabis users
7. Working with Polydrug Users
8. Assertive Follow-up
9. Prescribing for Drug Withdrawal
10. Managing Difficult and Complex Behaviours

Key Principles and Practices provides a theoretical and practical overview of what is considered to be 'best practice' when working with alcohol and drug clients. The authors deal with issues such as identifying and assessing drug problems and the client's readiness for change; the factors underpinning and influencing drug treatment such as models of dependence and harm minimisation; as well as highlighting approaches involving behaviour change, withdrawal and substitution pharmacotherapies. In addition, *Key Principles and Practices* addresses professional issues such as general counselling skills, consultation, casework supervision and ethical practice.

Key Principles and Practices contains copies of the Victorian Alcohol and Drug Treatment Services Specialist Assessment Form and the Youth Alcohol and Drug Treatment Services Assessment and Intervention Tool, essential tools for alcohol and drug assessment and treatment planning.

* The term 'drug' is used interchangeably with 'alcohol and drug' and 'alcohol and other drug'. The term refers to tobacco, alcohol, prescribed pharmaceutical products, illicit drugs and any chemical that changes the mental state and that may be used repeatedly for that effect.

WELCOME

Welcome to the *Clinical Treatment Guidelines* series, which Turning Point Alcohol and Drug Centre hopes will be an important resource for alcohol and drug clinicians.

There is much talk of 'best practice' these days, but trying to work out just what this means can be complex. Often findings from clinical research are published in journals – and stay there – reflecting the difficulties faced in the dissemination of research and its subsequent application in day-to-day practice.

Clinicians sometimes evolve their own practice from case studies and experience. However, the constant monitoring of research worldwide and its subsequent integration into working with clients is often beyond the resources of many clinicians and clinical organisations whose focus is practice, not research.

As a result, Turning Point has published the *Clinical Treatment Guidelines* series to help address the need for up-to-date alcohol and drug treatment resources for clinicians.

At Turning Point, our core business is to interface research, clinical practice, education and training. We explore what research suggests should be effective interventions, or 'best practice', and then we try to determine whether or not they are feasible and practical for clinicians in their day-to-day work with clients. We are committed to exploring new treatment approaches. However, we hold firm to tried and true practices until there is concrete evidence of a more effective method.

The *Clinical Treatment Guidelines* series represents the distillation of these efforts and combines practical and theoretical knowledge which can be adapted to specific work environments where necessary. The series:

- is suited to a variety of professional practitioners
- conveys practical information as well as covering some theoretical advances
- can be applied across many settings

The series reflects what is considered to be 'best practice' at the date of publication. However, new knowledge is inevitable and should be incorporated accordingly. Workforce development is integral to supporting changes in practice through education, training, staff supervision and management.

I trust that the *Clinical Treatment Guidelines* series, in its entirety or publication by publication, will be useful to you in your work with people who have alcohol and drug-related problems.

Professor Margaret Hamilton

Director, Turning Point Alcohol and Drug Centre

ACKNOWLEDGMENTS

Working with Families is part of the *Clinical Treatment Guidelines* series developed by Turning Point Alcohol and Drug Centre under funding from the Drug Treatment Services Unit, Department of Human Services Victoria. This publication was made possible by the input of many people who willingly gave of their time. Their contributions – in the form of professional advice, suggestions and critical commentary – are greatly valued.

These guidelines are based on a report produced by the Children's Protection Society under contract to Turning Point. They have subsequently been updated in collaboration with the authors to ensure that they continue to reflect best practice and changes in service development. The authors and Turning Point especially acknowledge the contribution of the following individuals in the development of these guidelines:

- Colleagues at Turning Point: Pauline Drosten, Rob Lacy, Kerri Jackson, Tracey Brooke, Megan Christmas, Darryl Coonan, Kelly Richards, Pam Palser and Dr Alison Ritter
- Colleagues from other organisations: Miranda Manning (Odyssey House), Lesley Edwards (East Care), Ross Mortimer (Eltham Community Health Centre), Mazz Hall (TaskForce), Bronwyn Murphy (St Vincent's Hospital), Rosalie Freeman (Epworth Hospital), Emma Musella and Barb Smith (Barwon Health), Deb Homburg (Buoyancy), Freda Minas (The Salvation Army: Bridgehaven), Clare Harris and Marni Sheehan (Children's Protection Society)
- Jane, Samantha, Alice, Beth, Joanne, Carmel, Lisa, Mandy and Kylie from Bridgehaven
- The Turning Point project team: Dr Suzy MacKechnie (project coordinator), Bridget Fitzgerald, Pauline Drosten, Michelle Keenan, Dennis Cooney, Moses Abbatangelo, Phoebe Spry-Bailey, Tracey Brooke, Brenda Irwin, Pam Palser, Kelly Richards, Anne Mills, Rob Lacy
- Family Drug Help: Kathy Crowe for her valuable feedback on the updated guidelines and Alan Murnane for assistance in compiling the resource list for clinicians
- John Toumbourou (Centre for Adolescent Health) for update on current research

About Turning Point

Turning Point is a specialist alcohol and drug organisation with a mission to lead and support the community in the development of policies and programs to prevent and reduce the harm caused by alcohol and drugs. Turning Point integrates treatment and support service delivery with research, education and training. This approach to alcohol and drug issues is designed to have an impact in three key areas:

- advancing the range and quality of treatment and support services available to people affected by alcohol and drug use
- building the capacity of the professional workforce to provide alcohol and drug services
- supporting the process of sound, evidence-based policy and program development

Turning Point has a comprehensive understanding of the alcohol and drug sector and other allied fields of health and welfare, operating within an extensive local, national and international service network. Turning Point's work is undertaken in collaboration with government, the alcohol and drug sector and allied fields, professional workforces, people affected by alcohol and drug use, and the wider community.

The authors of the *Clinical Treatment Guidelines* are thus in a unique position to draw from the latest clinical wisdom, research findings, and education and training resources. They are also well placed to consult with expert practitioners who are engaged in the provision of clinical treatment.

CONTENTS

Section 4: CLINICAL RESOURCES

INTRODUCTION

There is growing acknowledgment across all health and welfare professions, including the alcohol and drug sector, of the need to develop a range of approaches that are inclusive of families when working with individuals who experience problems. Every individual is a member of a family and wider community. While there is a great deal of variation in the degree to which people are involved with their families, and the helpfulness of this involvement, individuals continue to carry their family 'in their heads' throughout their lives, even if they are not having direct contact with them. Furthermore, the impact of problems not only affects individuals who may directly experience that problem, but also those around that love and care for them.

These guidelines were developed to assist organisations in developing family inclusive alcohol and drug services. Their primary aim is to inform and empower families to utilise their own expertise and resources to cope with drug use and support their family member as a client in treatment.

The needs of families and significant others of those with alcohol and drug related problems are significant and have been identified at the federal, state and local government level to warrant consideration and support. The Victorian Government's Department of Human Services has funded a number of initiatives, including commissioning a report on *Involving Families in Treatment of Young People with Problematic Substance Use* (Success Works, 2000), and has implemented a range of family-specific options. Funding has been provided for the delivery of family focused interventions that respond to the specific needs, experiences and ongoing learning of families of drug users. These services can act as an important point of referral and advice, and can support the development of family inclusive practice within the alcohol and drug treatment sector.

The involvement of families in alcohol and drug treatment is helpful for a number of reasons. Families are considered a valuable source of support (Kaufman, 1986); research indicates that most drug users under the age of 35 years are in daily contact with at least one parent (Stanton & Shadish, 1997). A meta-analysis of research literature suggests that involving families in the process of alcohol and drug treatment is more effective than individual treatment for both adolescents and adults (Stanton & Shadish, 1997). Approaches that have been evaluated include family therapy with both adolescents and adults with alcohol and drug difficulties; couples or marital therapy with a behavioural framework in the treatment of alcohol difficulties; unilateral family therapy where a non-drug-using family member is trained in behavioural approaches to managing problem drinking; and parent education and support groups. All of these approaches are considered to have value in reducing conflict in relationships caused by drug use and in reducing the drug use itself.

Identifying family needs

Families have particular needs in their own right related to the experience of having a relative with a drug-related problem. Family and significant others of those who use drugs are exposed to high levels of stress and are at risk of stress-related physical and psychological disorders (Orford, 1994). There is a general need for families to have support and guidance to develop coping strategies and assist with other problems that may develop (Dear, 1994).

A study conducted in Victoria investigated the intervention opportunity that can arise when parents initially recognise adolescent drug use. Parents in these situations often experience considerable distress, which can undermine effective response. In an effort to provide a cost-

effective method of assistance, Blyth et al. (2000) developed an eight week, professionally led group intervention known as the Behavioural Exchange Systems Training (BEST) program. The program intervention theory aimed to reduce parental stress and depression, increase communication, and encourage assertive parenting including the use of appropriate consequences for adolescent misbehaviour. High rates of depression among participating parents at pre-test (87% with high symptoms on the General Health Questionnaire) were observed to drop substantially over the course of the intervention (down to 24% after eight weeks) (Toumbourou et al., 2001). A small evaluation incorporating a wait-list control group revealed differential improvements for those exposed to the intervention in mental health, parental satisfaction and assertive parenting behaviours (Toumbourou et al., 2001). The impact of these changes on youth drug use is not yet known.

The BEST program has been supported for dissemination in Victoria and in South Australia. In an analysis of parent changes achieved through participation in the BEST program, Bamberg et al. (2001) noted that further reductions in youth drug use might have been achievable for approximately one third of families had additional family intervention been provided at the end of the program. Future research is planned that will investigate the potential to impact youth drug use by adding behavioural parent training and family systems components as a follow-on intervention for parents that have completed the BEST program.

The majority of studies have focused on family interventions when the person using drugs is in adolescence or early adulthood. There has been some literature examining effective interventions for families with drug-using adult children or partners (Meyers et al., 2003).

Literature and reflections on clinical practice suggest that family members and significant others vary greatly in their response to drug-related problems and their ability to cope with the effects of drug use on them (Dear, 1994). This means that, although theoretical models of family dynamics and psychopathology are sometimes useful, they may not always be appropriate and that models of stress and coping may also be useful to guide interventions (Orford, 1994).

Alcohol and drug service providers treat a heterogenous group of adults, some with very long-term problematic drug use, who have different levels of relationship to family. There is a need to develop practice guidelines that can meet the range of needs of families.

Developing guidelines for alcohol and drug services

Research and literature on involvement of families in treatment of clients using alcohol and drug services has predominantly focused on family therapy as the mode of intervention. Workers in alcohol and drug services vary in the type of qualifications and experience they possess and some have expressed concern at being required to undertake complex family therapy as a core component of their work.

These guidelines were developed in consultation with alcohol and drug treatment and support service users and providers as part of a project carried out in 2000–1. The project proposal was developed by the Turning Point Alcohol and Drug Centre project team, which included psychologists, social workers, telephone counsellors, alcohol and drug workers, researchers, peer support representatives and nurses. Collaboration with Turning Point and contributions from alcohol and drug practitioners from a range of services (including Community Health Centres, the Salvation Army, Barwon Health Service, Odyssey House, Buoyancy Foundation, St Vincent's

Hospital, Epworth Hospital and Turning Point programs) informed the project. The guidelines have subsequently been updated (May, 2004) to ensure they continue to reflect current practice and include recent developments in family support services. Case examples provided reflect the Victorian focus of this project; however, these guidelines are translatable to all practitioners working throughout Australia.

These guidelines are based on a model of family inclusive practice that incorporates the needs of families and significant others of adults with drug-related problems. It includes:

- principles of family inclusive practice
- standards of family inclusive practice
- a continuum of options for family inclusive practice
- a discussion of professional practice issues

The guidelines outline the range of family inclusive practice interventions that can be utilised by practitioners working in alcohol and drug services. One of these is family therapy but a number of less sophisticated interventions have also been described. Organisations will decide on the level of family inclusive practice they have the resources and skills to undertake.

Definitions

Family

A broad definition of **family** has been developed for use in these guidelines. Individuals describing 'family' may refer to blood relations, partners, people they live with, friends and others who have a significant role in their life.

Family inclusive practice

For the purposes of these guidelines, **family inclusive practice** in alcohol and drug services refers to practice that includes the concept of 'family', although the main focus of the work may be on individual issues. This is further defined in the following sections.

Family inclusive practice describes a model of service delivery that:

- values the importance of families
- includes families in the scope of the work even though the main focus of intervention may be on an individual within the family
- focuses on the range of different ways that families may be involved in the lives of individuals
- empowers families to utilise their own expertise and resources
- can be undertaken by generic workers who are not necessarily trained in family therapy

Consultation with service users and providers

As part of this project, service users were consulted through surveys of clients attending the Turning Point clinic and family members ringing the DirectLine telephone counselling service, and through a focus group with residents at the Bridgehaven residential rehabilitation program. Service provider consultation took place through focus groups with alcohol and drug practitioners from a range of agencies providing services in Victoria and through peer review of the draft guidelines by the field.

The Turning Point 'Families Project' was another important component of this consultation process. This 18 month initiative (1999–2000) utilised an action research approach to the development of family inclusive practice in alcohol and drug treatment. The aim of the project was to enhance Turning Point's ability in responding to the needs of families of adult clients with drug-related problems.

Client views

Client views on family and their involvement in treatment (both residential and non-residential) showed that, while the importance of family to the individual varied, the majority of clients had some contact with their family. Partners, friends, mothers and sisters were ranked by clients as the most important family members in their lives. The majority of clients thought it could be helpful to include family in their treatment; however, caution was expressed around issues of confidentiality, being clear about the nature of family involvement and overcoming past negative experiences. Many service users had family who were involved in their treatment in the past and the experience of this varied, although most described it as positive for both family and client. A range of family needs were identified, including access to counselling, information and referral, the importance of having someone to listen to their story in a non-judgmental manner, the need to 'demystify' their concerns and fears, and assistance in understanding the treatment process.

Service provider attitudes to family

A range of prevailing attitudes to family was identified by practitioners.

- In general terms, the family was often conceptualised as part of the problem. Concepts such as enmeshment, the need for separation/individuation, and lack of boundaries in families were common.
- Those who had worked with families found it satisfying and often got 'results'.
- A phone call from a parent was seen by some as a great point of engagement.
- Services found it more acceptable to work with families when the client was a young person rather than an adult.
- Workers felt that involving families meant having to do 'family therapy' for which they were not qualified.
- There was a general feeling that the onus was on families to determine their needs and shape treatment.
- Practitioners felt that working with individuals who experienced problematic drug use was complex enough and that introducing the concept of family into the work would further complicate the process.
- There was a general sense that new workers in the field would not be confident to see families.
- Most participants felt that support groups for families worked well.
- Individual practitioners with skills and interest in the area have put family work on the agenda of their agencies, but this work had been pursued by a minority of practitioners.
- Most practitioners felt that confidentiality was a major issue.
- Resources required to undertake family work was also raised by practitioners.

Current practice

A review of current practice and identification of constraints to undertaking family work were key aspects of the consultation with service providers, allowing for a clearer picture of the environment in which services were operating. There was a general acknowledgment by the service providers consulted that workers should take all opportunities to enhance the relationship between a client and their family, to increase the client's connectedness. This was seen as being beneficial to their treatment. There was an acknowledgment that everyone involved with clients with drug-related issues gets affected by the downside of drugs and a number of services had been trained in 'Family Sensitive Practice'. Service providers felt that workers were learning about the different ways to invite family involvement and were more open to families than they had been in the past. A range of practices were represented within the focus group, including:

- facilitated groups providing education and support (carried out by most agencies who attended the focus group)
- telephone support to parents (offered by most agencies)
- some agencies had formalised linkages to family therapy services, while others referred families out
- families were being seen on an ad hoc basis by workers with skills and interest in the area

Note: since this project was completed, additional family support services have been developed around the delivery of family-specific alcohol and drug support. Services within this sector work to support and encourage the continued development of family inclusive practice within alcohol and drug treatment services.

Constraints to family inclusive practice

Service providers listed the following constraints to developing or improving family inclusive practice in their services:

- lack of resources to undertake family work (eg time, training, skill development)
- lack of confidence of workers to see families, particularly new workers who are on a steep learning curve
- not having a clear framework to undertake family work
- the need for practical steps to engage families
- the need to clarify the difference between family therapy and family inclusive practice to make the idea of family work less threatening for workers
- concerns about managing confidentiality
- lack of commitment to family work by organisations
- family work not marketed as a valid intervention by services

Note: the nature and extent of constraints to family inclusive practice may have shifted with the development of family-specific services since 2001. Since this project was completed, understanding has grown of the specific (and different) needs of families in supporting a family member with drug-related problems. A lack of knowledge about how to access expertise in this area or lack of government funding to alcohol and drug agencies to provide family support programs may have further constrained the effective delivery of family inclusive practice in some services.

SECTION 1

PRINCIPLES OF APPLICATION

A family inclusive approach to working with clients

Family inclusive organisations believe:

- All family members have needs and rights that should be respected.
- Family members can be an important resource to each other.
- Families go on for ever and services are short-term.
- People carry family with them regardless of their level of current contact.
- Family members have a high level of knowledge about each other.
- Families can change and are often wanting to.
- Involving families in treatment services can lead to better outcomes for individual clients.

Family inclusive organisations develop practices that:

- provide services in respectful ways
- include the family in the scope of their work, even though the main focus may be on an individual within the family
- focus on the range of different ways that family may be involved in clients' lives
- empower families to utilise their own expertise in dealing with difficulties in their own or the client's life
- develop a partnership approach to addressing difficulties
- promote practice that is honest and accountable

Guiding principles for family inclusive practice

Families are valued for their expertise

Families are often considered to be 'problems' in the lives of people who are experiencing difficulties with drug use. While this may be true for some clients, family members have a lot of knowledge about each other that, if harnessed appropriately, can assist in client work.

Strengths, relationships and existing resources within families can be used by services in working with clients with alcohol and drug issues

Services working with clients with drug-related issues often focus on what is not working or on what is absent in families. Looking for strengths and resources within families can often open up alternatives for action and change.

Clients are the best judges of who their family is and the extent to which their family should be involved in treatment

Family inclusive practice acknowledges that family includes any significant person in the client's life. This can include immediate family, partners, friends, work colleagues or anyone else nominated by the client. Services will value whoever the client chooses to involve in their treatment.

Family inclusive practice is a way of thinking. It can occur directly or indirectly

Services operating on family inclusive principles may not directly provide services to families but services will consider the client's family when they are working with clients.

Clients are part of multiple and interconnected systems

Family inclusive practice understands that clients and families operate within wider social and political systems and that these systems have an impact on them.

Family inclusive practice is non-blaming

Family inclusive practice acknowledges that relationships and actions between people have effects on them. It does not seek to apportion blame for past events but endeavours to focus on future actions and relationships.

Family inclusive practice should be located within organisations that value families

Organisations should reflect the importance of family in the lives of clients – in governance, management and service delivery.

Family inclusive organisations attend to the physical environment

Organisations undertaking work with families need to attend to the physical environment of service provision. This includes facilities, privacy, resources for children, and attitudes of staff toward clients and their families.

Staff need to be trained and resourced to work with families

Working with families can involve different activities ranging from having access and knowledge about the importance of family through to undertaking complex family therapy. Staff need to be provided with training commensurate with the level of direct family work they are required to do.

Family inclusive practice acknowledges the possible tensions relating to confidentiality

Services working with adults and adolescents with drug-related issues often face the dilemma of breaching client confidentiality. Client confidentiality will only be breached where there is clear indication that clients pose a safety risk to themselves, others and the community. In family inclusive practice, clients will give their consent to what information they would like family members to have.

Models of family inclusive practice

Stages in the development of family inclusive practice

In developing family inclusive practices, it is acknowledged that alcohol and drug agencies have as their core business the treatment of people with problematic alcohol and drug use. Organisations will vary in the amount of resources they will have available to develop family inclusive practice. Organisations need to assess where they are currently situated on the continuum of family inclusive practice so that they can set priorities for progression through the stages. Figure 1 describes the possible stages involved in developing family inclusive practices. These are outlined below. Where applicable, issues related to their effective delivery are also highlighted.

Stage 1: Being conscious of family

Practitioners consider family when they are working with individual clients with alcohol and drug issues. Workers think about family when they are undertaking assessment and interventions with individual clients. Some workers may see families on an ad hoc basis but do not consider it as part of their core business.

Stage 2: Referral

The organisation has developed procedures for referral of families who want support to family focused services or telephone referral and support in their area. Written information is available for families, and online and hard copy referral information is easily accessible. Organisations utilise existing referral databases (where available) and contact family support services in their state. Workers may see families on an ad hoc basis but will have knowledge and resources about self-help groups and other supports for families that they will actively use.

Issue: More resources are required in administration and worker time to access or compile information.

Stage 3: Organisational development

The concept of working with families is reflected in the organisation's mission, vision and policies and procedures. Organisations at Stage 3 will make a conscious commitment to developing family inclusive practice. Organisations may establish a subcommittee of managers and staff to review their current procedural and governance materials to see how well these reflect family. Collaboration with existing family support services encourages ongoing organisational and staff development in this area and informs new opportunities for the involvement of families in alcohol and drug treatment.

Workers will be seeing families on an 'as needs' basis, providing referral and information to families, and may look at establishing a facilitated support group for families of clients.

Issue: Commitment by management is required to support the process of reviewing procedural and governance materials and for staff to begin to deliver direct services, such as groups.

Stage 4: Implementation plan

Management supports the adoption of family inclusive practice in the organisation and develops an implementation plan.

Stage 5: Family program

Existing staff are provided with training in family inclusive practice. An active policy of recruiting staff who are committed to the notion of including family in alcohol and drug services is followed. This is reflected in position descriptions and key selection criteria. Policies are developed that address confidentiality and record keeping in family inclusive practice. Data recording and information collection processes are developed. A family program is developed that includes a range of service options including counselling, group work and family work.

Issue: The allocation of significant additional resources is required for this stage to be implemented effectively, especially in areas such as organisational development, staff training and direct service provision.

Stage 6: Evaluation and review

Evaluation and review should address:

- ongoing training and staff recruitment
- collaboration and networking with other family support services
- evaluation of the impact of family inclusive practice on clients or organisation
- continuing practice development

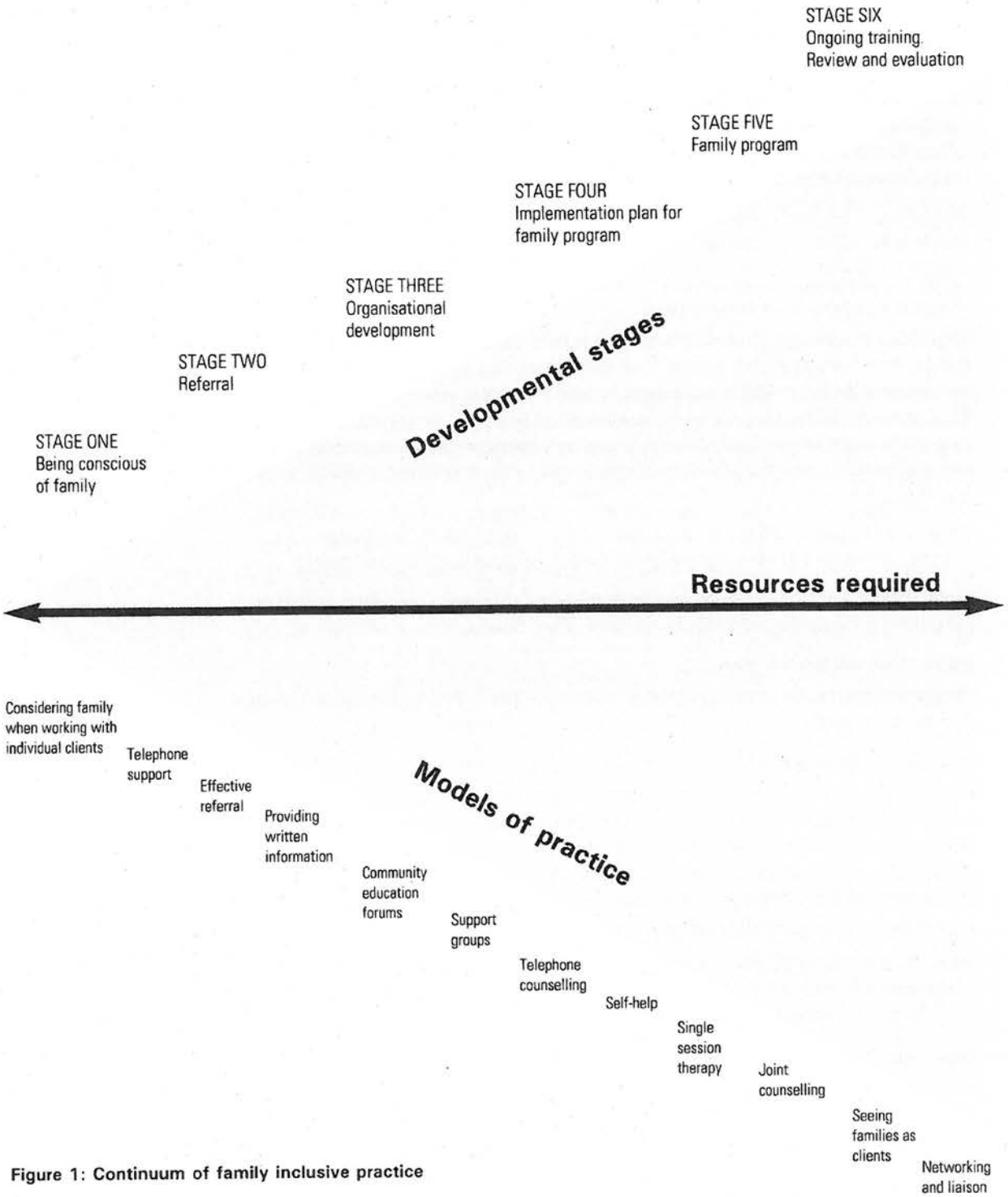


Figure 1: Continuum of family inclusive practice

Practice issues

Confidentiality

Organisations working with adults with drug-related issues will be assumed to have policies and procedures in place to address client confidentiality. When working with more than one family member, practitioners often face the dilemma of breaching client confidentiality. This particularly occurs when family members contact the organisation seeking information about whether the client is attending appointments, is still using drugs and/or where they are living.

Families may seek this information for a range of reasons. They may be anxious and worried or they may be wanting to 'catch clients out' or to gather evidence to support actions they may be contemplating.

Family inclusive practice supports the rights of all clients to a confidential service. It is the right of the client to determine to whom they or others disclose details of their treatment. No information regarding a person's treatment will be given without the client's explicit consent.

Confidentiality will only be breached where there is clear risk of harm to the client or to others. This will include circumstances where clients are suicidal or whose behaviour is potentially life threatening, where children or young people are at risk of harm, or where there are significant threats to harm others. Decisions to breach confidentiality will be made following consultation with a senior clinician in the service.

Organisations will outline their confidentiality policy to all clients attending the service and this will include information on the limits of confidentiality. Organisations will ensure that they:

- have prior agreement with the client and informed consent before releasing any information regarding treatment
- have a signed release of information form from the client
- check after each consultation whether the client continues to agree to have information passed on
- clarify with the client the purpose and types of case records and what happens to them
- do not disclose to a family member details of a client's treatment without consent. In some cases, a worker may want to give family members general information about the types of services offered to clients without identifying that the client is a user of the service
- do not tell family members whether the client is attending the service without prior client consent

Where family members of clients attending the service are seen either with or without the client, a separate file will be established for the family member or separate intake and case record forms will be included in the client's file. In the case of two separate files, a cross-reference code will be established between the two files.

When undertaking joint work with clients and family members, practitioners will establish confidentiality guidelines for this work in conjunction with both parties prior to commencing. Practitioners will take reasonable steps to ensure that information disclosed by them in joint work is shared knowledge; however, it is recognised that from time to time workers might not be clear where information they hold has come from. If in doubt, a reasonable question to be asked of both client and family member is:

Is it OK if we talk about this here?

Both parties should be respected if they decide they do not want to talk about a particular issue.

In some circumstances, it might be more appropriate for different practitioners to work with the client and family member. Each practitioner will maintain their own client's confidentiality unless there are circumstances (as mentioned earlier) that warrant a breach.

If a family member requests a service from the organisation but the client is not wanting this to occur and will cease contact if this service is offered, the family member will be actively referred to another service to assist them with their issues.

A general discussion of confidentiality and other areas of professional ethics within clinical practice can be found in *Clinical Treatment Guidelines – Key Principles and Practices.*

Supporting clients as parents

Adults attending alcohol and drug treatment services may be parents of young children or adolescents. Clinicians may identify the need to provide support and information to clients who are parents. While most alcohol and drug treatment agencies are not funded to deliver parenting support services, organisations may consider developing responses to the needs of clients and their children as a form of family inclusive practice. These might include:

- referral to specialist parenting or family support programs
- attention to child safety issues within the physical environment of the agency
- provision of 'child-friendly' areas within the clinic, including toys and resources for children, posters and other aids to establish a welcoming and age-appropriate environment
- provision of information on a range of welfare, child care and family recreation services available in the local area

The effects of drug use can impact significantly on the ability of parents to care for their children. Referral to specialist parenting programs or family therapy services can provide clients who are parents with support in areas such as parenting skills and information, validation, counselling and respite.

Parent support programs are being developed within the alcohol and drug sector as early intervention strategies with the aim of acknowledging and minimising the impact of parental drug use on children and other family members. Early research is also underway into identifying and responding to the specific needs of 0–4 year old children of drug users as a prevention strategy against future alcohol and drug use. For more information and research results as they become available, refer to the DrugInfo Clearinghouse (Australian Drug Foundation) at http://www.druginfo.adf.org.au

Child protection

While some workers in alcohol and drug treatment services (eg doctors, nurses, teachers) are mandated to report suspicions of child abuse and neglect to the Department of Human Services, many are not. Although services have the adult client as their primary focus, practitioners should keep the needs and rights of children in their minds throughout their contact with clients. Safety issues for children can arise quickly when individuals (either their parents or other people they are exposed to) are affected by alcohol and drug use. This can include exposure to violence, exposure to known perpetrators of sexual abuse, exposure to criminal activities or being left in the care of unsuitable carers.

Practitioners in the alcohol and drug field are well placed to receive information that might impact on the safety of children, and have a responsibility to respond. They do not have to make the assessment but should notify on the basis of reasonable suspicion and concern. Organisations should have policies and procedures in place to assist practitioners in responding to suspicions of child abuse and neglect. These will include access to immediate supervision from an experienced practitioner, knowledge of what constitutes risk, knowledge of the child protection system, and training in how to discuss concerns about safety with clients. The Department of Human Services Victorian Risk Framework outlines risk assessment processes that can be used by practitioners in assessing potential for risk or harm. This is available through the Commmunity Care Division of the Department of Human Services website, which is at http://www.dhs.vic.gov.au

Organisational capacity

Deciding to embark on family inclusive practice will have a significant impact on the organisation's resources and this impact will need to be considered when deciding to develop these practices. It is acknowledged that resources will be required to train and support practitioners, to develop and implement data recording systems, and in additional time to provide direct service to families. Alcohol and drug treatment agencies may not be funded to provide family support services.

If involving family in the organisation's work is seen as an onerous extra task for practitioners, it is unlikely that they will embrace the idea. Resource constraints might result in services deciding to implement family inclusive practice in phases over time. Including this in the organisation's strategic plans will ensure the issue remains on the agenda. Organisations may collaborate with existing family-specific services providing alcohol and drug related support in their area in delivering interventions to families.

Support structures to assist in the process include:

- clear roles and responsibilities
- clear and accessible policies and procedures
- supervision and debriefing
- skills for managing conflict and decision making
- staff development and training
- confidentiality

SECTION 2

PRACTICE GUIDELINES

Strategies for engaging families

General approach

Engaging families in the work of alcohol and drug organisations is no different to engaging families in any service system. Families who self-refer or contact the service directly are likely to be easy to engage. This process may be more difficult when services are wanting to engage families who are not already involved.

The crucial key to any engagement is listening to and not blaming or judging families who contact the service. If families contact the service but the service is not able to provide them with what they want, the family should be actively supported to obtain a resource or service elsewhere. Many clients get referred to multiple services because time is not taken to listen or to pro-actively support referral to the most appropriate service.

Families are often unclear what sort of service they actually are wanting. People who have not had counselling seldom know what this might involve and can feel threatened and frightened by the notion. Explaining what service you offer in simple terms makes a big difference to engagement, as can be seen from the following example:

Would you like counselling? (less engaging)

Would you like to speak to someone who knows a little bit about these difficulties? (more engaging)

There are a number of strategies that services can utilise to assist in engaging families. These include:

- providing a range of service options for families to choose from
- being active in engagement (following up with phone calls and letters)
- not giving up easily
- delivering flexible services that are not constrained by targets, funding and geographical areas (if you need to get the map out to see if a client is in your catchment, this is likely to be unengaging)
- being flexible about where you see families (homes, other services etc)
- acknowledging family members' expertise in their own lives and working in partnership with them to achieve outcomes
- making sure that the family's highest need is the one addressed first
- being responsive to crisis
- ensuring that the resource or service offered is what the family wants (don't refer a family to a self-help group when they have said they want counselling)
- presenting clear information
- ensuring that promises and commitments are met
- promoting competency based conversations

Competency based approaches

'Competency based' approaches have developed from the work of narrative therapists (White, 1989; Epston & White, 1989) and solution focused therapists (de Shazer, 1988; O'Hanlon & Wiener Davis, 1989).

These approaches attempt to deconstruct the strong cultural beliefs and deterministic ways of thinking about the lives of marginalised families and individuals. They promote new or different stories that are more in line with what families want for themselves and less tied up in cultural assumptions about what 'these people' will do or can expect from their lives.

Workers can become overwhelmed at the task of making a difference in a family that has been dominated by problems for years and, often, generations. In approaching families from a solution focus rather than a deficit or problem focus, a new range of possibilities is created. Rather than looking at the causes of problems, these approaches look at the effects of problems on the lives of people and on the times in their life (exceptions) when these problems have been less present or not present. Changing the focus of conversation from negative or problem saturated can open up opportunities for the family and the counsellor to bring energy into new or different stories about the lives of people.

The different approaches to working with families are outlined below. This comparison is helpful to workers in understanding the distinction between problem focused and solution focused conversations and their consequences.

CONSTRAINING BELIEFS	**CREATIVE BELIEFS**
Workers hold 'expert' knowledge about clients' lives	Clients hold expert knowledge about their lives
Clients are viewed as 'damaged' by problems	Clients struggle with the effects of problems
Working from a deficit model which seeks to 'fix' people	Resource model which builds on the resources of the client
Solutions will only be found with 'expert' assistance	Clients view themselves as having some control over problems
Professionals hold the key to change	Clients hold the key to change
Clients are resistant to change	Clients are real partners in the work

Leads to conversations

PROBLEM TALK	**SOLUTION TALK**
Lengthy description of the problem and past problems	Description of goals, exceptions to the problem, and forward progress made
Focus on other handicaps and deficits	Explores a competency history
Focus on the negative consequences of problems	Focus on resources, strengths and abilities
Involves diagnostic labelling	Explores the learning and growth from experience
Focus on previous unsuccessful attempted solutions to the problem	Involves creative naming of problems
Seeks explanations or causes of the problem	Focus on previous successful solutions to problems
	Seeks explanations of past exceptions and potential future progress

Promoting competency based conversations

Competency based approaches focus on individuals' strengths and competencies that are viewed as the keys to effective change in their lives. The approaches are designed to enable people, and to open up creative options for choice and change.

The following ideas can be helpful for workers in developing competency based conversations. They are broadly described as solution focused ideas.

- Solutions/exceptions, like changes (and problems), are always occurring.
- Never miss one (it is easier to build on one that is occurring than to search for a new one).
- If it works, do more of it.
- If it doesn't work, stop doing it – do something different.
- If it isn't broken, don't fix it.
- If you look for an exception you think should be occurring, you may miss one that is.
- Use small solutions to build larger more comprehensive ones.
- If a solution is random, help it to become more deliberate.
- Goals are easier to work on if they are concrete, realistic, simple, measurable and achievable.
- Big goals can be broken down into small steps – do the easiest step first.
- Solution focused ideas are not only a way of working, they are a way of thinking.
- Clients' views of the problem are generally accepted and conversations are oriented to helping them achieve their goals.
- Support and encouragement is helpful in finding solutions but attention needs to be given to what needs to happen to keep solutions going and build on them.

Developing family inclusive interventions

Having decided to implement family inclusive practice, organisations must decide on what types of interventions they want to develop. A number of interventions may be implemented at the same time; however, these should be managed as part of a coordinated treatment or counselling plan. The range of interventions listed on the following pages is not exhaustive but gives a number of options along the family inclusive practice continuum, each requiring differing levels of resources to implement. Not all of these interventions may be funded as part of the alcohol and drug treatment service system.

Intervention 1: Considering families when working with clients

Practitioners may not be directly working with family members but are conscious of the presence of family in the client's life. This can assist practitioners to develop creative or different options for change and broaden their thinking away from an individual focus.

While there has been acknowledgment of 'family' in work undertaken in the alcohol and drug field, the prevailing belief has been that problems experienced by clients are related to complex family dynamics and issues of separation and individuation. Family has not always been seen as helpful in addressing individual client's difficulties. While this may be true in some cases, this belief can constrain practitioners from maximising potential strengths and resources in families, and overlook the potentially positive influence that families can play.

Research has indicated that involvement of family members in work undertaken with clients with drug-related issues results in better outcomes for the client.

Practice guidelines

At the point of first contact with a client, practitioners ask clients questions that relate to family and significant others. It is 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 to ask could include:

- Who is important in your life at this moment?
- How do they support you?
- Do they know that you are 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.)

It is the practitioner's role to keep the concept of family alive in all ongoing client work. The role of family can change over time and, while clients may initially not wish family to be involved in their treatment, this can be subject to change. In order to do this, practitioners continue to ask questions that are inclusive of family to ensure that the client is understood within the broader context of family and community.

When working with individual clients, genograms may assist practitioners to explore and conceptualise family relationships and potential alliances that could be developed to address drug-related issues. This can include talking about and defining the role of family in the development of treatment plans with clients.

Documentation

Information about family relationships is documented on the client's file. At this stage, a genogram might be drawn for the practitioner's purpose to give them a visual record of the client's family for use in future work. Genograms at this stage of involvement are used as a descriptive tool and not used to describe family dynamics.

Please refer to *Clinical Resource 1: Genograms*.

Case example

John is a 30 year old man attending a methadone program. He has been involved in the agency in the past but hasn't really wanted to discuss his drug use with a counsellor. On this occasion, he has requested an appointment with a counsellor.

John's assessment notes indicate that he has a hostile relationship with his immediate family and has little contact with them. On this visit, the counsellor decides to explore John's family with him again. John initially states that he has no contact with anyone and hasn't seen his family for 12 months. On further questioning, using a genogram, the counsellor asks more specific questions about what no contact meant.

John reveals that he has spoken to his paternal uncle several times in the last few months. When John was an adolescent, he and his uncle had shared an interest in football and, although he has not seen him for over a year, the phone contact has always been positive.

From this information, the counsellor can explore how John's relationship with his uncle may be utilised in the therapeutic work. It may also help John to challenge his belief that he has no positive contact with any family member and it may assist him to consider them differently in his life.

Intervention 2: Telephone support to families

Telephone support to 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.

Telephone support is often the first point of contact that family members make with an organisation. It can be anonymous and caters well to people who are working or people who find the notion of counselling and other interventions threatening. Telephone support enables family members to control the amount of support they require from the organisation. If handled well at this point, telephone support can also assist family members in dealing with the client.

Practice guidelines

Family members ringing the alcohol and drug service are provided with support over the phone.

Family members are informed of the general agency policy of the right of all clients to confidentiality and the service's inability to comment on an individual's involvement with the service.

Families are acknowledged for their own concerns and, if phone contact has been helpful to them, they will be encouraged to use this again in the future or they may be referred to another service.

Practitioners providing telephone support to families use a range of interventions and strategies including:

- providing information on drugs
- providing information on treatment services
- providing referral information
- crisis intervention

- problem solving
- support
- validating concerns

Family-specific telephone support services are available in some states of Australia. Practitioners can support families who contact their alcohol and drug service by informing themselves about family-specific services and making families aware of those that are available in their area.

Please refer to *Clinical Resource 6: Contacts*.

Documentation

Data is collected on family members receiving telephone support. Data collected may include identifying information (if provided), relationship to the person with problematic drug use, the types of information they are seeking, and outcome of the call.

Please refer to *Clinical Resource 2: Consultancy Form*.

Case example

John's cousin Robert rings the service seeking information about methadone. He explains that he is planning a fishing trip with his cousin and is concerned about the fact that he is on methadone. He wants to know what he should be aware of, what to expect in his cousin's behaviour, and whether or not it is safe for him to go away for a weekend. The worker tells Robert that, while they are unable to give out personal information about any clients, they are able to provide general information about methadone treatment and what is involved. The information is provided and Robert is encouraged to provide support to his cousin.

Intervention 3: Effective referral of families to other support services

Organisations 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 Help in Victoria – see *Clinical Resource 6: Contacts* for services in other states), support groups, 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 service 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 from problematic alcohol and drug use.

Practice guidelines

Organisations ensure that the capacity for effective referral is established and maintained within their service.

- A wide range of online and printed referral information is easily accessible across Australia. Organisations are encouraged to utilise existing databases and telephone referral services or contact family support services in their area. Where no such information or support is available, the organisation may need to resource the development of its own database and/or resources.

- Material is accessible to all staff and updated/reviewed at least six monthly.
- Organisation has made direct contact with services or people to ensure that they are clear about the referral processes, referral criteria, the type of service they offer, the length of service and the costs. This information is easily accessible to staff.
- When referring on, practitioners assess whether the family members' needs will best be met through an alcohol and drug service or whether their issues may be better dealt with through other specialist services.

Organisations may choose to develop a system of active referral. Many people are anxious about self-referring and do not end up following up with a service. Active referral includes supporting family members to contact another service, following up to see if they have made the referral, and/or referring on behalf of the family member if they want this. A useful question to ask family members might be:

What might you need in order to feel OK about contacting this service?

Documentation

Data is collected on family members referred to other services for support. Data collected may include identifying information (if provided), relationship to the person with problematic drug use, the types of information they are seeking, and outcome of the contact.

Please refer to *Clinical Resource 2: Consultancy Form* and *Clinical Resource 6: Contacts*.

Case example

John's mother, Jane, rings the service. She explains to the worker that she has a son that she thinks might be attending the methadone program but she has not seen him for months. Jane is distressed on the phone and angry that the service will not give her information about her son. She explains that her husband was an alcoholic who died of liver cancer and she can't cope with her son's addiction. After listening to Jane's story, the worker asks if she would like someone to talk to. Jane is reluctant to talk to someone as her past experiences of joint counselling with John had left her feeling blamed for his addiction.

The worker talks about the possible service options available and what she might expect from each of them. Jane thinks counselling might be helpful for her on her own. The worker asks Jane if she would feel confident to make the call to a local Community Health Centre herself or if she would like assistance. Jane agrees to ring herself. The worker asks Jane if it would be OK to contact her next week to see how she went. The worker makes a note in her diary to call at a time agreed to talk with Jane.

Intervention 4: Provision of written alcohol and drug information to families

There is a substantial amount of written information on drug use that is available in the community. This information can be helpful for families in understanding the facts about and treatment options for drug use.

Family members often have very poor knowledge of drug use and its physical, psychological, social and cognitive impact on those using. They often lack knowledge of the treatment system and of services available for clients and themselves. They have little information about the withdrawal

process, and the change process as it relates to those with drug-related difficulties. This is often confounded by media stories that can scare and frighten family members, or make them overoptimistic of new cures and treatments. Realistic information can assist family members to understand what the client is experiencing, and can reduce anxiety or give them a clear base from where to take action.

Adults learn and absorb information in different ways. Written information can be extremely helpful for some family members in making them feel supported and included in the work that the client is undertaking. A wide range of information is available online through services like the DrugInfo Clearinghouse (Australian Drug Foundation). See *Clinical Resource 6: Contacts* for more information.

Practice guidelines

Practitioners are aware of existing resources and support services that are available for families and of their organisation's referral procedures. Organisations have resources that can be provided to families (such as links to suitable websites or fact sheets on drug use, withdrawal, alcohol and drug services, parenting support and education, or other relevant issues). In Victoria, Family Drug Help has devised a family information kit (and protocol for its use) for distribution by alcohol and drug services. This kit includes the booklet: *Is someone you care about using drugs?*

Material is presented to families relative to their level of comprehension and understanding, and acknowledges that family members differ in the amount of information that they might find helpful. It may be helpful to ask: *'Are you comfortable with written information or is there another way we can provide you with this information?'* or *'Do you like reading or is it a bit of a chore?'* or *'Are you much of a reader or isn't it your thing?'*

Accessibility, acuracy and relevance of material is considered.

- Materials are provided in a range of languages to assist families of clients from other cultural groups.
- Where families do not speak or read English, they are supported to access this material through interpreting services.
- Systems are in place within the organisation to ensure that information for families is up to date and relevant.

Documentation

Records are kept on what information is provided to whom.

Please refer to *Clinical Resource 2: Consultancy Form* and *Clinical Resource 6: Contacts*.

Case example

John's cousin Robert rings back and requests some general written information on methadone programs. A fact sheet is sent out to him, which includes the website address for the DrugInfo Clearinghouse (for online drug information about methadone) and contact numbers for 24-hour telephone information and referral services (such as DirectLine and Family Drug Helpline).

Intervention 5: Provision of 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 drugs, the impact of drug use on clients and families, and the resources available. Information is available at these forums on specific services that families may choose to refer themselves to. There may be a series of community education forums held throughout the year on a range of different topics. Forums are held during the day or after hours depending on the target audience.

Community education forums can provide a safe place for family members to access information about drug use and its effects. They provide a level of anonymity for some family members who may feel embarrassed, guilty or anxious about direct contact with an agency. They are forums where questions can be asked and responded to by skilled and experienced practitioners, family members who have lived with a drug-dependent person and even people who are/were drug dependent. Family members can gain information from others present about the resources and supports available in the wider community. These forums can help demystify drugs.

Practice guidelines

Priority is given within the organisation for running community education forums.

Collaboration and networks are used in developing and running forums (eg Family Drug Help in Victoria provides advice and information about working with families).

A community education forum is organised.

- Speakers from local family services and alcohol and drug services are invited to present at the forum. This may include a mix of professionals and those with lived experience.
- A community venue is booked.
- Forums are advertised in local media/press and to local agencies in the two weeks leading up to the forum.
- Forum content is developed.
- Interpreters are booked depending on community need.
- Catering is organised.
- Written materials are available for participants.
- Feedback forms are developed.
- Session held.
- Feedback collated.

Documentation

A Community Education Forum Record is completed which details the date of the forum, the content, the location and the number of participants, and outlines a summary of the feedback. An attendance form is completed by those participants who feel comfortable to do so.

Please refer to *Clinical Resource 3: Community Education Forum Record* and *Clinical Resource 6: Contacts – Interpreting and translation services.*

Case example

A representative of the Vietnamese Welfare Association contacts the agency to discuss their increasing concern about the impact of drug use on young people in their community. After further discussion, it is decided that a community education forum might be helpful. A reference group is formed with key stakeholders and details of the session are planned. The session is conducted in conjunction with the Vietnamese Welfare Association.

Intervention 6: Establishment of facilitated support groups for families

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

All policies and procedures of the organisation cover family members attending support groups. These include their rights to privacy and confidentiality, their rights to safety, their rights to complain and their rights to feedback.

Facilitated support groups can provide a safe place for family members to access information about drug use and its effects. They can provide a supportive and safe environment to enable participants to normalise reactions, decrease feelings of isolation, and increase feelings of competence in relation to the client's drug use. They provide a forum where questions can be asked and responded to by skilled and experienced practitioners, and family members can gain information from others present about the resources and supports available in the wider community.

Practice guidelines

A needs analysis of family members is conducted to establish whether there is enough interest to establish a facilitated support group.

Organisation auspices the development and facilitation of family support group.

- A decision is made about the focus of the group and length of time it will run (eg will it be an eight week skills-based group focusing on coping strategies or an ongoing support group?)
- A decision is made on whether to run the group onsite or in a community venue (taking into account accessibility, environment, time of day and childcare needs).
- Facilitated support groups are advertised to families either directly, through mail out or by phone contact (depending on the family member's relationship to the service).
- Prior to group commencement, all applicants are interviewed by the group facilitator to establish whether their needs will best be met through this type of activity. The issues of confidentiality and emotional safety are discussed with potential participants.
- Link group with family focused services as available (eg Family Drug Help in Victoria).

- Family members who are accepted into the group are registered as clients of the service. They are given written information on what data will be collected, for what purpose, and how they can access this if they choose.
- Group facilitators prepare an outline of each group session that guides the content of the group. Support groups are flexible to ensure that the needs of family members are addressed but some focus is given to assist with containment. Potential session topics may include: drug information, information on services and treatment options, harm minimisation, communication, crisis management, financial advice, boundary setting, self-care and stress management.
- At the commencement of the first session, group rules are established. Facilitators guide these to some degree but group rules are best established, and more likely to be adhered to, if families develop these themselves.
- Goals for each group member are established.
- Group members decide whether they want the group to remain closed or whether new members can join in over time. (As a guide, the shorter the duration of the group the more likely it is to be closed).
- If participants are distressed during or following group, facilitators are responsible for ensuring that they feel safe and supported before leaving, and that referrals are made for further support if appropriate.

Documentation

Each family member attending the group is registered as a client of the service and each contact is recorded. Individual participants' goals are recorded on their files and form part of the individual treatment plan. Attendance records and brief notes are completed following each session and are included on family members' case files.

A Group Record will be completed by the group leader after each session. Information on date, venue, attendance, topics and issues raised will be collected.

Please refer to *Clinical Resource 4: Group Record.*

At the completion of the group, feedback is sought from family members in relation to their individual identified goals. This is incorporated into the design and development of subsequent groups.

Files are closed on participants who will no longer be having direct contact with the service, in accordance with service guidelines.

Case example

In the team meeting, a family member's need for a group on self-care when living with someone with a drug use issue is identified.

Two clinicians agree to develop a group that will address self-care and coping strategies in relation to drug use and its effects. This will be a skills-based group, will run for eight weeks and will have closed membership after the second week.

The clinicians contact Family Drug Help for advice and information resources.

Intervention 7: Self-help groups

Peer support (self-help) groups for families whose relative has problems with drug use are usually developed in partnership with alcohol and drug services. They aim to develop mutual support and information opportunities for friends and families of those using drugs. Establishment of peer support 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. It may also involve the provision of meeting space.

While self-help groups require support from services, it is important that these groups steer their own direction and participants have a sense of ownership. Family focused services (such as Family Drug Help in Victoria) can provide ongoing support, information and resources to self-help groups.

Peer support groups offer families the opportunity to meet with other people whose circumstances are similar to their own. They can gain support from hearing strategies that others have used in dealing with difficult issues, and can provide a venue for their issues to be heard as often as they need to be. They can increase people's sense of connectedness and reduce the isolation that living with complex difficulties can cause.

Practice guidelines

A needs analysis of family members is conducted to establish whether there is enough interest to establish a self-help group.

Organisation decides to provide support to develop a self-help group. Organisers:

- Arrange a venue for the group to meet in.
- Invite interested family members to attend an initial information forum.
- Advertise the initial forum through the local media.
- Link group into family focused services, if available, which provide specific support to self-help groups (see *Clinical Resource 6: Contacts*).
- Assist the group to develop group rules and objectives.
- Provide information on chairing and leadership of groups.
- Provide information on process recording.
- Assist the group to develop safety plans if issues arise that cannot comfortably be addressed in the self-help group, including access to individual support for group members where necessary.
- Appoint a liaison person from your organisation who will attend the self-help group until participants feel comfortable to run the groups on their own.
- Appoint an ongoing resource or liaison person for the group who will provide information and support over time, or link the group to existing specialised services (such as the Family Drug Help mutual support network in Victoria).
- Monitor progress.

Documentation

For the purpose of evaluation, a Group Record is completed by the group leader after each session. Information on date, venue, number of participants and issues raised will be collected. This information will be given to the liaison person from the agency on a regular basis. On a six monthly basis, a feedback form will be given out to participants. The feedback will be analysed and reported on to inform the ongoing development of self-help groups for families. The agency liaison person will record the hours that they have spent supporting the group.

Please refer to *Clinical Resource 4: Group Record.*

Case example

Following community consultation in 1999, the City of Port Phillip engaged Crossroads and Turning Point to look at the support needs of families and friends affected by drug use. In consultation with Turning Point and Crossroads, a Support for Families and Friends project was developed to provide support and information to enable people to respond more effectively to drug use in their family and to provide family members and friends with an opportunity to share their experiences in a safe environment without shame or judgement.

The aims of the project were to:

- assist with the development of ongoing and sustainable mutual support and information opportunities for friends and families of those using drugs
- reduce the shame and fear associated with disclosing drug use in the family and offer assistance when needed
- enable the City of Port Phillip to better address the needs of these families in complement with other family support services
- raise awareness, and provide useful information about a pressing social problem and help for families to support the drug user
- allow those who need the opportunity to share pent-up feelings and concerns to do so in an empathetic community environment

Two forums were organised to explore the support needs of local people affected by a friend's or family member's drug use, and the forums were publicised in the local media and through relevant health and welfare services.

Having been presented with a number of options, forum participants opted for the establishment of regular support groups that provided information through an invited speaker, followed by open discussion. By asking participants to determine the group's meeting location, frequency, time and day of the week, the organisers were seeking to impart ownership of the project to potential group members at the project's initial stages.

The initial forums were held in May 2000, and the support group formed from these forums continues to meet on a regular basis with assistance from Family Drug Help. Group members have taken on active roles, with professional involvement reducing over time.

Intervention 8: Telephone counselling

Telephone counselling is similar to telephone contact with family members as described in Intervention 2. However, 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 (see Intervention 9) can be useful in telephone counselling.

Family members who are not able to attend directly or who are not comfortable with direct contact with counselling services can find the anonymity of telephone counselling helpful. Telephone counselling is usually less intensive and ongoing than direct counselling, and can mean a greater number of families are supported.

A limitation of telephone counselling is that it is not always possible to ensure that the same counsellor is available each time a family member calls. This can be minimised if telephone counsellors book in times for family members to call back.

Services such as DirectLine and Family Drug Helpline in Victoria also provide 24-hour telephone counselling and referral. See *Clinical Resource 6: Contacts* for details of these and similar services in other states.

Practice guidelines

Practitioners providing telephone counselling provide families with a range of interventions and supports including:

- information on drugs
- information on treatment services
- referral information
- crisis intervention
- problem solving
- discussion of self-care and family member's own needs
- discussion of fears of drugs
- discussion of responsibility issues
- discussion of attribution of blame for drug use (ie guilt)
- understanding drug use (eg positive functions, their own drug use)
- supportive counselling regarding distress
- setting limits on user's behaviour
- conflict resolution
- communication strategies
- information about strategies for taking the focus off drugs and onto other aspects of life

Documentation

Data is collected on family members receiving telephone counselling. Data collected may include identifying information (if provided), relationship to the person with problematic drug use, the types of information they are seeking, and outcome of the contact.

Please refer to *Clinical Resource 2: Consultancy Form* and *Clinical Resource 6: Contacts*.

Case example

The worker who had spoken to Jane the previous week recontacts her to see whether she has had success in following up with individual support. Jane has rung the service and has been placed on an eight week waiting list. She still sounds distressed and angry and is feeling like she can't cope. She has not been to work for the past 10 days and is worried she'll lose her job.

The worker suggests that she might be able to give her some telephone counselling and explains that this will involve booking in some regular times over the next few weeks when they will have space and time to talk. Jane thinks that this is a good idea and they spend some time establishing what she would like to talk about in counselling.

Having explored the influence of her son's drug use on her life, some questions to ask Jane might include:

- How is it that you have been able to take action to seek support at this time?
- What does this tell you about your ability to take action in your life?
- Have there been other occasions in your life when you have taken action on problems?
- What sorts of things were helpful for you at that time?

(These questions assist in building up Jane's view of herself as resourceful and competent, which can reduce the impact of her feelings of not coping.)

The worker might end the conversation with a request that Jane notice the things she does in the next week that might add to her story of competence. They make a time for a further session in a weeks time.

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 is 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.

Although single session therapy can be economical for organisations facing resource constraints, it is a valid intervention in its own right and may be one of a range of interventions that counselling services provide.

Single session therapy provides a framework for counsellors to prepare for each counselling session as if it were the only one they will have with the client or family. This focuses the counsellor to look for constructive outcomes and maximises the potential for the client's own resources to be mobilised (Hoyt et al., 1992).

Single session therapy lends itself well to use in alcohol and drug services where families are predominantly seen as the secondary client of the service. Single session therapy can include the client and family members or can be undertaken with the family on their own.

Single session therapy can be provided in an opportunistic manner that can ensure that motivation and readiness for change are maximised.

Practice guidelines

Staff are trained in single session therapy.

Single session therapy is undertaken in three discrete phases:

- **Intake:** The family completes an intake questionnaire aimed at focusing their thinking on the problem to be addressed, on existing resources or strengths, and on change that has already occurred.
- **Counselling session:** The family is offered a session, ideally conducted with two counsellors, that goes for approximately 90 minutes. The elements of the session include: setting a context, finding a focus, investigating attempted solutions, investigating constraints, reflection, client feedback, addressing last minute issues and discussing where to from here.
- **Follow-up:** The family is followed up by phone/letter three weeks after the session to see how things are going. At this point, another single session might be offered or the family may be booked in for more intensive therapy. Families who have made the changes they were seeking may not require any further intervention at this point and their files will be closed.

Documentation

Families attending the service are registered as a client of the service. Treatment goals are established with the family, and a plan to meet these goals is drawn up.

Services open a separate case file for the family, which would include established treatment goals and notes of contacts with family. In cases of joint counselling, services may choose to copy two sets of notes: one for the individual client file and one for the family file. Alternatively, some services may choose to use the one file.

Please refer to *Clinical Resource 5: Family Intervention Form.*

Case example

John and his mother, Jane, have initiated some contact with each other while Jane has been having telephone counselling and John has been attending individual counselling. Jane lets John know that she has been using this service, and they begin to think about the idea of joint counselling. John asks his counsellor for a joint appointment with his mother.

The joint counselling session is held and the following questions were some of those asked:

- What would each of you like to get out of this session?
- If this session was over and you found it to be useful, what would be different/happening?
- How is it that the two of you have been able to come together today?
- What does it say about your relationship?
- What has been the influence of drug taking on your relationship?
- Have there been times when this influence has been less powerful?

Intervention 10: Providing counselling to families – individual and joint

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

The issues that clients with drug-related problems 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 of an alcohol and drug 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.

Family members are in the client's life on an ongoing basis whereas counsellors and services are not. Mobilising family members' strengths, resources and supports can provide a resource to clients that is available on an ongoing basis and not limited to the counselling relationship.

Involving family members in clients' counselling can also support family members. They can feel informed, important, and it can reduce feelings of guilt and anxiety.

Counselling principles and practice are further discussed in *Clinical Treatment Guidelines – Key Principles and Practices.*

Practice guidelines

Organisations providing counselling support to individual clients with alcohol and drug problems have practitioners trained in a range of counselling modalities. These may include cognitive behavioural therapy, rational emotive therapy, psychodynamic and psychoanalytic therapy, humanistic psychotherapy, behavioural therapy, solution focused therapy, narrative therapy, mediation and relationship counselling.

Some of these modes of therapy are not adaptable for joint or family work but the majority have been adapted for use in family or relationship counselling.

Practitioners who are not experienced in family work can lack confidence in dealing with competing demands of working with more than one family member at a time. If this is the case, practitioners should be offered training in a suitable counselling style before attempting joint work. These include:

- mediation
- solution focused therapy
- narrative therapy
- relationship counselling
- single session therapy

Practitioners may sit in on joint sessions with a more experienced counsellor as a direct way of increasing their skills and confidence in undertaking this work.

Confidentiality is also an important issue for practitioners undertaking counselling with more than one family member. The issue of confidentiality is discussed in section 2 of these guidelines.

After discussions with all family members, a decision is made about whether there is some value in family members being seen independently of the person with the drug-related issue prior to proceeding with joint counselling. The interests of all family members should be considered at this time.

Separate counselling for family members may occur when there is a high level of hostility between family members that may impact negatively on individuals. Separate counselling can provide:

- an opportunity to vent feelings
- education about the impact of drugs
- an opportunity to explore the impact of the current drug and alcohol issues on their own issues (family of origin)
- preparation for joint session

Documentation

Families attending the service are registered as a client of the service. Treatment goals are established with the family, and a plan to meet these goals is drawn up.

Services open a separate case file for the family, which would include established treatment goals and notes of contacts with family. In cases of joint counselling, services may choose to copy two sets of notes: one for the individual client file and one for the family file. Alternatively, some services may choose to use the one file.

Please refer to *Clinical Resource 5: Family Intervention Form.*

Case example

John has been doing well in counselling but on his recent return to work he is finding things pretty tough. He has been close to dropping out of the treatment program. John and his counsellor decide that it might be helpful for him if a family meeting were held, in order to strengthen his support system. John decides to invite his mother and his uncle. The counsellor rings to invite people to the meeting and explains the purpose of it. The following guidelines helped the counsellor in running the family meeting:

- The counsellor welcomes everyone in the reception area.
- People are oriented to the building, toilets and other organisational facilities.
- The purpose of the meeting is clarified with all family members.
- The counsellor acknowledges the commitments that people have made in attending.
- Confidentiality is discussed and agreement is reached on what is OK to talk about.
- An agenda is written on a whiteboard or piece of paper that everyone can see.
- There is discussion about the intense feelings that can surface in these meetings and how this will be managed to ensure safety for everyone.
- There is a discussion about what family members might do if they get distressed or angry (eg go for a walk, have a cup of tea, have a cigarette).

- The family is told how long the meeting will go for and that the counsellor might need to bring everyone back to the agenda 15 minutes before the session ends.
- The counsellor ensures everyone has his or her say.
- The counsellor has eye contact with all family members.
- The counsellor acknowledges any positive interactions or actions noticed or discussed in the meeting.
- Key issues and agreed actions are summarised in the meeting.
- The counsellor arranges a time to telephone follow-up.
- Everyone is thanked for coming.

Intervention 11: Support for family members whose relative is not a client of the service

Family members may contact alcohol and drug treatment services seeking support for themselves, where the person with the drug-related issue 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.

Individuals with drug-related issues may be at different places in the change cycle and may not be ready to address their issues through contact with a treatment service. They may have made some attempts previously to make change or they may not yet have made any attempts.

At times, families experience guilt, anger, grief and anxiety that can result in difficulties and distance in family relationships. By providing support to the family around these issues, it may be possible to strengthen family relationships and to enhance the probability that the individual will feel supported to take action to address their difficulties at some time in the future.

Practice guidelines

Families are registered as clients of the service and are provided with the same standard of professional conduct as other clients.

Family members are offered the range of options available within the organisation. These may include individual counselling, single session therapy or family therapy.

Documentation

Families attending the service are registered as a client of the service. Treatment goals are established with the family, and a plan to meet these goals is drawn up.

Services open a case file for the family, which would include established treatment goals and notes of contacts with family.

Please refer to *Clinical Resource 5: Family Intervention Form.*

Case example

Peter's wife has a significant problem with alcohol and he has been attending a peer support group established by the service. A group leader contacts a counsellor to see if they will see Peter. Peter's wife attends AA but is not involved directly in this service. Peter is offered a single session appointment and the outcome of this is a second appointment two weeks later.

Intervention 12: Networking and liaising with other family focused organisations

When services have developed and are practicing 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.

Families have been acknowledged as a priority by local, state and federal governments through the development of family focused services. Funding has been provided for the delivery of family focused interventions that respond to the specific needs, experiences and ongoing learning of families of drug users. These services can act as an important point of referral and advice, and can support the development of family inclusive practice within the alcohol and drug treatment sector.

Practice guidelines

A Families Interest Group is developed within the organisation.

- A representative of senior staff or management is on this interest group to give it status within the organisation.
- The Families Interest Group meets regularly, is minuted, and minutes are circulated.
- Local family support organisations and family focused services are invited to share knowledge and practice.
- Links are made with specialist family-specific services. In Victoria, Family Drug Help has devised a protocol for practitioners on the distribution of their family information kit by alcohol and drug services.
- Joint initiatives with other community organisations are undertaken.
- Protocols on joint work (eg group, individual or family) are developed.

Documentation

Records should comply with organisational requirements for accountability.

Case example

A 'Family Interest Group' has been initiated in an alcohol and drug service. This group comprises clinical staff with interest and experience in working with families. In the initial stages of the group, an audit of internal practices and needs is completed. Family Drug Help is contacted to assist with advice and information resources. The next stage involves broadening the membership and scope of the group to the community context in which the service operates. Local agencies within the community are invited onto the group – including family support, local government, community health, maternal and child health, and schools.

The focus of the group is on responding to the needs of families who are seeking to support a family member with drug-related problems. The group develops relevant local initiatives to respond to the identified needs including:

- improved dissemination of information
- invitation of guest speakers to staff meetings
- establishment of referral protocols
- development of a joint proposal for funding of a group in schools for children of parents with drug issues or who have overdosed

CLINICAL RESOURCES

1. The Use of Genograms
2. Consultancy Form
3. Community Education Forum Record
4. Group Record
5. Family Intervention Form
6. Contacts

SECTION 4

THE USE OF GENOGRAMS*

The genogram is a convenient tool for summarising material from intake and early interviews. It provides a pictorial representation of the family structure and has become a standard form for describing families. The genogram can assist the practitioner to explore and conceptualise family relationships and identify potential alliances that could be developed to address drug-related issues. This may include talking about and defining the role of family in the development of a treatment plan with the individual client.

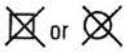
The genogram should include:

- names of family members
- ages of family members
- marriages, separation, divorce, death and other significant events
- any other notation that is useful such as occupation, illness, changes of life course or relationships

Key symbols

Female ○ Male □ Unknown △

Death is shown by a cross through the symbol.



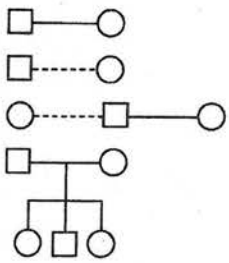
Relationships are illustrated with a line drawn between symbols.

Married

De facto

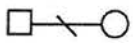
Multiple relationships

Children (placed in order of age)

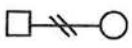


Separation and divorce are shown with a single or double slash (respectively) through the relationship.

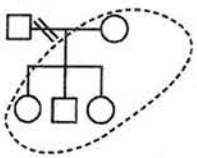
Separation



Divorce

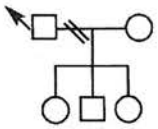


In representing separation or divorce, the slashes should reflect who the child(ren) are living with by cutting off the parent with whom the children are not living. A dotted line around the people living in the same household illustrates the family unit.

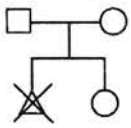


Other relevant symbols

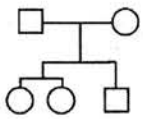
Father has moved away and there is no further contact



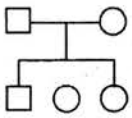
Miscarriage or termination



Twins

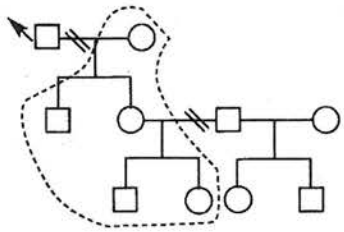


Adoptions or foster children



Example

Two children are currently living with their mother, their maternal grandmother and their uncle. The maternal grandfather has no contact with the family. The father has remarried and has two children from this relationship.



CONSULTANCY FORM

A consultancy form is used to collect data on family members seeking support and to record the services provided by the organisation, including telephone support and counselling, information and effective referral to other services. Data collected may include identifying information (if provided), relationship to the person with problematic drug use, the types of information they are seeking, and outcome of the contact.

Date of call \ \

Caller's name (optional)

Relationship to person with problematic drug use

☐ Partner ☐ Parent ☐ Sibling ☐ Other family member

☐ Friend ☐ Employer ☐ Community agency ☐ No relationship – general enquiry

☐ Other (specify) _____

Information sought

☐ Information on drugs ☐ Information on treatment services

☐ Support/crisis intervention ☐ Referral and advice

Outcome of contact

Referral to specific service (specify)

Date and details for follow-up (if appropriate) \ \

Other notes

Worker

SECTION 4

COMMUNITY EDUCATION FORUM RECORD

The community education forum record can be used to document details about the community education forum, including the date of forum, the content, the location and the number of participants, and outlines a summary of the feedback. An attendance form is completed by those participants who feel comfortable to do so.

Date of forum \ \

Presenters

Session outline/topic (attach if available)

Location/venue/time

Audience

Number of participants

Summary of feedback from forum

SECTION 4

GROUP RECORD

A group record is used to record information about group sessions, including the date, venue, attendance, topics and issues raised. It is completed by the group leader after each session and provides an effective method of weekly process recording. It can be used to document support group intervention within the organisation, or to evaluate the effectiveness of self-help groups for families and to inform ongoing development of this service.

Date of group \ \

Group leaders

Participants

Session outline/topic (attach if available)

General process notes – issues arising/addressed

Follow-up necessary

Ideas for future groups

SECTION 4

FAMILY INTERVENTION FORM

A family intervention form can be used to document services provided to a family. This may include individual counselling or joint counselling interventions such as mediation, solution focused therapy, narrative therapy, relationship counselling and single session therapy.

Worker's name

Date of contact \ \

Name(s) of family member(s)	**Relationship to person with problematic drug use**

Description of the impact of drug use on the family

What do the family identify as their current needs?

Strengths of family – relationships, support networks, past success in dealing with the problem

Form of intervention

- ☐ Counselling included person with problematic drug use
- ☐ Single session
- ☐ Phone support and referral
- ☐ Ongoing counselling
- ☐ Other _____

Focus of intervention

- ☐ Information on drugs
- ☐ Referral information
- ☐ Problem solving
- ☐ Discussion of fears about drugs
- ☐ Discussion of attribution of blame for drug use/guilt
- ☐ Supportive counselling in relation to distress
- ☐ Conflict resolution
- ☐ Taking the focus off drugs
- ☐ Information on treatment services
- ☐ Crisis intervention
- ☐ Discussion of self-care/own needs
- ☐ Discussion of responsibility issue
- ☐ Understanding drug use (positive functions, own drug use)
- ☐ Setting limits on user's behaviour
- ☐ Communication strategies
- ☐ Other issues (specify) _____

Other notes

FAMILY INTERVENTION FORM (CONT)

Genogram (attach additional sheet if insufficient space)

CONTACTS

This resource provides contact details for a range of alcohol and drug-related and family support services in Australia. The listings are a useful starting point for clinicians; however, they are not comprehensive and service information can change over time. To meet the needs of clients and their families, clinicians can call their local ADIS or DirectLine for the most current information relevant to their area.

24-hour A&D information and referral

ADIS (Alcohol and Drug Information Services)

ACT
02 6205 4545

New South Wales
02 9361 8000
1800 422 599 (country)

Northern Territory
1800 131 350

Queensland
07 3236 2414
1800 177 833 (country)

South Australia
08 8363 8618
1300 131 340

Tasmania
1800 811 994

Western Australia
08 9442 5000

DirectLine (Victoria) 1800 888 236

DirectLine's experienced counsellors provide 24-hour confidential telephone counselling, information and referral for anyone concerned about alcohol or drug issues. Information about a wide range of alcohol and drug treatment and support is available through this number.

Family Drug Helpline (Victoria) 1300 660 068

The Family Drug Helpline is a 24-hour anonymous peer-based service offering support, information and referral to local services to anyone affected by or concerned about another's alcohol or other drug use.

Family Drug Support Hotline 1300 368 186 (All states)

The Family Drug Support Hotline is a 24-hour Australia-wide telephone service staffed by volunteers providing help in crisis, advice on strategies for coping with drug use and information.

Parent Drug Info Service (Western Australia) 08 9442 5050/1800 653 203

The Parent Drug Information Service (PDIS) is a 24-hour confidential telephone support, counselling, information and referral service for parents in Western Australia.

YSAS Line (Victoria) 1800 014 446

YSAS Line is a 24-hour telephone service that provides information, counselling and referral to Youth Substance Abuse Services and youth-specific alcohol and drug services throughout Victoria.

Family support services

Family Drug Help (FDH)

Family Drug Help is a Victorian based service which addresses the support and information needs of parents, other family members and significant others of someone with problematic alcohol or other drug use. The service model is peer based, in tandem with other professional forms of helping, and aims to support families and friends to reduce the harmful consequences of the alcohol or drug use for everyone in the family. People with personal experience of the effects of alcohol or other drug use within their family or friendship group are involved at all levels of the service.

T: 03 9572 2855
F: 03 9572 3498
www.familydrughelp.sharc.org.au

Family Drug Support (FDS)

Family Drug Support provides assistance to families throughout Australia who are struggling as a result of drug use. FDS is committed to working with professional organisations and forming constructive partnerships to assist in empowering families in dealing with drug issues in a way that strengthens relationships and achieves positive outcomes.

Head Office/New South Wales

T: 02 9798 0001
www.fds.org.au

South Australia

T: 08 8384 4314

Queensland

T: 07 3252 1735

Families and Friends for Drug Law Reform (ACT)

Families and Friends for Drug Law Reform was formed as a direct result of heroin-related deaths in the Australian Capital Territory. It believes that prohibition laws are more the problem than the solution. It seeks laws and policies which will eliminate the deaths and minimise the health and social harm.

T: 02 6254 2961
Mob: 0401 732 129
www.ffdlr.org.au

Kids Help Line 1800 551 800

Kids Help Line is a 24-hour telephone counselling service for children and young people.

www.kidshelp.com.au

Parent/Carer telephone support

A range of state-based services provide telephone information, counselling and referral for parents and carers.

Parentline (Vic)

T: 132 289
www.parentline.vic.gov.au

Parentline (NSW)

T: 132 055

Parent Help Line (SA)

T: 08 8303 1555
1300 364 100

Parentline (QLD & NT)

T: 1300 301 300
www.parentline.com.au

Parentlink (ACT)

02 6205 8800
www.parentlink.act.gov.au

Support programs

Support groups are provided for parents and other family members. Programs provide support to parents and families of drug users, assisting them to look after themselves and to respond effectively to children and other family members with an alcohol or drug problem.

Victoria

For peer-based support groups, contact the Family Drug Helpline on 1300 660 068

For Al-Anon and Al-Ateen family groups, phone 03 9642 3330

For Families Anonymous groups, call 03 9889 8112

Western Australia

Parents for Drug Information and Support
T: 08 9442 5050 or 1800 653 203

Other States

Family Drug Support Hotline on 1300 368 186

Family Counselling Programs (A&D)

Counselling for families affected by the drug and alcohol use of a family member.

Victoria

Alliance Family Counselling
Focusing on families – Dandenong and Peninsula
Intake and referral: 03 8792 2330
Office: 03 8792 8999

Raft
Northern Region Service
21 Victoria Street, Coburg 3058
T: 03 9355 9900

Cyrene
CentreShop 5, 49–52 Douglas Street
Noble Park 3174
T: 03 9574 6355

Mary of the Cross Centre
7 Brunswick Street, Fitzroy 3065
T: 03 9495 6144

Other states

For family counselling programs in other states, contact your local 24-hour alcohol and drug telephone referral and information service.

Parenting support and education programs

About Better Communication About Drugs for Parents of Early Adolescents (ABCD) Program

ABCD is a Victorian statewide parent drug education program targeted to parents of young people in years 7 and 8. Parents can learn to enhance their communication skills, parenting practices and knowledge to help them build positive, trusting relationships with their children and prevent or cope with adolescent drug use.

For further information, contact Moreland Hall.
T: 03 9386 2876

Anglicare Eastern Region

A guide for those parenting young people who are using drugs. An 8-week group-based program which runs in a number of locations in the Eastern Region.

T: 03 9720 3488

BEST Plus

An 8-week program for parents and siblings experiencing drug and alcohol abuse in their family.

For further information, contact Mary of the Cross.
T: 03 9495 6144

Alcohol and drug information

Australian Drug Information Network

The Australian Drug Information Network (ADIN) provides a central point of access (portal) to quality Internet-based alcohol and drug information provided by prominent organisations in Australia and internationally.

www.adin.com.au

DrugInfo Clearinghouse (Australian Drug Foundation)

The DrugInfo Clearinghouse is a service of the Australian Drug Foundation which aims to inform and support drug prevention in Victoria. It provides easy access to information about alcohol and other drugs, and drug prevention. Professionals and members of the general community can use the service as their first port of call for information from local, national and international sources.

T: 1300 858 584
F: 03 9328 3008
www.druginfo.adf.org.au

Drug information in languages other than English

Victorian Drug Services

Department of Human Services
State Government of Victoria

T: 1800 123 234
www.drugs.vic.gov.au/language.htm

Cultural and ethnic organisations may also provide drug information relevant to their communities. Contact your local community organisation.

Interpreting and translation services

Victoria

Translation and Interpreting Service (TIS)
T: 131 450

Other Victorian agencies are listed in the Yellow Pages telephone directory under 'Interpreters' and similar agencies provide interpreting and translation services in other states of Australia. Agencies or individuals requesting a service via these interpretation services may be required to pay for the service.

REFERENCES

Bamberg, J., Toumbourou, J. W., Blyth, A., & Forer, D. (2001). 'Profiling changes for families in the BEST program, for parents coping with youth substance abuse'. In *Australian & New Zealand Journal of Family Therapy, 22*, 189–198.

Blyth, A., Bamberg, J., & Toumbourou, J. (2000). *Behaviour Exchange Systems Training: A program for parents stressed by adolescent substance abuse.* Camberwell, Australia: Australian Council for Educational Research.

Dear, G. (1994). *Do families really need treatment?* Alcohol Drugs and the Family. Proceedings of the 1994 APSAD National Conference. Melbourne, Australia. 141–152.

de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy.* New York: W. W. Norton.

Epston, D., & White, M. (1989). *Literate means to therapeutic ends.* Adelaide: Dulwich Centre Publications.

Hoyt, M. F., Rosenbaum, R., & Talmon, M. (1992). 'Planned single session psychotherapy'. In S. H. Budman, M., F. Hoyt & S. Friedman (Eds), *The First Session in Brief Therapy*, 59–85. New York: The Guilford Press.

Kaufman, E. (1986). 'A contemporary approach to the family treatment of substance abuse disorders'. In *American Journal of Drug and Alcohol Abuse, 12*, 199–211.

Meyers, R. J., Smith, J. E., & Lash, D. (2003). 'The Community Reinforcement Approach'. In M. Galanter (Ed). *Recent Developments in Alcoholism: Research on Alcoholism Vol XVI.* New York: Kluwer/Plenum.

Morgan, A. (2000). *What is Narrative Therapy? An easy to read introduction.* Adelaide: Dulwich Centre Publications.

O'Hanlon, W. H., & Wiener Davis, M. (1989). *In Search of Solutions: A new direction in psychotherapy.* New York: The Guilford Press.

Orford, J. (1994). 'Empowering Family and Friends: A new approach to the secondary prevention of addiction'. In *Drug and Alcohol Review, 13*, 417–429.

Single Session Therapy Training Package (2000). Melbourne: The Bouverie Centre, La Trobe University.

Stanton, M. D., & Shadish, W. R. (1997). 'Outcome, Attrition, and Family-Couples Treatment for Drug Abuse: A meta-analysis and review of the controlled, comparative studies'. In *Psychological Bulletin, 122*, 170–191.

Success Works (2000). *Involving families in the treatment of young people with problematic substance use.* Melbourne: Department of Human Services, State Government of Victoria.

Toumbourou, J. W., Blyth, A., Bamberg, J., & Forer, D. (2001). 'Early impact of the BEST intervention for parents stressed by adolescent substance abuse'. In *Journal of Community and Applied Social Psychology, 11*, 291–304.

REFERENCES

Victorian Risk Framework: A guided professional judgement approach to risk assessment in child protection (1999). Version two. Practice Leadership Unit, Child Protection and Juvenile Justice Branch, Department of Human Services Victoria, Australia. Accessed on 7/6/04 at http://hnb.dhs.vic.gov.au/commcare/yafsinte.nsf/obj/VRF_1999v2a/$FILE/VRF_1999v2a.pdf

White, M. (1989). 'The externalising of the problem and the re-authoring of lives and relationships'. In *Dulwich Centre Newsletter*, Summer, 88/89.

Turning Point
Alcohol & Drug Centre

Working with Families is the eleventh in the series of *Clinical Treatment Guidelines for Alcohol and Drug Clinicians* developed by Turning Point Alcohol and Drug Centre. The series has been produced in response to the need for quality, standardised and broad-based resources for use in day-to-day client care.

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Turning Point is a specialist alcohol and drug organisation with a mission to lead the community in the development of policies and programs to prevent and reduce the harm caused by alcohol and drugs. This is achieved by advancing the range and quality of treatment and support services, expanding the capacity of the professional workforce to provide alcohol and drug services, and supporting the process of sound policy and program development.

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