Involving Families in Alcohol and Drug Treatment
Further information

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Executive Summary

In 1996, the Victorian Government published the Report, Drugs in Our Community. This Report drew attention to the need for improved access to drug and alcohol services for young people and identified gaps in service provision—particularly for those young people with complex substance-related issues (Success Works, 1998). In 1996-97 Success Works Pty Ltd undertook a major investigation for the Department of Human Services called Young People and Drugs Needs Analysis. This Project involved considerable consultation with service providers, young people and their families and/ or carers.

The Young People and Drugs Needs Analysis found that there had been very little consultation with parents/ carers in the past about their support needs in terms of their child’s drug use and treatment. There had also been almost no engagement of parents/ carers in the development of treatment options.

The aim of the current Project was to examine the ways in which the Drug Treatment Service System can best work with families and/ or carers of young people with problematic substance use, in order to engage them effectively in the treatment process for the young person. It also aims to provide timely support to the family and to address some of the needs of the family/ carer.

Methodology

Consultations were held with 97 young people and family members through questionnaires, interviews and self-help groups.

Forty-five community health and drug and alcohol services were interviewed regarding their current practices.

Detailed case studies were documented for four Victorian, nine interstate and two overseas programs.

A key aspect of the Project was the testing of the frameworks, approaches and models with workers from both the drug and alcohol and youth and family sectors. These workers contributed their expertise, through a series of six workshops over a four-month period, to the development of the models which appear in this Report.

Definitions

Family

One of the barriers to working effectively with young people and their families is the narrowness of understanding about what constitutes a ‘family’. In this Project a family was defined as relatives and/ or significant others with whom the young person had an ongoing relationship.
Most of the literature seems to indicate that greater success is achieved if those
involved are from the immediate family. However, extended family and significant
family friends or community members can be recognised as ‘significant’ when
immediate family members are unsuitable, unavailable or unacceptable to the young
person.

The key issue is that the young person is able to make strong ongoing connection
with this person(s).

**Harm Minimisation**

Harm minimisation ‘involves a range of approaches to prevent and reduce drug-
related harm, including prevention, early intervention, specialist treatment, supply
control, safer drug use and abstinence’.

(Commonwealth Department of Human Services and Health, 1993)

**Themes from the Literature**

**Family Connections**

The literature indicates that there is a vital connection between the functioning and
characteristics of a young person’s family and the subsequent development of
problematic substance abuse patterns in adolescence. A theme in the research
indicates that substance abuse patterns among adult parents positively influence
adolescent children toward substance abuse. Therefore, there is a concern for the
modelling which takes place in adult/child interactions, particularly in the area of
alcohol abuse.

Even more compelling research has been undertaken which has established that the
degree of connectedness between parental figures and adolescents is a vital variable
in the development of problematic substance abuse. Relationships between parents
and young people which reflect warmth and attachment; concern and interest;
positive authority and control; involvement in shared activities; and mutually
satisfying interactions are more likely to correlate with control over the development
of problematic substance abuse.

On the other hand, the findings indicate that in families where the parent-child
relationships are detached, abusive, uninterested, uninvolved, overwhelmed by
other stressors, or structurally under-resourced, adolescent children are more likely
to adopt problematic substance abuse behaviours. The same type of link is also
established with drug using peer associations, where families in which there is not
attachment, involvement or interest, are more likely to result in the adolescent
associating with a peer group who are drug or alcohol dependent—almost as if to
meet the adolescent’s need for attachment and belonging.

**School Attending**
School attending is also an important variable, as research has indicated that school attending young people are less likely to seriously abuse substances than non-attending peers. Again, school attendance is inextricably linked with family connectedness. The interlinking of the variables of positive family relationships and communication patterns, associations with peers who are non-substance abusing, and positive connection with school communities, are all vital protective factors against the development of problematic substance abuse.

Models for Intervention

In considering programs or interventions aimed at reducing substance abuse among young people, a number of models have been adopted. The concept of parent training and support is one approach, based on behavioural learning theories. The premise of these programs is that parents can be supported and empowered to become more effective in their role with their adolescent children. This approach can be adopted either as a preventative measure, or universally, through whole-school approaches, in community run programs, or targeted to specific families where adolescent substance abuse has occurred.

The aim of these interventions is to provide parents with an improved repertoire of responses in their parenting roles, to provide support and confidence for the approach to be adopted, and to disseminate knowledge and information to help inform and raise the consciousness of parents.

Family-Centred Treatment

Another approach, termed ‘family-centred treatment’, operates within a family therapy framework, and involves the adolescent and their family members in counselling, with trained counsellors who specialise in the area of adolescent substance abuse. This model is structured and time limited, and involves the identification of dysfunctional interrelationships and communication patterns within families, with the aim of challenging and replacing these patterns with more functional approaches. The approach is family-centred, and thus is customised to the particular issues relevant to that particular family. This approach has the capacity to be culturally sensitive and responsive. The research which has been undertaken in this field has indicated positive results from the interventions, and demonstrated that family patterns can be improved and altered, with direct benefits to the adolescent.

There is further scope for the development of new models in this field which integrate family-centred therapeutic approaches with behavioural, learning theory approaches. The challenge is to develop models which are both effective and efficient in responding to family dynamics, and compatible with existing service delivery modalities.
Survey of Families and Young People

The main theme to emerge from the consultation with families was the initial feeling of total helplessness and lack of preparation experienced by family members when they have to deal with a child with a major drug problem. Families reported going through a process of shock, disbelief and not knowing where to turn, when they found out about their child’s ‘drug habit’. Key areas of concern identified by families included lack of emotional support, the impact on their own mental health, and lack of information.

Another common theme running through the consultations was that many families felt alienated and unsupported by health professionals and drug treatment services. Some of the issues raised centred on having received harsh advice from services and feeling alienated as a result. It was reported that many GPs lack knowledge/information about drug abuse, about treatment options, and about how to deal with users and their families. Agencies contacted through the phone book were mostly seen to be unhelpful, and experiences with the police were not described in a positive way.

Support Services Sought by Families

The main types of support families sought included information/education, advice/guidance, counselling, support groups, and families generally described these types of support as useful. Family members described their relief when they contacted a supportive service. The three service types reported as being of most help were drug and alcohol services; self-help groups; and telephone crisis services. At these services families generally found the workers’ attitudes helpful, and described community health services as those with the most helpful attitude.

Families also requested information which would assist their understanding of the effects of addiction, services/treatments for their family member with a drug related problem, and emotional support. With regard to service delivery, the approach most commonly endorsed by families included a non-judgmental style; quality of service; information and community education; and support for siblings.

Family Involvement

Most families reported having some involvement in their young family member’s treatment process, and emphasised the importance of this for both the user and the family. The ways in which families became involved was usually external to the service process. They included: offering encouragement and moral support; offering to do the research around rehabilitation programs and other treatment services available; encouraging and supporting the user’s progress; and encouraging and supporting other family members’ involvement. In a few cases parents had become directly involved in the treatment process through an in-home withdrawal program. Other ways in which families became involved were participating in counselling sessions and attending support groups, such as Families Anonymous.
In the consultations with young people the general feeling was that participants wanted the support of their family. All of the young people identified in some way with their family, and many were still living at home at least some of the time. The connection to family was felt by the young people as they identified their family as being a vital part of their treatment process. The focus groups with young people showed that substance users were wanting and needing the support of family in one way or another.

Families who were not involved in the treatment process failed to do so mainly because their involvement was discouraged by the user or the service. For instance, the user was not being encouraged by service workers to talk to family members due to confidentiality issues, or the user themselves wanted no involvement with their family.

Family members, such as brothers or sisters, were not usually involved in the young person’s treatment program because they were too busy with their careers, school studies, or had lost interest because of too much hurt and disappointment. Sometimes this was also the case for parents who chose not to be directly involved.

The overwhelming majority of families would like to provide support to their family member, and viewed this involvement as a crucial part of the user’s treatment. The most significant ways described by the families for supporting the user included: offering emotional support and encouragement; helping them access quality services; helping to improve community attitudes; and by offering financial assistance. Regardless of whether families were seeking direct involvement in the user’s treatment process, each family wanted to know what was happening and how to behave appropriately to support the treatment, and to that extent need to be involved even in a peripheral role.

Generally, family members wanted to be seen as part of the solution and not as the ‘enemy’. They also acknowledged that they needed to acquire a greater and deeper understanding of drug and alcohol issues in order to be in a position to provide the appropriate support to their young family member. The consultations with young people indicated that young people needed their family’s support while undergoing treatment, however they themselves sometimes discouraged it because their families lacked the knowledge and understanding to support them effectively.

In summary, families need to be in a position where they can make more informed choices when dealing with issues around their young family member’s addiction, because their support and understanding is greatly needed. Family support is considered crucial by the young people at this time in their life.
Survey of Current Practice

Initially, the Project needed to identify current practice and the key issues in involving families in the drug treatment process. It was found that 45 service providers were currently providing a drug treatment service to young people in Victoria, and these were interviewed. Eight workshops were held across the State (including one ethno-specific and one Aboriginal) with a total attendance of 72 service providers. All GP Divisions in the State were also contacted, however, their main area of focus in relation to young people and drugs was generally of a health education nature and increasing service access.

All services interviewed reported that they have contact with family members, and the proportion of direct involvement ranged from an estimated ten to 100 per cent. Family involvement in the treatment process was mainly in the form of one-to-one counselling and provision of information and advice separately from the young person, who is generally considered the primary client. The majority of organisations interviewed operated on a client focused, one-to-one counselling and harm minimisation model.

The involvement of family members in the treatment process was found to be dependent on a vast number of variables both within the service system and within individual families. This highlighted the complexity of working with young people and their families. In particular, it was identified that these key issues in relation to family involvement related to:

- Clarification of who the primary client is, and where confidentiality and duty of care rests.
- Individual client focused models of service.
- The client’s resistance to family involvement.
- The process of moving from an adult service model to a youth specific service model.
- Diversity of families.
- Family dynamics and conflict.
- Broader social and legal context of the family.

From the issues that emerge from the service perspective it is increasingly evident that families have many support needs, and this was acknowledged by all service providers. While fifteen of the 45 services reported that they currently provide a specific program to support the families of a young person using drugs, there was a view that there are still many gaps relating to information and education surrounding drug use, and access to counselling and specific support groups.
In reviewing case studies in Victoria, interstate and overseas, it is clear that there are a number of different levels of interventions in supporting and involving families in the treatment process. These include:

- Support and information telephone lines
- Parent support groups
- Family counselling and mediation with the young person
- Individual counselling for young people and families
- Integrated family service models.

A number of organisational and environmental factors that contribute to working with young people and their families effectively were identified from the service provider interviews. In terms of organisation, there is a need for both a youth-specific focus and an understanding of families. Externally, the main factors that were considered to contribute to successful interventions included the following:

- Resources and appropriate funding models
- Training for workers
- Service linkages and networks
- Education and information, particularly in relation to community attitudes.

**Approaches to Working with Families**

The literature and case studies have identified a number of approaches which could effectively be introduced in the drug and alcohol service system. The critical role of families in assisting both the young person and the service is underdeveloped in the sector, and much could be learned from allied fields, such as Child Protection and Juvenile Justice, about child-inclusive practice.

This Project has found a desire in the sector, and evidence in the literature, that would support all services in adopting what could be described as **Family Inclusive Practice**. This approach works on the fundamental assumption that the family is a resource to the young person and the agency, and that the involvement of family members is fundamental to an ongoing solution. The adoption of this framework for service delivery will require services to review their current organisational philosophies and service models, as well as ensuring that a range of skills and supports are available to workers and families alike. A Resource Kit for this process is provided in Appendix 4.

In addition to a general reorientation of all services towards the inclusion of families when working with young people, there is an identified need for **Facilitated Support Groups** for family members. Currently there are some services providing these on an ad hoc basis, although in the main, these focus on parents rather than on the broader extended family and siblings. Odyssey House, in conjunction with the Centre for Adolescent Health, has conducted a well documented and evaluated program for parents, which is recommended as a model for this approach.

Overseas literature demonstrates the value of engaging family members in the treatment process with young people, through approaches such as family focused...
counselling. This is perhaps the most challenging approach for the sector in Australia, and any models need to be trialled within the local context. However, young people and family members stress the importance of this approach. The theoretical frameworks are well documented and there is evidence of the efficacy of many of the models.

**Discussion and Recommendations**

This Project has explored new territory in the treatment of young people with a substance abuse problem in exploring the needs of family members and the potential for involving them in the treatment process. It is only recently that there was a recognition of the need for a different treatment model for working with young people than had been developed for work with adults. Key responses to this need were: the development of youth specific services in Victoria, and the appointment of workers with experience in working with young people.

**Improving Family Involvement and Support**

Key approaches have been explored which are aimed at improving the treatment outcomes for young people, ensuring that families are supported, and actively engaging families in the treatment process. In summary, these include:

- **Support for self-help groups.** Self-help groups are, by definition, self-supporting and require little intervention from drug and alcohol agencies. There is, however, indication that some support, in terms of basic administration and early formation, would be of assistance.

- **A sector-wide approach.** The adoption of a sector-wide approach, should see families as a valuable—and even essential—resource to work with young people in drug and alcohol treatment, and which results in Family Inclusive Practice as the norm in working with young people.

- **Specialist workers.** Development of a team of specialist workers who can conduct Facilitated Family Support Groups for the family members of young people who have a drug and or alcohol problem. These groups would focus on the specific needs of the family members and increase their capacity to both deal with their own issues and those of the young person.

- **Key services in each region.** Development of a key service in each region, which will ensure that there is a coordinated approach to working in a family inclusive way through worker training, supervision and support.

- **Treatment models.** Development of treatment models which draw on and adapt overseas evidence that engaging the family in the treatment process has positive outcomes for the young person.
RECOMMENDATION 1
That Drug and Alcohol services which work with young people adopt an approach of Family Inclusive Practice.

RECOMMENDATION 2
That Facilitated Family Support Groups be offered in each region so that family members can gain support for themselves as well as being supported to assist the young person requiring treatment.

Adoption of New Conceptual Frameworks
In the identification of new approaches it is important to acknowledge that some of the theories which have underpinned the work of drug treatment services might need to be re-examined. Working with families has not been an integral part of treatment in this sector. In addition, the particular issues to do with adolescent development may need to be explored in terms of their applicability in the drug treatment setting.

For some years now there has been considerable debate in allied fields, which work with many of the young people who are now accessing drug treatment services, about the role of the family in any intervention that is taken with a young person. This has lead to a number of government funded programs as well as non-government projects, such as strengthening families, family group conferencing, family and youth mediation and working with young people in the context of their family.

The skills and experience that have been gained in these fields may provide an important starting point in the development of new approaches. The evidence on which this practice is now based supports the literature and findings from overseas: that working with young people in the context of their family brings more positive outcomes than engaging them alone.

Resilience and Protective Factors
The work around resilience and protective factors is perhaps the most appropriate to consider as the basis for a new conceptual framework. A holistic approach, which addresses the needs of young people to feel connected to family or significant adults, school, positive peers and the community, is a critical starting point (see Chapter 2). In this regard, there are a number of allied services in Juvenile Justice, Mental Health and Education, such as the School Focused Youth Service, which would provide links into the school and community networks.

In addition, there is still work to be undertaken in relating these conceptual frameworks to the experience of Aboriginal young people and families, as well as families from culturally and linguistically diverse backgrounds. The processes currently being applied in creating more culturally responsive services provides a sound basis for this work.

Given that the approaches and models presented here are only a starting point it is important that processes are developed to ensure that there is an ongoing dialogue between workers with young people in drug treatment services and those in the
broader youth services sector. At a Departmental level, the Working Together Strategy is a valuable resource and model for this process.

Each region should have a lead agency, which draws on the range of expertise and skills in allied sectors, to ensure that an integrated and consistent approach is taken to developing new frameworks and practice in this area. This process would ensure the ongoing identification and promotion of best practice.

RECOMMENDATION 3
That a lead agency is identified in each region to develop a process for linking drug and alcohol services with the broader network of youth focused services, to both draw on skills and expertise in these areas, and ensure that young people are supported by the widest range of services.

One of the issues which emerged in the conduct of this Project was the applicability and relevance of the harm minimisation model in relation to young people. While there was no questioning of harm minimisation as a philosophy, there was a suggestion that it would be advantageous to have a discussion between practitioners in drug treatment services and those working from a framework of adolescent psychology, in regard to how the concept relates to adolescent development.

RECOMMENDATION 4
That workers from drug treatment services and adolescent development psychologists explore the particular issues in developing treatment models for young people within a harm minimisation framework through a series of forums and practice workshops.

Overall Training Strategy
In Chapter 5, a framework for Family Inclusive Practice is outlined; and in Appendix 4 further tools and processes are outlined. A number of organisations which conduct programs and provide services to young people do not have a youth focus, and may not have a concept of family inclusive work. This presents some challenges to both the organisation and the workers. The ways in which these workers are supported and supervised will be critical if any change is to be achieved.

The experience of working with young people in drug treatment is still relatively new, and working with them in a family context will be an additional challenge. Many workers will find this daunting without supervision and training, as engaging families will raise a number of personal issues for workers.

In fact, it is the very issue of workers’ personal experience and values which needs to be at the centre of a training strategy and of practice supervision in the sector. At a minimum, the training required to work with young people in a family inclusive way will include:

- Confronting personal attitudes and values
- Theories and conceptual frameworks of resilience and connectedness
- Approaches to assessment
Engaging young people and their families through dialogue (the experience of workers in family group conferencing and family and youth mediation is of relevance here)

Creating a family inclusive environment

Team approaches to family work

Confidentiality, consent and record keeping

Creating family action plans and drawing on the family as a resource

Evaluation.

Because of the newness of services and workers in this area it will be necessary to draw from the expertise of allied sectors for initial training models and curriculum, as well as for training for supervisors who can provide ongoing support.

**RECOMMENDATION 5**

That a training strategy is developed for supervisors of workers with young people; and that expertise is drawn from allied fields where there is a stronger base for working in a family inclusive way.

**RECOMMENDATION 6**

That a training program on Family Inclusive Practice for all services working in drug treatment with young people is developed and implemented.

In addition to Family Inclusive Practice being adopted by all services, a model of Facilitated Family Support was also suggested. This model was based on literature from a number of services in the USA and the work of Odyssey House in its BEST program. Full documentation of the BEST program will be published in the near future and this will provide a valuable resource for workers interested in providing structured support to families members.

**RECOMMENDATION 7**

That training is offered to workers who are planning to conduct Facilitated Family Support groups and that this training draws on the expertise already in the field.

**Active Engagement in Treatment**

The third approach that has been recommended is that of actively engaging family members in the treatment process with young people. While this is happening in home-based services there has been reluctance, and even some resistance, by workers and services to see families as having a legitimate role in treatment services of any type. In spite of the evidence from overseas studies, both in drug treatment services and in allied fields (also in Australia) there seems to be a number of reasons why services cannot conceptualise the value of this approach.

As has been reported, organisations such Odyssey New Zealand and Thunder Road in the USA have developed effective models which engage the family in every aspect.
of treatment. In addition there are numerous models of family focused work in Victoria in services which deal with the same population group but from a different perspective. Some of these include St Luke's Family Services and Anglicare's Southbridge Youth Services.

**RECOMMENDATION 8**

That a Task Force is established, which includes drug and alcohol services and youth and family services, to develop treatment models which actively engage family members.

One of the major issues in working with families—in any field that is focused on young people and their needs—is that a paradigm shift is required. This shift should change the focus from the family as the problem (and therefore requiring exclusion) to the family as a resource which is critical to the solution. This will require addressing the issues that emerge with intentionality rather than in an ad hoc manner.

**Episode of Care**

There is no question that Family Inclusive Practice can be implemented immediately, even at the level of direct service to family members, because non-users are regarded as a legitimate part of the client group in the Victorian drug treatment services system.

In addition, it would be valuable to create a new treatment service type of ‘family focused’ counselling. This would require the employment of drug and alcohol youth and family counsellors (not family therapists).

The unit cost for counselling funds 110 episodes of care per annum and each episode of care is based on the achievement of significant goals defined in an Individual Treatment Plan (ITP). Consideration needs to be given to the appropriate unit cost and number of episodes of care achievable in the multi-client situation of family focused counselling. Other issues, such as whether each family member would require an ITP, will have to be resolved.

**RECOMMENDATION 9**

That the Drug Treatment Services Program develops a new treatment service type of family focused counselling with appropriate key service requirements.

**First Point of Contact**

One of the critical issues for parents and other family members is the first point of contact. There were a number of complaints about telephone services. In particular, family members felt that their concerns were not taken seriously when they contacted these services. Another entry point into the service system is through general practitioners, and again the experience has not been positive.

At a basic level, when family members approach any service for help they need to be treated with respect, seen as a legitimate client and referred to an appropriate service for assistance.
To ensure that the most appropriate referrals are made, all telephone services should understand that family members require support and encouragement and have access to referral resources. ParentLine may have a particular role to play in providing parent support and referral to self-help and facilitated support groups.

As a service focused on the drug and alcohol sector, DirectLine has an important function in ensuring that all callers feel that they have been responded to appropriately and linked to services which will respond to their needs and concerns. Given the emerging interest in working with families, this may require additional data and briefing for staff.

All telephone queries should be referred by other telephone services to DirectLine.

**RECOMMENDATION 10**

That DirectLine establishes a family reference group with an understanding of the issues for Family Inclusive Practice and an effective response to families who contact the service.

**RECOMMENDATION 11**

That DirectLine provides briefing and orientation for telephone workers on family inclusive responses and referral.

**Self-Help Groups**

Although not the specific subject of this Project, self-help groups were seen by many parents as the only source of support available to them. As was pointed out in the Report, there is some variation in these groups, depending on the current membership and leadership. It may be useful for these groups to consider linking with a service for support and referral. In addition, there would be some benefit in self-help groups working with services that provide facilitated support for family members so that there is some ongoing support when the group finishes.

One of the groups which appears to have had little attention is the siblings of young people who have engaged in problematic substance abuse. As was reported earlier in the Report, this group has its own particular issues and concerns which need to be addressed.

Treatment services working with young people can assist the process of self-help in a number of ways, including:

- Advertising and referring to already existing groups.
- Providing venues and administrative support to both newly emerging and ongoing groups.
- Bringing together family members to establish new groups as appropriate.
- Assisting groups which have been meeting in an educational and/or facilitated group to maintain contact on completion of this process.

**RECOMMENDATION 12**
That services which work with young people encourage and support the development and maintenance of self-help groups through provision of resources, referral and initial facilitation.

Summary of Recommendations

1. That Drug and Alcohol services which work with young people adopt an approach of Family Inclusive Practice.

2. That Facilitated Family Support Groups be offered in each region so that family members can gain support for themselves as well as being supported to assist the young person requiring treatment.

3. That a lead agency is identified in each region to develop a process for linking drug and alcohol services with the broader network of youth focused services, to both draw on skills and expertise in these areas, and ensure that young people are supported by the widest range of services.

4. That workers from drug treatment services and adolescent development psychologists explore the particular issues in developing treatment models for young people within a harm minimisation framework through a series of forums and practice workshops.

5. That a training strategy is developed for supervisors of workers with young people, and that expertise is drawn from allied fields where there is a stronger base for working in a family inclusive way.

6. That a training program on Family Inclusive Practice for all services working in drug treatment with young people is developed and implemented.

7. That training is offered to workers who are planning to conduct Facilitated Family Support groups and that this training draws on the expertise already in the field.

8. That a Task Force is established, which includes drug and alcohol services and youth and family services, to develop treatment models which actively engage family members.

9. That the Drug Treatment Services Program develops a new treatment service type of family focused counselling with appropriate key service requirements.

10. That DirectLine establishes a family reference group with an understanding of the issues for Family Inclusive Practice and an effective response to families who contact the service.

11. That DirectLine provides briefing and orientation for telephone workers on family inclusive responses and referral.

12. That services which work with young people encourage and support the development and maintenance of self-help groups through provision of resources, referral and initial facilitation.
1. Introduction

In 1996, the Victorian Government-commissioned Penington Report, *Drugs in Our Community*, drew attention to the need for improved access to drug and alcohol services for young people. It identified gaps in service provision, particularly for those young people with complex substance-related issues (Success Works, 1998). In 1996-97 Success Works Pty Ltd undertook a major investigation for the Department of Human Services called *Young People and Drugs Needs Analysis* which involved considerable consultation with service providers, young people and their families and/ or carers.

The Project found that there had been very little consultation with parents/ carers in the past about their support needs in terms of their child’s drug use and treatment, and there had been almost no engagement of parents/ carers in the development of treatment options. The investigation also found that current drug and alcohol treatment models are based on assumptions of adult needs and do not address the particular needs of adolescents and their developmental stages. In addition, there was a strong indication that it is essential to locate young people in the context of their family and peers and develop treatment interventions which support a holistic approach.

The aim of this Project was to examine the ways in which the Drug Treatment Service System can better work with families and/ or carers of young people with problematic substance use, in order to engage them effectively in the treatment process for the young person, and to provide support to the family which is timely and addresses the needs of the family/ carer.

The Project objectives were:

- To identify and document ways in which both specialist drug and alcohol services and generic health and welfare services can better engage families and/ or carers in the treatment process for young people with problematic substance use.
- To identify and document the support needs of families and/ or carers of young people with problematic substance use.
- To undertake a search of national and international literature on the involvement of families in the treatment of young people with problematic substance use and document findings.
- To investigate and document innovative service models in the drug and alcohol treatment service sector and related fields (where relevant) in addressing the support needs of families and/ or carers of young substance abusers and engaging them in the treatment process.
The Project should be able to recommend:

- Innovative solutions and service models which can be used by existing drug treatment services to effectively engage families and/or carers of young people with problematic substance use in the treatment process.

and

- Innovative solutions and service models which can be used by existing drug treatment services to meet the support needs of families and/or carers of young people with problematic substance use.

For the purpose of this Project, substance abuse has been defined broadly, incorporating both legal substances, such as tobacco and alcohol, and illicit substances, such as cannabis, heroin and hallucinogens. The spectrum of drug use can be defined across four categories:

1. No use
2. Experimental use (referring to a one-off encounter with drugs)
3. Recreational use (a situation where a conscious choice is made by the individual as to when, where and how much drugs are used)
4. Dependent use (referring to when the individual having little or no control over their drug use, with prolonged use and a developed physical or psychological dependency emerging).

In 1987 the American Psychiatric Association defined substance dependence as ‘impaired control over the substance use and continued use despite adverse consequences’ (Burrows, 1994; Leccese and Waldron, 1994).

1.1 Project Methodology

The methodology was based on the following principles:

- An understanding of the philosophy and directions in drug and alcohol service provision; in particular, the needs of young people, parents, families and/or carers; and the capacity of services to respond.

- The importance of participation in this Project by young people and their families and/or carers, and other key stakeholders, in order to develop models of service delivery which are feasible, practical and acceptable to clients—and are realistic for implementation.

- The adoption of ethical, inclusive consulting practices, with a focus on process as well as product, so that the implementation of the recommendations and options of the Project might be easier to achieve.
A range of methodological approaches was utilised, including:

- Development of the process to ensure maximum involvement of all parties and clear communication at all stages.
- Literature review and data search related to the involvement of families and/or carers in interventions with young people with problematic substance use, in order to develop methods for supporting families in this process.
- Consultation with families, young people and service providers on the options for engaging families and/or carers.
- Consultation regarding the best approaches to supporting families and/or carers.
- Testing and development of options to address the support needs of families and/or carers.
- Formulation of options for families’ engagement with young people in treatment interventions.
- Report preparation and presentation.

Consultations were held with 97 young people, and with family members through questionnaires, interviews and self-help groups. Over 45 drug and alcohol services were interviewed regarding their current practice, and detailed case studies were documented for four Victorian, nine interstate and two overseas programs. In addition, a key aspect of the Project was the testing of the frameworks, approaches and models with workers from both the drug and alcohol and youth and family sectors. These workers contributed their expertise to the development of the models which appear in this Report, through a series of six workshops over a four-month period.

This Report highlights the key themes and findings from the literature and consultations and then provides three approaches or frameworks for engaging and supporting families when they have a young family member with problematic substance abuse. The appendices also provide resources which will assist practitioners. Appendix 3 has a series of case studies which describe examples of work on the ground, and Appendix 4 has resources which were drawn together and tested with service providers currently working with young people and families.
2. Themes from the Literature

2.1 Substance Abuse and Young People

Young People at Risk

For many young people, adolescence is a turbulent time, a period of transitions and changes which, hopefully, result in the young person developing a positive self-identify, constructive relationships with peers, a sense of self in relation to their social context, and a mastery of skills broadly classified as social intelligence. However, the failure to complete the tasks of adolescence successfully, or the failure to develop a positive self-identity, may result in processes of maladjustment which are reflected in problem behaviours, such as offending, school leaving, and substance abuse (Success Works, 1998).

Many researchers now maintain that young people with poor relationship skills, learning and behaviour difficulties in school, poor self-esteem, family disorganisation or dysfunction, and self-labelling as a failure, can identify themselves as outside the mainstream of their peer culture, and are thus at risk of the development of a multiple range of behavioural problems, such as substance abuse, offending, school absenteeism, etc (Liddle, 1996: 92).

High risk behaviours are interrelated, and it is difficult to assess these interrelationships, as services often categorise and collect information regarding only on their own aspect of involvement. Most programs serve adolescents with one problem or another, but few address the overlap of problems in the same population. A growing body of research indicates that high risk behaviours are interrelated, and that there is some segment of the adolescent population who is at high risk for multiple problems.

Furthermore, family dynamics and interactions have been shown to be critical factors in the degree and extent of adolescent risk, as family members act as role models and sources of incentive or disincentive to adolescent behaviours. Families vary in their ability to provide support, guidance, and assistance to the young person. Therefore, families may either contribute to the development of adolescent problems or simply not respond adequately to interrupt them. Problems may arise from long-standing family issues, disturbed family function, or difficulty in negotiating the transition of a family member into young adulthood (Snyder, 1996).

There is controversy about the notion of adolescent addiction in abuse of drugs and alcohol with classic family therapy literature, suggesting that adolescent substance abuse is more about ‘misbehaviour’ than illness.

According to Todd and Selekman:

... there is little or no empirical evidence that the disease model of drug abuse treatment is effective with this age group. We are primarily concerned that these concepts are not useful for adolescents, and may, in fact, be harmful (Todd and
Studies indicate that adolescents do not accept labels, such as ‘addict’, ‘alcoholic’, or ‘chemically dependent’, because such labels are at odds with the values and norms of their social world. As many young people are capable of ceasing drug use in their adult lives it is often considered that referral of adolescents to Twelve Step recovery groups is not appropriate. This is because these programs expect identification as an addict and are based on adult models of treatment, with ramifications for the young person’s sense of self (Todd and Selekman, 1996).

There are a number of interacting factors which need to be taken into account when considering drug abusing behaviour and/ or dependence. Biological factors can be seen in the differences in the way that individuals metabolise alcohol and other drugs. In other words, individuals vary in their physiological and biological vulnerability to becoming dependent on alcohol or other drugs. It is unlikely that a single gene is linked in a causal way. Rather, that a combination of physical variations mean that some individuals who experiment may be more vulnerable to using the substance in a dependent way.

While temperament is likely to be heavily influenced by genetic factors, it is also influenced by family environment. For example, in multi-generation temperament studies, high aggression in conjunction with shyness is linked to increased vulnerability to substance dependence (Hawkins et al, 1992). A child could potentially have family experiences which encouraged them to manage aggression and overcome shyness which are protective. On the other hand, aggression and shyness could be exaggerated by a home life which was neglectful.

Temperament could be said to be both a biological and a psychological factor. Psychological factors contributing to substance abuse have been identified and these include depression, low tolerance for frustration, coexisting psychiatric conditions, as well as specific traumatic experiences which may heighten personal vulnerability.

Social factors include such aspects as school environment, community tolerance and availability; both the actual use of substances by peers and the perception of peer use; and the cultural acceptability of use.

This approach does not provide an explanation or single cause for one person’s drinking socially and another drinking to loss of consciousness. What it does indicate is that dependent use of substances is the outcome of many factors in the individual’s life. This is one of the reasons substance abuse has a tendency to divide community opinion. The individual makes a personal choice, however they make that choice in the setting of having personal strengths and vulnerabilities, as well as the perception of these.

**Family Factors**

As outlined above, there are many causes of substance abuse in young people. Risk factors can come from many different sources, including the individual themselves, their family, community and environment. While the origins of substance abuse in adolescence are still unclear, a number of studies identify that it is influenced by a complex, interacting network of sociological, psychological and biological variables.

Research has established a relationship between adolescent substance abuse and family characteristics. Family drug usage patterns and family atmosphere have both
been found to be contributing factors. Research indicates that drug use by family members significantly increases the chances that other family members will use drugs. ‘Family atmosphere’ refers to inadequately supportive family environments and weak relationships, which are also seen to correlate with substance abuse problems. ‘Family environment’ has been identified as a significant factor in the socialisation of adolescents (Foxcroft and Lowe, 1995; Denton and Kampfe, 1994).

In 1993 Hoffmann’s research indicated that numerous factors, such as socioeconomic status, number of parents in the home, parental supervision and parent–child relations, influence the probability of drug use by adolescents, with the predominant influence being the quality of the parent–child relationship. A warm, loving relationship with full family involvement and adequate supervision has been seen to result in decreased adolescent substance abuse. In addition, higher levels of family attachment serve to reduce peer associations which support drug use.

St Pierre et al (1997) found that low parental involvement with children, maternal isolation, poor family management, and family approval of drug use are variables that put young people at risk. In addition, a bond between the young person and at least one family member who can buffer adolescents from risks is considered a critical protective factor.

Research undertaken by Denton and Kampfe (1994) found that adolescents with a substance abuse problem often identify their family environment as hostile, void of understanding, lacking in love, cohesiveness, and cooperation. There are further reports of young people experiencing a sense of alienation; feelings that parents are self-centred and not supportive; experiences of closed, unclear or rigid patterns of communication; and perceived lack of honesty, trust, acceptance and understanding. Furthermore, there is indication of a lack of confidence in child rearing in such families, characterised by extremes of either permissive or punitive discipline. Denton and Kampfe concluded that certain types of family interaction encourage adolescents to reject their families, and steer towards peers for support. It is thus seen that proactive parent–child counselling and education are required to help families interact, with a focus on levels of satisfaction, communication and discipline within the family unit.

A model for understanding family involvement in adolescent substance abuse, suggested by Foxcroft and Lowe (1995), is based on two fundamental components of parenting: control and support. ‘Control’ is either demanding and controlling, or undemanding with low control attempts. ‘Support’ is either accepting, responsive and child-centred, or rejecting, unresponsive and parent centred. The paradigm is depicted in Figure 1.
Figure 1 Support/Control Paradigm

<table>
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<tr>
<th>SUPPORT</th>
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<th>CONTROL</th>
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<tr>
<td>Accepting, responsive, child-centred</td>
<td>Rejecting, unresponsive, parent-centred</td>
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<tr>
<td>Demanding, controlling</td>
<td>Warm-directive</td>
<td>Authoritative and reciprocal</td>
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<tr>
<td>Undemanding, low in control attempts</td>
<td>Indulgent</td>
<td>Neglecting, ignoring, indifferent, uninvolved</td>
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(Foxcroft and Lowe, 1995:161)

Similar ways of looking at family functions have also been developed, however the attempt to identify causal factors is fraught with difficulty. Much of the research is retrospective, and attempts to form links between circumstances, events and drug use. Many of these events have happened in the distant past and it is impossible to identify causes through such investigations.

Brown (1991) focuses on the multiple variables of family background—peer pressure and current distresses in the young person’s life—and notes that family violence, family breakdown, physical/emotional/sexual abuse, loss of a close adult relative and parental drug taking are often associated with adolescent drug use. In addition, he notes that the initial incidence or onset of illicit drug use can be related to issues of family background together with current emotional disturbances. Common disturbances identified included low self-confidence and difficulty adjusting to school and to other facets of life.

Young people who are involved with substance abuse were characterised as having difficulty in accepting responsibility; being easily discouraged by setbacks; and displaying rebelliousness, aggression, impulsiveness and impatience. On the other hand, there is increasing evidence that many young women who are presenting to drug and alcohol services have been victims of sexual and/or physical abuse, often within the family.

Other researchers have made similar findings. Towberman and McDonald (1993) found that family dysfunction is associated with adolescent drug abuse, typified in families in which there is a great deal of conflict, with one or more parents frequently absent from the home, and characterised by negative parent–child relationships. Horan and Straus (1987) also found that the relationship between an individual’s drug taking and the drug taking behaviour of peers, older siblings and parents, is a significant factor, providing support to the notion that modelling and reinforcement are significant factors in drug taking behaviour.

Research also indicates that positive parental attitudes to substance use correlate with higher participation rates in children. Specifically, parental drinking patterns can be a predictor of frequent and heavy drinking in offspring (Towberman and McDonald, 1993).
Peer Influences

Peer-pressure is seen to be a factor which correlates with illicit drug use, as well as being a significant dynamic in adolescent behaviour. Rejection by peers, self-disparagement, divergence from expectations of the conventional social group and associations with illicit-drug using peers have all been found to be major influences (Brown, 1991; Kaplan, 1984).

In exploring the possibility that peer influences contribute to adolescent substance abuse, Ranisseski and Siegelman (1992) found that they also affect the feelings young people have in relation to treatment. This research identified that young people's perceptions of treatment were not so much influenced by peer pressure, as they were by the young person's desire to fit in, to conform—hence resisting any processes which singled them out, or made them look different from their peers.

The literature indicates that males, who generally exhibit higher drug use rates, may be more dependent on peer influence in shaping attitudes and behaviour than young women, and that young men's intentions to drink were associated with perceived peer acceptance of drinking (Towberman and McDonald, 1993).

The literature clearly identifies the impact of family relationships and peer involvement with substance abuse patterns. Research has indicated that there is an inextricable link between family relationships and peer effects, in that adolescents with stronger family bonds are less likely to have friends who use drugs than adolescents with lower family bonds. Furthermore, strong family bonds are also associated with educational commitment and school connectedness. This research indicates the fundamental interplay between characteristics that cannot be tested and examined independently of each other. Family and peer relationships interact with each other and operate in a synergy during adolescence (Muisener, 1994; Bahr et al, 1995).

2.2 Rationale for a Focus on Families in Treatment for Adolescents

Definition of ‘The Family’

The family is generally defined as those people who live together in a household and who share blood relationships, however, definitions in contemporary society need to be broader and more flexible than this. The modern conception of family must account for an increasing variety of situations if effective work is to be done with adolescents. Each case must be evaluated according to who is important in their family system; that is, who is considered by the adolescent as ‘family’ (Snyder, 1986).

The extended family is commonly part of the drug user's environment, and despite negative characteristics, such as interpersonal conflict, poor communication and poor interpersonal boundaries, the majority of drug users maintain close ties to their families of origin, often being more involved with them than non-drug users are (Griffith et al, 1998).

In the treatment of drug-using young people, the involvement of the extended family is important. Inclusion of extended family members, such as grandparents,
aunts and uncles, and extra-familial adults, such as family friends, can be useful resources to the single parent of an adolescent drug user (Muisner, 1994: 180).

Early theories about adolescent development, which were based on the work of Freud and Erickson, asserted that breaking away and gaining independence from the family of origin were the fundamental tasks of adolescents. Accordingly, treatment programs attempted to complete the adolescent’s emancipation from family and in many cases the rifts between adolescents and their families were deepened.

More recent work emphasises the role of renegotiating the parent-child relationship during adolescence, and maturing within the context of the family unit.

Treatment in drug and alcohol dependence has begun to recognise the problems or issues underpinning problem behaviours amongst young people as family related, and the family is now being seen as a potential source of support for stable behaviour change.

**Resilience, Social Competence and Social Intelligence**

The concepts of resilience, social competence and social intelligence provide a framework for considering the ability of young people either to withstand or capitulate to the influences which potentially involve them in substance abuse (Brown, 1991; Poulson, 1993; Goleman, 1996). Positive family influences are seen to provide the young person with a reserve of resiliency which enables them to handle everyday challenges. The resilient child has the capacity to withstand stressors, overcome adversity, achieve higher degrees of self-mastery and self-esteem (Poulson, 1993). The opposite of resiliency is vulnerability, which characterises the lives of many young people at risk. At risk young people are overwhelmed by psychosocial or environmental circumstances that are stressful. Vulnerable children can develop into adolescents who offend, substance abuse, leave school, etc. Poulson notes that:

> Children who are healthy, temperamentally easy, and developmentally competent, who are born into families that can provide rich relationships, appropriate expectations, and low environmental stress, tend to develop the internal resources that allow them to easily cope with the demands that are a part of all children’s lives. These resilient children develop the internal self-regulation to respond to and recover from environmental challenges. They acquire a repertoire of responses, and they have the flexibility to respond in a manner that matches the situation in context and intensity. Resilient children accomplish transitions smoothly and easily. They recover from stressful events in a period of time that matches the traumatic significance of the event. Stress and distress responses do not linger (Poulson, 1993:29, 30).

Essential features for the development of resilience in children include parental self-esteem, parent-child attachment, and basic needs of shelter, food and medical needs (Erikson Institute; Chicago reported in Poulson, 1993). Risk factors that can work against the development of resilience in children include under-resourced single parenthood, substance abuse, domestic violence, young parenthood, social isolation, mental illness, intellectual disability, and a history of child neglect (Poulson, 1993). Goleman identifies the characteristics of resilient children within disadvantaged and severely chaotic families as a
Involving Families in Alcohol and Drug Treatment—Themes from the Literature

...winning sociability that draws people to them, self-confidence, an optimistic persistence in the face of failure and frustration, the ability to recover quickly from upsets, and an easygoing nature (Poulson, 1996: 256).

In building on the notion of resilience, Goleman maintains that the intelligence quotient, or IQ, which has been overemphasised in the past as a feature of success or failure in development, actually accounts for only about twenty per cent of the factors which determine life success. The remaining balance of factors are attributable to abilities, such as motivation, persistence, impulse control, ability to delay gratification, ability to regulate mood, stress management, empathy and hope. These competencies can be learned and improved on by children, though it is recognised that women are traditionally groomed for the role of emotional manager, while men are socialised to be less adept in this arena. Ineffective parenting styles are identified as being: ignoring feelings in children, being laissez-faire, and showing no respect for how the child feels.

Goleman further comments that those young people who experiment with alcohol or drugs and become addicted, use drugs as a form of medication to ‘soothe feelings of anxiety, anger or depression’ (1996: 253). It is those who report higher levels of emotional distress who go on to have higher rates of substance abuse. Goleman further argues that acquiring the ability to handle these feelings removes the need for the use of substances, and that these basic emotional skills need to be taught remedially in treatment programs for drug and alcohol abuse. According to Goleman, emotional intelligence can be taught, and doing so would prevent problematic substance use to a great degree. Emotional intelligence can be learned by teaching self-awareness and empathy, how to manage feelings and stress, communication and decision making, self-disclosure and insight, self-acceptance, personal responsibility, assertiveness and conflict resolution.
**Protective Factors**

According to Catalano et al, adolescent behavioural problems, such as substance abuse, offending, teenage pregnancy, school refusal and violence, stem from a similar set of underlying experiences and issues. Both risk and protective factors can be identified which shield young people from these problems.

**Risk Factors**

The risk factors which underpin the development of problematic adolescent behaviour follow.

**Family Risk Factors**

Family history of the problem behaviour, family management problems, family conflict, favourable parental attitudes and involvement in the behaviour.

**School Risk Factors**

Early and persistent antisocial behaviour, academic failure in elementary school, lack of commitment to school.

**Individual/Peer Risk Factors**

Alienation, rebelliousness, lack of bonding to society, friends who engage in the problem behaviour, favourable attitudes toward the problem behaviour, early initiation into the problem behaviour, constitutional factors, such as lack of impulse control, sensation-seeking.

**Community Risk Factors**

The availability and ease of access to drugs and firearms, the laws and policies in relation to drugs, offending and violence, media portrayal of violence, low neighbourhood attachment and community disorganisation, extreme economic deprivation.

**Protective Factors**

Some young people are exposed to multiple risks but do not develop problematic behaviours. Balancing the risk factors are protective factors, and these reduce the impact of the risks or change the way a person responds to them. Research indicates that protective factors fall into three basic categories:

**Individual Characteristics**

A resilient temperament or positive social orientation. Four individual characteristics include:

1. Gender (girls are less likely to develop health and behaviour problems in adolescence than are boys).
2. A resilient temperament (the ability to adjust to and recover from misfortune or change).
3. A positive social orientation (being good natured, enjoying social interactions, eliciting positive attention from others).

4. Intelligence (bright children are less likely to become delinquent or drop out of school).

**Bonding**

Positive relationships that promote close bonds, warm relationships with family members, relationships with teachers and other adults, and close friendships. Risk can be effectively reduced by strengthening the young person’s bond with positive, pro-social family members, teachers, or other significant adults and pro-social friends.

**Healthy Beliefs and Clear Standards**

Schools, families and/or peer groups teach their children healthy beliefs and set clear standards for behaviour, for example, being drug and crime free, doing well in school (Developmental Research and Programs Inc, 1993).

**The Effect of Risk and Protective Factors**

Two of the protective factors, bonding and clear standards, concern the relationship between the young person and their social environment, including the community, the family, schools and peer groups. Werner and Smith (1982) found that two critical protective factors are: the relationship with a significant adult family member and a caring relationship with an adult in the community.

...caring connections promoted resilience among vulnerable children throughout their lives (McDonald et al, 1997).

The overview of high risk adolescents in placement and support services with the Department of Human Services, Victoria in 1997 indicated that 85 per cent of this target group were non-participants in school or day programs. Furthermore, only 30 per cent had regular contact with family members. The sample group was characterised by lack of placement stability, lack of connectedness to family or significant others, family violence, inability to be maintained in school or day programs and the involvement of a high number of services. The profile of this high risk group of young people indicates a high degree of vulnerability, consistent with the risk factors identified above, and possibly without the necessary resilience. The lack of placement stability, lack of ongoing meaningful relationships with family members and other adults, and non-involvement in school were found to contribute to this vulnerability (Department of Human Services, 1997).

The literature on resilience, social competence and social intelligence highlights the importance of the family in the development of life skills in young people, and the need for intervention strategies to be developed within the context of the family. Recent research claims that regardless of the family’s relationship to the young person’s problem, they always need to be involved in the solution, and that treatment that does not include the family is less likely to be successful in the long run.
Furthermore, Snyder and Ooms write:

Treatment services must avoid further overwhelming and undermining the family or the troubled adolescent. The goal is to help parents regain their competence and ability to help their teenager survive the passage to responsible adulthood. Treatment must empower the family in order to help the adolescent... However troubled and alienated from the family the youngster may be at the time, it is the family that is the one constant factor in their life; family members have an ongoing relationship with and commitment to the adolescent. The primacy of the family should be respected; the family should be empowered rather than supplanted by treatment (Snyder and Ooms, 1996:1&6).

There has been a growing respect for the integrity, rights and needs of the family in service delivery. The parent and consumer movements, in the fields of mental health and drug and alcohol treatment, have led to an increased awareness of the rights, roles and responsibilities of parents. The child welfare reform movement also identified the need to preserve the family and avoid institutional placement.

In the USA and Canada, both outpatient and residential drug and alcohol abuse treatment programs are increasingly including families in the treatment of adolescents. This is done through a wide range of modalities, including family therapy, multi-family groups and family education programs (Snyder and Ooms, 1996).

2.3 Models of Intervention

Theoretical Frameworks

Drug treatment programs overseas are increasingly targeting families of young people who are at risk of substance abuse. This is occurring at a variety of levels, from preventative and early intervention to treatment and active intervention. Furthermore, there is a range of approaches used in working with young people and families, from working with the young person alone, providing support to families as a group to approaches which involve working with both young people and their families in a family-centred approach.

In Australia there have been limited attempts to involve families in the prevention of adolescent substance abuse related to the overall inadequacy of adolescent prevention and treatment efforts (Toumbourou et al, 1997).

Family Systems Theory

Bry (1988) has developed a framework to explore the range of approaches to intervening in the arena of adolescent substance abuse. This framework draws on family systems theory and behavioural theory, which generate different explanatory concepts and interventions.

Family systems theory maintains that adolescents can best be understood by studying the characteristics of the family system and attempting to change family characteristics, by:

- Gaining access to and influencing the family system
Interrupting the relationship between the dysfunctional characteristics in the family system and the adolescent’s problematic behaviour and

Establishing new family characteristics to interact with new adolescent behaviour (Bry, 1998).

**Behavioural Theory**

In contrast, behavioural theory proposes that adolescent behavioural change is dependent on parental behaviour change, and that parent training methods are appropriate approaches to adopt. Behavioural family therapists work more closely with the parent, rather than the adolescent behaviours, focusing on the development of skill areas, such as parental management, communication, problem-solving, contracting, self-management and reinforcement. Common behavioural approaches to intervention are:

- Providing reading material
- Informal, oral instruction
- Modelling by teaching new parent behaviours
- Prompting, shaping and behavioural rehearsal
- Providing reinforcement
- Assigning homework (Bry, 1988).

In commenting on the differences between the family systems and behavioural approaches, Bry concludes that:

> Theoretical differences lie in choices of salient family and adolescent variables, units of measurement, levels of scientific analysis and notions about cause and effect. Both theories, however, currently are generating knowledge that reduces adolescent substance abuse and this bodes well for the future (Bry, 1988: 61).

Blume et al (1993) comment on the proliferation of treatment programs in the USA for adolescents with substance abuse problems and the different treatment approaches which span family therapy, individual therapy and early intervention programs. They note on the pragmatic considerations and cost implications which favour short-term approaches.

**Preventative Approaches Based on Learning Theory**

Preventative programs identify young people who present with multiple risk factors and provide interventions, such as family life skills training programs and parenting programs. St Pierre et al (1997) argue that these programs tend to work well for functional and motivated middle-class families, but not for high risk families where it is difficult to recruit and retain them in the programs.

**Boys and Girls Club of the USA**

A program was developed for the Boys and Girls Club of the USA with at risk young people. This program is based on a psychosocial approach focusing on peer...
and other social influences and the development of skills to respond to these pressures, also included a parent involvement program.

The aim of parental involvement was to strengthen the bond between young people and their parents, reduce maternal isolation, facilitate joint pleasurable activities, providing parental support and helping parents to influence the direction of their children’s lives (St Pierre et al, 1997).

Parental involvement was based on the family support/resource model incorporating principles of:

- Focusing on families’ strengths rather than on deficits
- Inspiring parental confidence and competence
- Responding to family cultural preferences and values
- Recognising the developmental needs of parents
- Providing flexibility and responsiveness to parental needs
- Encouraging voluntary participation by parents
- Including parents as partners in the planning and implementation of the program (St Pierre et al, 1997: 26; Weissbourd and Kagan, 1989).

This prevention strategy included four groups: a program for young people including monthly youth activities but without parental involvement, a program for young people alone, a program with monthly activities and parental involvement and no program. The evaluation findings indicated positive program results for the youth prevention program with monthly youth activities and the parental component. In fact, the parental involvement component was seen as making the most valuable contribution to the program effects.

In conclusion, recruiting and maintaining parent involvement with high risk populations is a fragile process, relying on the personal skills of the staff and requiring considerable time and effort.

**Behavioural Exchange Systems Training (BEST)**

A parent training program, consisting of nine two-hour sessions, was run for parents attempting to cope with an adolescent drug problem and operated jointly in Melbourne by Odyssey House, the Centre for Adolescent Health and the Australian Greek Welfare Society. This is an example of a program operating for parents of young people with substance abuse problems in a groupwork model (see Appendix 3 for details).

Observations of the group members indicated that parents experienced problem solving difficulties through experiences of anxiety and depression, difficulties in discipline, parental conflict, absence of a supportive partner, and that these had the effect of weakening limits that constrain their child’s behaviour. Parents appeared to benefit from the opportunity to discuss their feelings and groupwork was seen to offer opportunities for behavioural modelling, communication and support.

Rohrbach et al (1995) suggest that the proliferation of parent groups devoted to the prevention of adolescent substance abuse have focused on drug education, rule
setting and communication skills training and that these activities have had a positive impact on family relations and parental control.

The authors investigated the relationship between parental participation in a multi-component prevention project and adolescent use of alcohol and tobacco. It was found that though peer influences were stronger than parental influences, parental participation, and the degree to which adolescents cared about their parent’s expectations, were nevertheless associated with adolescent substance abuse.

**Family-Centred/Family Therapy Models and Approaches**

Another model for family involvement in treatment of adolescent substance abuse is a family-centred clinical approach, which involves young people and their families in counselling. Family-centred assessment either starts with the whole family, or begins with the parents alone, but it does not focus solely on the adolescent. Family-centred treatment services and procedures are based on family systems theory, which views the family, rather than just the adolescent, as the unit of treatment (Synder and Ooms, 1996). Furthermore, at a program or agency level, ‘family-centred’ refers to support for the family’s involvement in treatment through every aspect of the organisation and includes financing, policies and procedures, staffing, training and record keeping, as well as the program.

Practice which is family-centred provides:

- A respectful orientation toward the family as a major force in adolescent development and the primary resource for most adolescents. The fundamental assumption of family-centred treatment is that the best way to help a troubled adolescent is to support, strengthen and empower their family (Snyder and Ooms, 1996).

Research supporting family-centred treatment for adolescents falls into two areas: social science research, which identifies the central role of the family in the development of the adolescent, and outcome research, which documents the clinical effectiveness of family-based interventions (Snyder and Ooms, 1996).

The aim of these programs is to re-establish the family as a significant resource system, and to this end the family must become involved in the assessment and the planning of solutions to the adolescent behavioural problems. It is seen as necessary to do the following:

- Consider the family as part of the solution.
- Keep in mind that while problems occur in the context of certain family patterns, families do not ‘cause’ these problems.
- Understand that problems occur in a developmental context, that involves all family members.
- Recognise that there are underlying issues in family relationships that may be stirred up by developmental or other stresses (Combrinck-Graham, 1996).

It has been estimated in the USA that 93 per cent of drug treatment programs have family therapy as the treatment of choice for people with drug problems (Lewis et al, 1990).
Furthermore, there is research to indicate that when families are given systemic (family-based) intervention, there is a higher treatment success rate in relation to decreased drug dependence and reduced recidivism. Family therapy is thus seen to be a viable treatment model for families that have substance-abusing adolescents.

Many family-centred models of intervention stress the importance of the entry phase, where engaging the adolescent is an important task. It is seen to be important to impart non-blaming messages. It is suggested that emphasis should be on:

- Stressing the need for maximum, coordinated helping where families are part of the help offered and available.
- Belief that parents and other family members have a genuine desire to be helpful to the adolescent.
- The primary goal of reduced drug involvement (Todd and Selekman, 1996).

Engaging the adolescent is undertaken through individual session time in the early stages of treatment, using techniques such as positive connotation, use of metaphors, empathy and humour, familiarity with street language, use of self, etc. The adolescent is seen to be in the position to provide ‘invaluable diagnostic information about the function of drug-abusing behaviour for the family system’ (Todd and Selekman, 1996: 81).

Questions are asked of the family with the objective of establishing the degree to which the problem is shared, establishing the processes of family interactions and level of functioning. In this approach it is seen as necessary to explore the pattern of drug use by the adolescent, in order to assess how significant a life change is required and how compromised the young person’s thinking and judgment may be. The therapist must then follow up on the responses to questions until they have an understanding of the extent to which drugs are controlling the adolescent’s life and affecting the family’s willingness and capacity to invest in effort to help the young person stop (Combrinck-Graham, 1996).

**Adolescent and Families Project**

Liddle (1996) reports on the Adolescent and Families Project, which started in 1985 at the University of California in San Francisco and moved to Temple University in 1990. Adolescents age 13–18 years presenting with drug problems were assigned to three randomly assigned treatment groups:

- The multi-dimensional family therapy model
- A group therapy model
- A multi-family treatment model.

A non-clinical sample from the normal population served as a comparison group.
The multi-dimensional family therapy model, which takes place over sixteen sessions, emphasises individuals as sub-systems within a family system. Parents and adolescents are seen both together and alone at all stages and there is intervention with the school, the Juvenile Justice system, peer groups, etc. There is an emphasis on parental competence in developing new relationships with their adolescent, as well as past trauma which has taken place in the lives of adolescents and their families. Liddle argues that ignoring this past content can ‘keep the therapist stuck in an ineffective, present-centred, problem-solving quest’ (1996: 96).

Relative Approaches
Joanning et al (1992) undertook a study to determine the relative effects of family systems therapy, adolescent group therapy and family drug education in treating adolescents with substance use problems, where physical addiction had not occurred.

The family systems therapy was an integration of structural and strategic family therapy, where subjects were seen weekly by two therapists for 60–90 minutes. The Adolescent Therapy Group met weekly for twelve 90-minute sessions, without their families, with an emphasis on group process. The family drug education group met bi-weekly for six sessions of 2.5 hours in groups of three or four families which involved a formal presentation of information and material.

No significant post-test differences were detected among treatment groups and all three groups appeared to improve the adolescent’s perception of communication with their parents. The finding was that ‘any treatment positively affected adolescent’s perception of inter-generational communication’ (Joanning et al, 1992: 353). On balance, however, it appears that family therapy was more effective than family drug education or adolescent group treatment in intervening to stop adolescent drug use.

The Purdue Brief Family Therapy Model
According to the report in Lewis et al, 1991, the Purdue Brief Family Therapy Model is a 12-week program integrating strategic, structural, functional and behavioural family therapies. This model establishes the nature and extent of drug use and assesses components of family functioning, including family structure, interactions and communication. Four phases of treatment are identified: ‘joining’, where rapport is established; ‘implementation’, where dysfunctional behaviour is challenged and skills training undertaken; ‘facilitating/monitoring’, where progress of strategies is reviewed; and ‘termination’, where progress is evaluated. The major treatment goals of the intervention are to:

- Decrease the family’s resistance to treatment
- Consider negative consequences of change and deal with ambivalence to change
- Establish appropriate parental influence
- Assess cycles of family interactions around drug abuses
- Interrupt dysfunctional sequences of behaviour
- Provide assertion skills training.

**Functional Family Therapy**

This approach was developed by James Alexander, Bruce Parsons and others at the University of Utah. Its effectiveness is due to an emphasis on the factors required for positive change with young people and their families. It has now been replicated in a number of communities over many years. The model is compatible with the philosophies of family preservation, with an emphasis on education and skill development, to ensure that the family provides a secure and safe place for the young person.

The model has been tested in a range of ethnic communities in the USA and Europe with increasing success. It is suggested in the literature that FFT is successful because of its identification of specific phases, each of which includes an outline of goals, worker skill and techniques.

During the early phases the therapist works with family members to assist them to interpret their world, build an alliance and overcome negativity to the process. Functional Family Therapy begins an assessment with the family based on a ‘genogram’ and identification of family patterns and key issues. Later interventions include ‘teaching’ and activities designed to bring about long-term changes in family interaction and behaviour.

**2.4 Summary**

The literature indicates that there is a vital connection between the functioning and characteristics of the family of origin and the subsequent development of problematic substance use patterns in adolescents. There is a theme in the research that problematic substance use patterns among adult parents positively influence adolescent children toward substance use problems, and thus there is a concern for the modelling which takes place in adult–child interactions, particularly in the area of alcohol.

Even more compelling research has been undertaken to establish that the degree of connectedness between the parental figures and the adolescent is a vital variable in the development of problematic substance use. Relationships between parents and young people which reflect warmth and attachment, concern and interest, positive authority and control, involvement in shared activities and mutually satisfying interactions are more likely to correlate with control over the development of problematic substance use.

The corollary of this equation is that families where the parent–child relationships are detached, abusive, uninterested, uninvolved, overwhelmed by other stressors or structurally under-resourced are more likely to result in adolescent children adopting problematic substance use behaviours. The link is also established with drug-using peer associations, where families in which there is not attachment, involvement or interest are more likely to result in the adolescent associating with a peer group who are drug or alcohol dependent—almost as if to meet the adolescent’s need for attachment and belonging.
School attending is also an important variable, as research has indicated that school attending young people are less likely to have serious substance use problems than non-attending peers. Again, school attendance is seen to be inextricably linked with family connectedness. The interlinking of the variables of positive family relationships and communication patterns, associations with peers who are non-substance abusing and positive connection with school communities are all vital protective factors against the development of problematic substance use.

Programs or interventions aimed at reducing substance use problems among young people have been based on a number of theoretical models. The concept of parent training and support is one approach, based on behavioural learning theories. The premise of these programs is that parents can be supported and empowered to become more effective in their role with their adolescent children. This approach can be adopted either as a preventative measure or universally, through whole-school approaches, in community run programs or targeted to specific families where adolescent substance abuse has occurred.

The aim of these interventions is to provide parents with an improved repertoire of responses in their parenting roles, to provide support and confidence for the approach to be adopted and to disseminate knowledge and information to help inform and raise the consciousness of parents.

Another approach, termed ‘family-centred treatment’, operates within a family therapy framework and involves the adolescent and their family members in counselling, with trained counsellors who specialise in the area of adolescent substance use problems. This model is structured and time limited and involves identification of dysfunctional interrelationships and communication patterns within families, with the aim of challenging and replacing these patterns with more functional approaches. The approach is family-centred and thus customised to the particular issues evidenced in that particular family. It therefore has the capacity to be culturally sensitive and responsive. The research which has been undertaken in this field has indicated positive results from the interventions and demonstrated that family patterns can be improved and altered, with direct benefits to the adolescent.

There is further scope for the development of new models in this field, which integrate family-centred therapeutic approaches with behavioural and learning theory approaches. The challenge is to develop models which are both effective and efficient in responding to family dynamics and compatible with existing service delivery modalities.
3. Survey of Families and Young People

A major part of the consultation process was engaging family members and other carers of young people who have a substance abuse problem—as well as the young people themselves. This process involved contact with the major self-help groups and other family groups, facilitated through funded drug and alcohol treatment services. A total of 97 family members, carers and young people were involved in the consultation. Thirty-four (34) were surveyed; 63 were involved in four focus groups; and five family members were individually interviewed.

Just over 340 surveys were mailed out to eight organisations, including CHCs, community centres, support groups and drug and alcohol services. The survey was distributed by the service workers who either handed it to their clients along with a reply paid envelope, or asked clients to complete the survey while waiting at the service. The survey was also handed out at a community forum.

As already stated, families were also contacted through a series of consultations with existing support groups. Three different kinds of support groups were operating and had very different styles and outcomes for families. Five group consultations were held, as well as telephone interviews with a number of individuals who volunteered to participate.

Consultations with young people were held to discuss the roles they want their family to play in their treatment, and the kind of support that they thought their family might need. Young people in the Youth Substance Abuse Service residential unit were interviewed individually, and a group consultation with thirteen young people in the SHARC program was also held.

Gender Differences in Participation and Response

There was generally a higher number of females than males participating in the consultations, however, mostly males responded by questionnaire. Because of this identified lack of participation by males in most of the groups consulted, particular effort was made to reach males to discuss what they thought they needed in terms of support.

Family members’ responses were highly consistent across all methods of consultation and were also highly consistent with the young people’s responses. Findings have been integrated in this chapter to eliminate any repetition.
3.1 Background Details of Families and Young People

Families/Carers Responding to the Survey

More females than males (25:9) completed and returned the survey, and respondents were mainly between 45–59 years of age. English was the most common language spoken at home (97 per cent). Almost two-thirds of the survey respondents were the mother (65 per cent) of the young person with problematic substance use, while close to one quarter were the fathers (24 per cent); six per cent were a sibling. Other relations to the young person with problematic substance use who completed the survey included an uncle/aunt and a partner.

A total of 33 young people with problematic substance use were referred to in the survey by respondents. The gender ratio of males and females was 22:11. The majority of these young people were over 19 years of age, although the age range was 13–26 plus.

Family/Carers Participating in the Focus Groups

The self-help groups were attended by a wide range of families who were experiencing grief, anger and helplessness. Many had been attending these groups for years; others just attended a few times. There were no formal processes for following up people who did not continue, and friendships and social contacts appeared to be important for many of the people attending. Groups held workshops, public forums and major events, for instance, memorial services for the families of young people who had died as a result of drugs. One clear outcome of these groups was lobbying for legal change and new treatment options.

The Worker Facilitated Support Groups were facilitated by a professional worker—usually a drug and alcohol worker—who had identified the need to support families and involve them in supporting their clients in some way. People attending these groups tended to have their feelings resolved in some way to a greater extent than those in self-help groups. They could speak about the pain and grief, but could also focus on themselves and dealing with the issues that had brought them into the group. These groups also had an educational focus, bringing in speakers and sharing information. Some people attending these groups also became involved in self-help groups to work for change.

The Structured Education and Support Group for family members of young people with drug and alcohol issues (run by Odyssey House/ Centre For Adolescent Health) was different from the other two groups. This was a group for families without necessarily a connection between the host organisations and the young people. It was a structured group that was time limited (ten weeks), and support was a secondary effect of bringing people together for drug and parent education. Families who had been through the course were expressing the desire to continue meeting for social contact and ongoing support, and follow-up groups are now being held monthly for those who wish to continue.
Gender Imbalance in Attendance

With the exception of the Structured Education and Support Group, one outstanding feature of all other groups was that they were predominantly attended by females. When this issue was raised in the groups the assumption expressed was that females tend to prefer to share their problems and want to talk about their feelings and work them through with others. The Structured Education and Support Group was attended by men and women in equal proportions. A feature of this particular group was that families attending this group had children with mixed substance problems (heroin, speed, marijuana), while in the other groups, all had children with heroin addiction primarily, sometimes with additional substance problems.
3.2 Experiences of Family Members of Young People with Problematic Substance Use

The overwhelming theme that emerged from the consultation was the total helplessness and lack of preparation families feel when they have to deal with a child with a major drug problem. Initially, families appear to go through a process of shock, disbelief and not knowing where to turn when they find out about their child’s drug habit. Later they become angry, and finally resigned, although this may be a long, drawn-out process. The groups engaged in the consultation all agreed that the process is similar for everyone. It appears that the experience is very similar to the grieving process, except without any final resolution or support from the extended family, friends or community.

The family has been somewhat socially ostracised and stigmatised as a result (mother responding to the survey).

Sometimes family members were aware that either one child or another in the family was using marijuana or drinking alcohol and did not think of this as a problem. However, when problems with heroin or other addictive substances became apparent they did not know what to do or where to turn for help. Families in the focus groups consistently used words such as ‘despair’, ‘desperation’, ‘confusion’, ‘helplessness’ and ‘ignorance’ to describe their feelings. Similar results were obtained from the surveys and three key areas were identified: lack of emotional support, the impact on their mental health and lack of information.

Lack of Emotional Support

This was expressed in terms of:

- Frustration with the welfare sector’s capacity to deal with the issue, with the young person, with the authorities, with society which, on the whole, just wants the problem to disappear.
- Emotionally draining, in having to support the family member through a treatment program, trying to keep the rest of family together, dealing with family conflict, lack of male support.
- Financial difficulties with the user’s stealing, lying and cheating and lack of respect for other people’s belongings; having to repair the house after the user has damaged it.
- Unsupportive siblings who do not want to know the user. This sometimes led to parents having to choose between children.

   Everywhere I took my son for help, no one worked with me. Consequently we would go back home and nothing much would change. In hindsight I can now say that recovery for me was equally as important as recovery for my son (mother responding to the survey).

   The hardest thing was probably the constant nagging/haslising for money and having money and possessions stolen from us. I had to look on as my brother sold many of my grandmother’s possessions and she almost wasted away into
nothing. Also I was followed to school on several occasions and once I was threatened with a syringe (sister responding to the survey).

A wonderful trusting, funny, intelligent, caring son became a shifty, lying thief... his whole concern in life became money (father responding to the survey).

The Impact on their Mental Health
This was expressed in terms of:

- Feelings of inadequacy, hopelessness and despair.
- Anger, shame and guilt which led to a lot of self-examination and self-blaming.
- Stress and anxiety.
- Loneliness and isolation through being socially ostracised.

Lack of Information
This was expressed in terms of:

- Ignorance about the young person’s behaviour. For instance, some families did not see alcohol and marijuana as problematic and it was not until heroin became involved that they took drugs seriously. In the consultation with young people many users said one of the major concerns they had regarding their relationship with family was the lack of understanding and support by family for them in their recovery. Many felt pressured and unsupported by their parents, while others had been the recipient of ‘tough love’ from their parents (in some cases on the advice of parent support programs).

  Our son had been taking drugs for four years before we found out and I never know if my actions are making the problem better or worse (mother’s response to survey).

  Mum and dad joked about me being ‘the drunk in the family’—they didn’t think it was serious until I started using heroin (focus group participant—user).

- Lack of information and access to comprehensive, honest, accurate information in time of need.

  [I was] frustrated with the welfare sector’s capacity because of government control to get people off drugs without myopic views and ideologies getting in the way. There is a plethora of models and systems run by compassionate, hard working people seemingly all doing their own thing in an un-unified way (father’s response to the survey).

In the focus groups the general feeling was that most knowledge people have about drugs comes from the media, which is biased and colours their thinking. People know about alcohol and soft drugs to some extent, but when a serious problem emerges they carry the baggage of myth, prejudice and ignorance for which they blame the media. Many do not see ‘soft’ drugs or alcohol as a problem and have no idea how to identify early signs of a problem, or if they fear a significant problem, have no idea where to turn for help or assistance.
Our only knowledge of drugs was from TV or magazine/newspaper articles. The feelings of isolation, inadequacy and fear were overwhelming (mother responding to the survey).

I felt like I was operating in the dark, I had no idea what to do who to turn to for help (focus group participant—parent).

In the consultation with young people concerns were raised about parents not having the necessary knowledge and understanding required to adequately support the young family member going through drug and alcohol treatment. The general feeling was that young people wanted their family’s support and would welcome it if parents were more educated about drug and alcohol issues.

[I felt I was] under a great deal of pressure from parents who do not understand what we’re going through in terms of rehabilitation and staying clean (focus group participants—users).

When mum found out I was using it was like an emotional bomb went off... she hasn’t let up on me since (focus group participant—young person).

Families felt it would be valuable to have the treatment process clearly identified so that they could understand what was happening to their family member and not feel so alone. It was also suggested that it would be valuable to have clear steps that could be taken to address problems and help deal with the specific issues that arise in each stage.

Other Feelings

Other common expressions used by survey respondents to describe their experiences included:

- Loss of trust in being able to depend or rely on the addict—the stealing and cheating, feeling betrayed.
- Family distress, unhappiness, disruption/ chaos/ turmoil.
- Shock/ horror/ nightmare.
- Love and hope, which developed when the young person decided to participate in rehabilitation programs and grew stronger, and began to communicate and bond with the family.

In the focus groups families reported that they felt like social pariahs when they had a child with problematic substance use. A frequent pattern was that the mother wanted to help and support, the father wanted the problem to be fixed and siblings felt shame, fear and anger. The usual result was that none of the problems were dealt with and the family started to break apart:

There was unbearable family conflict and aggression; being forced to choose between siblings. I felt loss of control over my life and the ability to make firm plans (mother responding to survey).

The life of the family was in absolute chaos and turmoil with emotions running riot and ranging from guilt to anger to shame. Our family felt helpless and at ‘arm’s length’ in terms of being able to stop the destruction that addiction caused (mother responding to survey).
3.3 Support Services for Family Members

A common theme running through the consultation was that families felt alienated and unsupported by health professionals and drug treatment services. Many families called for community education to help the entire community to understand drugs and alcohol, to help in the parenting of adolescents and to recognise behaviour problems before they became entrenched. They also called for mediation and counselling services to be available for families, and for workers to be trained and skilled in working with families. Families accepted that they have a role to play in prevention, treatment and recovery for their children who have problems. Issues raised in the focus groups were consistent with those raised by survey respondents, as summarised below:

Many parents have received ‘harsh’ advice from services and felt alienated as a result. Common responses included ‘Prepare for your child to die’ (doctor); ‘Throw your child out’ (Drug Advice Service Worker).

We needed to persist and do a lot of our own research in order to find options (father responding to the survey).

Services sometimes have no empathy and just treat you as a number... They make you feel worse than what you were feeling at the time by telling you their problems of short-staffing, lack of funding—which is not my problem (mother responding to the survey).

Authorities said nothing can be done to stop a woman from using heroin while she is pregnant, however they take the baby away after child birth (mother responding to the survey).

It was never explained how the service worked, which made me feel un-entitled to any of their services and that the whole rehabilitation scene was difficult to access (father responding to the survey).

I was crying out for help and had no idea about what to do. Did not get the sympathetic help and understanding from the service at the level that I needed it (father responding to the survey).

Many GPs lack information about drug abuse, treatment or how to deal with users or their families although there were some positive experiences reported. Most families have had very negative experiences with doctors.

GP did not offer any support or sympathy (mother responding to the survey).

The local GP was helpful as long as you didn’t go over the ten-minute appointment time (mother responding to the survey).

I went to see my family doctor, he was sympathetic and understanding but told me that while he would like to help that he could not help my son as his family practice could not tolerate ‘those kind’ of people (focus group participant—parent).
Many families initially turned to the phone book to seek help, which most found lacking. Agencies contacted through the phone book were mostly seen to be very unhelpful. Some responses included:

...the phone service gave me phone numbers of services which were not open after hours when I needed them (mother responding to the survey).

Telephone crisis services sometimes said ‘get on with your own life... forget the user’ and other times encouraged us to tell our children to ring them, but gave us no information (parents responding to the survey).

I called a telephone counselling service to seek help. They told me the only way was for me to throw my son out onto the streets and let him fend for himself (focus group participant—parent).

It was hard to ring the telephone counselling service in the first place, I was all in shock, it was hard to even get the words out (focus group participant—parent).

**How Respondents Saw Professionals**

There was a perceived lack of information about drugs among health professionals in general. Families reported the following:

All services seem to have their own philosophies about it, either the soft or hard approach, with no set guidelines. Professionals seem to know theory but do not have practical experience—that is, they have not lived with drug users and do not really know the problems (father responding to the survey).

...no psychiatric problems, so a suicide attempt was ignored and access to mental health services denied (mother responding to the survey).

Mental health service said ‘it is criminal not health’ (mother responding to the survey).

Drug and alcohol and mental health services are helpful but more youth-orientated rather than parent/carer orientated (mother responding to the survey).

Drug and alcohol professionals are helpful but usually lack understanding of how addiction affects the family. Recovery must embrace the whole family, otherwise it is only a band-aid (mother responding to the survey).

**Police**

Experiences with the police were also described as being very negative. If a young person had been identified with the drug culture, the police were seen to target and harass them and their families in the long term, regardless of whether they were using or not. This had a destabilising effect for everyone in the family.

Police identified marijuana as tea leaves and left it at that. The police attitude was just a lost cause. No help from police—‘she is 16 and can do what she likes’ (father responding to the survey).

Police told us it was not their job, ‘we are not welfare workers’ (mother responding to the survey).
Even though our son has been clean for some time and is living at home with us and has a job, the police still pay us visits in the middle of the night to question him. We frequently get dragged out of bed without good reason (focus group participant—parent).

There was a feeling that friends and extended family members had a self-righteous attitude towards families with drug problems: ‘My kids are fine, I must have done something right’. The implication is that families with the drug problem must have done something wrong. As a result, families feel like failures, keep their problems a secret and miss out on much-needed support. Community education and attitude change is seen as the answer.

There is a perception on the part of family members that services are overstretched. This was seen as a major issue by families who reported the following:

Drug and alcohol services have no capacity for crisis support, there are waiting lists everywhere and detox units were a waste of time because the addict just came back into the same environment (father responding to the survey).

The detox centres were helpful and understanding of the problems faced by addicts and their families and many workers were recovering addicts themselves... however, funding cuts resulted in long waiting lists (mother responding to the survey).

Services are constrained, fragmented and unsynchronised with other providers and have opposing philosophies and treatments. Also, they are under the dictates of government policies and are restrained by their preoccupation with self-survival (father responding to the survey).

Services are overstretched. I would like counselling for myself and my son but feel others' needs, such as heroin addicts, are greater (mother responding to the survey).

There was a one- to two-week wait for assessment at two detox services. An addict who is desperate to detox needs to do it now because the next hit could be a fatal one (mother responding to the survey).

<table>
<thead>
<tr>
<th>Types of Support</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information/Education</td>
<td>28</td>
</tr>
<tr>
<td>Counselling</td>
<td>27</td>
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<tr>
<td>Referral</td>
<td>17</td>
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<tr>
<td>Financial</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
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</table>

The main types of support respondents sought for themselves or their families included information/education (82 per cent) and counselling (79 per cent). Close to half of the respondents reported counselling (52 per cent) and information/education (50 per cent) were very useful when received.
Table 2  Usefulness of the Support Received by Respondents

<table>
<thead>
<tr>
<th>Types of Support Sought and Number of Respondents</th>
<th>Level of Usefulness (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>not at all useful</td>
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</tr>
<tr>
<td>Information/education (N=24)</td>
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<td>Counselling (N=21)</td>
<td>14</td>
<td>100</td>
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<td>Referral (N=13)</td>
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<td>100</td>
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<td>Financial (N=2)</td>
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<td>100</td>
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<td></td>
<td>somewhat useful</td>
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<td>very useful</td>
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<td>Referral (N=13)</td>
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<td></td>
</tr>
<tr>
<td>Financial (N=2)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Information/education (N=24)</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Counselling (N=21)</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Referral (N=13)</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Financial (N=2)</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

The different types of support received by the survey respondents were generally described as ‘somewhat useful’ or ‘very useful’. Respondents found the least useful any financial support sought and almost one quarter of all agency referrals were regarded as not useful.

Table 3  Sources from Which Support was Sought

<table>
<thead>
<tr>
<th>Sources of Support</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>(N=34)</td>
<td>%</td>
</tr>
<tr>
<td>Drug and Alcohol Service</td>
<td>27</td>
</tr>
<tr>
<td>Self-Help Groups</td>
<td>23</td>
</tr>
<tr>
<td>Telephone Crisis Service</td>
<td>21</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>17</td>
</tr>
<tr>
<td>Community Health Centre</td>
<td>13</td>
</tr>
<tr>
<td>Police</td>
<td>10</td>
</tr>
<tr>
<td>Mental Health Service</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
</tr>
</tbody>
</table>

The three main sources of support for respondents were an drug and alcohol service (79 per cent), self-help groups (68 per cent) and a telephone crisis service (62 per cent). Other sources of support included self-help (for example, reading books, attending lectures, talking with people who have knowledge and experience), the phone book, focus groups, local church, courts, Coronal service, the Premier’s Department and the Salvation Army.
Table 4  General Attitude of Services from Whom Support was Sought

<table>
<thead>
<tr>
<th>Service types and number of respondents</th>
<th>Attitude of Services (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>not at all helpful</td>
</tr>
<tr>
<td>Drug and Alcohol Service (N=21)</td>
<td>5</td>
</tr>
<tr>
<td>Self-help Groups (N=17)</td>
<td>0</td>
</tr>
<tr>
<td>Telephone Crisis Service (N=16)</td>
<td>6</td>
</tr>
<tr>
<td>General Practitioner (N=12)</td>
<td>8</td>
</tr>
<tr>
<td>Community Health Centre (N=26)</td>
<td>10</td>
</tr>
<tr>
<td>Police (N=7)</td>
<td>14</td>
</tr>
<tr>
<td>Mental Health Service (N=6)</td>
<td>17</td>
</tr>
</tbody>
</table>

Respondents generally felt service workers' attitudes were 'helpful' or 'very helpful' and described CHCs as having the most helpful attitude and police as having the least helpful attitude.

Survey respondents provided accounts of instances when services had been useful or helpful. These accounts have been grouped under the four most common types of support respondents received and are described below:

**Practical Assistance**

For respite for families I found the best days were when the patient was in detox for three weeks at a State hospital. The Austin Hospital gave a lot of time, support and advice (mother responding to the survey).

Odyssey House was ideal for limit setting in an ideal environment, with past patients and counsellors doing a great job there. Monash CHC is fantastic (mother responding to the survey).

Psychiatrist gave practical help to the patient and was non-judgmental (mother responding to the survey).

Helped the addict get admitted into a detox centre, helped her sort out her marriage problems and got her financial help (mother responding to the survey).

**Counselling Assistance**

Coronial services counselled me once and referred me to Families Anonymous and a grief counselling service (mother responding to the survey).

Individual counselling and family counselling were very useful (father responding to the survey).

**Support Groups**

Listening to other people's experiences helps because one can identify with people's feelings and gain inner strength (mother responding to the survey).
KOKAAS was very helpful but we found out about the service too late (that is, after my brother died). The women’s self-help group is fantastic. Families Anonymous was very supportive (sister responding to the survey).

Information and Advice
The crisis number I rang late at night was very helpful and the counsellor made an appointment to see my daughter the next day and on a regular basis thereafter over a 12-month period (mother responding to the survey).

Drug Help Line put me onto community centre help groups, etc. Direct Line was generally very good in providing information and advice (mother responding to the survey).

Types of Support Needed by Families
The main support that families wanted for themselves generally related to understanding the effects of addiction and treatments available; emotional support and broadening knowledge on substance abuse; and services available for people with a drug related problem and their families.

In the focus groups, families felt that initial support was somewhat problematic with brochures seen as useful but not readily accessible for most families. All agreed that they were not enough. Families provided an account of the types of support they needed and responses have been summarised below:

Information/Education for Families
Comprehensive information about substance abuse, the effects of addiction and the various treatment options available and medications.

Want to understand what is happening to my child and to my family (focus group participant—father).

Want to understand how drugs work, the drug culture, symptoms of abuse and how to handle the problems (focus group participant—father).

Provide an educational service for families (focus group participant—parent).

Provide reading lists (focus group participant—parent).

Courses and programs for families would be useful (focus group participant—parent).

Information about drugs and the effects they have, how to recognise danger signs (focus group participant—young person).

Information about harm minimisation and what this means (focus group participant—young person).

Advice/Guidance
Families needed guidance on what are ‘realistic’ expectations. For instance, they needed to know whether they will have a lifelong dependant and they needed accurate information and referral to appropriate services/ agencies.
Need information about drugs and alcohol (focus group participant—parent).

**Counselling**

Families reported a need for one-on-one counselling that was inexpensive. Grief counselling for parents/carers, addicts and other family members was considered vital.

Initial counselling to help identify the problems (focus group participant—parent).

Early intervention should be provided by a counsellor or mediator between young person and parents (focus group participant—young person).

**Support Groups**

Families needed emotional support, to help deal with mixed emotions, and considered meeting people who are experiencing the same circumstances and anxieties as a way of being reassured that feelings experienced are normal. Families described their initial difficulties in finding out about the support group they were currently attending and strongly emphasised the importance of families having easy access to help early on.

Once men are in a group and ‘hooked’ by a practical ‘chalk and talk’ approach; they will stay involved and find emotional support (focus group participant—father).

Self-help groups are vital (focus group participant—mother).

Families need to learn how to deal with their own feelings of guilt and shame and not impose their problems on their children (focus group participant—young person).

Parents need to work on themselves so it could make it easier for us kids (focus group participant—young person).

The pressure is to always be perfect so mum will be OKAY (focus group participant—young person).

**Non-Judgmental Services**

It was reported that often addicts are classified as belonging to the ‘lower socioeconomic strata levels’.

**Service Quality**

Families clearly needed programs that would provide both education and information, support and counselling for families, and which would be conducted in conjunction with treatment services for young people with problematic substance use. It was believed such programs would give family members the opportunity to address and deal with their own issues and also work towards understanding what the user is going through.

Families wanted sympathetic, supportive counsellors available on a drop-in basis in community health centres. They believed the worker’s role should be to involve
Involving Families in Alcohol and Drug Treatment—Survey of Families and Young People

families; to mediate between the child and the family and help them negotiate the treatment maze. Families were wanting total honesty from the system and services which do not hide behind rules and regulations.

Social workers should listen to the parents as well as the users, because parents should have rights too (mother responding to the survey).

Need forums where the professionals, policy advocates, law makers, addicts and their families, can express themselves and listen to each other (father responding to the survey).

They want a structured, practical program where they can learn the basic, legal and policing issues relating to drug use (focus group participant—father).

Community Education

General community attitudes towards young people with drug problems were perceived as being problematic. It was felt that young people are often stigmatised, labelled and marginalised which made it harder for them to get help and harder for their families to cope. Families in the focus groups maintained that drugs should be seen as a community problem, not a shameful secret.

Demystifying the drug culture so that people who have problematic use can be seen as in need of help rather than monsters (focus group participant—parent).

Families felt that they are seen as the enemy and to blame for their children’s drug use by drug treatment services, the police and the law. Families who came from poorer or working class areas were more likely to be seen in this light and did not have the resources to hide the problems or protect their children. Families with more resources reported that being able to keep their children out of trouble and had not involved the police even though they were regularly robbed by their children. Some had even bought their children’s drugs as a short-term measure prior to detox rather than expose them to danger on the streets.

It was also felt that written materials on drugs and their associated problems should be readily available and accessible so that families know where to turn and what to do when faced with a problem relating to drugs or alcohol. It was also suggested that there should be community education programs available for families, which are easily identified and accessible that families can attend when they are ready.

Understanding and appreciation of the issues faced by parents of users, together with means of coping with and assisting the user (focus group participant).

Families also emphasised the need for community education so that responsibility for problematic substance use among young people becomes a community responsibility. Problems would therefore be identified early on and the community would learn about appropriate responses and interventions.

Support for Siblings

Siblings of young people with drug problems were seriously affected and yet there was no help available to them. They are often angry and feel ashamed but cannot talk about the problem because of the stigma attached. It was suggested that peer support groups for siblings would be very useful and families wanted a program for
siblings of drug users to be established, like the Kids with Cancer support group for siblings.

It was also noted that there is no support for parents or siblings in the school system and that siblings particularly would benefit from having informed supportive student welfare teachers to talk to at school.

There seems to be services around for the addict and parents but not for siblings (focus group participant).

**Other Types of Support Described**

Respite, in times of crisis, and a safe place for the user, home withdrawal, crisis service, financial assistance and service follow-up, such as continuing education and counselling were identified.

The majority of family members responding to the survey were able to provide a description of the type of support they believed other members of their family would benefit from. Although ‘other family members’ sometimes included the substance user, it mainly included siblings and extended family members of the user. The descriptions provided varied within themselves, but were not dissimilar to those types of support needed by the respondents.

**Information/Education and Guidance**

This included pamphlets in chemist shops/ doctors surgeries, educational booklets for ‘family members’, learning to negotiate, conflict management).

**Counselling/Psychotherapy**

Participants identified looking at the issues surrounding the user’s lack of communication with their family and surrounding issues, such as reduced school performance, lack of motivation, self-care and self-esteem, practical counselling sessions, and what to do if this happens.

**Support Groups**

Becoming involved with people in like circumstances.

**Non-Judgmental Services**

Being made to feel useless and hopeless when accessing a service.

### 3.4 Family Involvement in the Young Person’s Treatment Program

**Comments about Men’s Participation and Attitudes**

Close to two-thirds of survey respondents reported that they had been (or were currently) involved in the treatment process their young family member was going through (62 per cent). The results showed that male carers tended to become more involved than female carers, which was an interesting finding, because the opposite
result emerged from the focus groups where the involvement of men in supporting and involving families was minimal and sometimes seen as problematic.

Very few males attended the focus groups and it is possible that females feel more comfortable talking about problems and seeking support, while males need to solve problems and when they cannot they tend to withdraw. The feeling was that males felt ashamed and embarrassed by their children who were using drugs. They felt like they had failed in their role as a parent and that the child they raised is ‘no longer their child’. They did not have a culture of talking to their men friends about their problems and often lost touch and felt ostracised because they had ‘failed’. This resulted in depression and despondency, and they had no idea how to handle their own feelings or their family’s problems.

Many of the families who were involved in support groups had experienced a family break-up or a personal/emotional crisis as a result of their family member having problematic substance abuse.

**Family Involvement (62 per cent)**

The main ways in which survey respondents reported being involved in their family member’s treatment program included:

- Encouragement and support through finding out about rehabilitation programs and other treatment services, and encouraging the user to access these services; encouraging socialisation and work practices; regular communication; providing food and shelter and offering support to other family members.

- Direct involvement in the treatment process through an in-home withdrawal program which involved supervising the user’s medication, eating and sleeping programs; providing information to workers in an interview for a detox program in order to provide the workers with a broader perspective of the family dynamics; ensuring user attends groups when in treatment and participating in counselling sessions.

**No Family Involvement (38 per cent)**

Eleven survey respondents reported not having any involvement in their family member’s treatment program and the reasons given for their lack of involvement mainly centred around the user discouraging family involvement. Reasons given included:

- User not being encouraged to talk to family members because of confidentiality issues; detox units being patronising and unwilling to discuss even in a general way the treatment process users undergoing.

- User wanted no involvement with their family.

- User not needing support from any family members because they were on the right track and ‘doing okay on their own’.
Ways in which Other Family Members are Involved in the Treatment Program

According to more than half of the respondents (59 per cent), other family members (usually the siblings) were not involved in the young person's treatment program and reasons given by respondents centred around the following issues:

- Family members too busy with their own lives/ careers/ school studies
- Lost interest because of too much hurt and disappointment
- Felt it was time the user ‘owned their problem’.

Other reasons included:

- Young person has no contact with family
- Young person currently in prison
- Family not aware of situation until user’s death
- Parents being too old to cope with situation.

The ways in which other family members (41 per cent) were involved in the treatment program were very similar to the way survey respondents were involved and included:

- Encouragement and support of user’s progress, of other family members, living with the addict and regular communication.
- Participating in counselling sessions.
- Attending support groups, such as Families Anonymous.
- Searching for information.

Ways Respondents Would Like to Support Their Family Member

Regardless of their relationship to the young person, the overwhelming majority of respondents (97 per cent) would have liked to support their family member. The most common ways described for wanting to do this included the following categories:

Emotional Support and Encouragement

In the consultation with young people the general feeling was that participants wanted the support of their family. All of the young people identified in some way with their family and many were still living at home at least some of the time. The connection to family was felt by the young people as they identified their family as being a vital part of their treatment process. Most defined their family as parents (including step-parents) and siblings, and also included extended family like grandparents and aunts and uncles. Several young people were not connected to their family of origin but had developed connections with adults with whom they felt a bond, for example, their girlfriend’s parents or grandparents. Young people were therefore needing the support of family in one way or another.
For instance, taking family member out of the environment associated with drug taking, helping them cope with the shame, open discussion of issues, love and moral support, encouraging them to enter rehabilitation programs, supporting any treatment method the addict chooses to undergo (mother responding to the survey).

Involvement in any treatment processes undergone by the addict and wanting to attend counselling as a family (mother responding to the survey).

Service Access and Quality
Respondents identified these issues:

- Having easier access to services with shorter waiting lists and better resources.
- Directing the family member to services which support addicts in developing the capacity to put strategies in place to overcome their depression and drug problem.
- Basically assisting the user to link in with services which have a holistic approach and address the mental as well as the physical issues of addiction and which would have constructive long-term follow-up.

  Learning coping mechanisms during the addiction would be useful (mother responding to survey).

Improved Community Attitudes
Survey respondents would like community education so that the general community as well as service workers have a greater understanding on drugs and treatment options available and are aware that this is a medical/social problem and not criminal.

Problematic drug use is identified at present as a criminal issue with health implications. This leads families to avoid knowing about the issues involved or the real dangers for their children. There is a strong feeling that this approach needs to be reversed so that drugs are seen as a health problem with criminal implications.

Financial Assistance
Survey respondents reported also wanting to assist their family member by lending them money and contributing financially towards their treatment.

  The difficulty is keeping the user safe and alive while trying to sort out the mess (father responding to survey).

Support Groups for Families
In the focus groups none of the families were seeking direct involvement unless this was at the request of their child. All, however, wanted to know what was happening and how to behave appropriately to support the treatment and to that extent wanted to be involved in a peripheral role. All wanted to be treated respectfully by workers who were caring for their children.

In the focus groups, participants from the Odyssey House CAH group identified a number of benefits in becoming involved with this support group. Participants
learned to stop blaming themselves and instead to focus on changing their own behaviour rather than trying to control their children's. They learned to let their children grow up and take responsibility for their own behaviour. Meeting people also helped families realise that they were not alone, and contact was often continued socially long after the group had finished.

There were some differences in the approaches of the self-help groups and the worker facilitated groups. The worker facilitated groups tended to focus on the experience of family members, assisting them to deal with their anger, grief and distress. Although a generalisation, the self-help groups tended to focus externally on political change, such as heroin trials, legislation, decriminalisation or the legal system. Clearly there is room for both approaches. While there was no difference in how each of the groups described their initial experience or support needs, there was a considerable difference in how they presented the issues and viewed the ‘problem’.
3.5 Summary

The main theme to emerge from the consultation with families was the initial feeling of total helplessness and lack of preparation experienced by family members when they have to deal with a child with a major drug problem. Families reported going through a process of shock, disbelief and not knowing where to turn when they found out about their child’s ‘drug habit’. Key areas of concern identified by families included lack of emotional support, the impact on their own mental health and lack of information.

Another common theme running through the consultations was that many families felt alienated and unsupported by health professionals and drug treatment services. Issues raised throughout the consultation centred around having received harsh advice from services and feeling alienated as a result. It was reported that many GPs lacked knowledge/information about drug abuse, about treatment options and about how to deal with users and their families. Agencies contacted through the phone book were mostly seen to be unhelpful and experiences with the police were not described in a positive way.

The main types of support families sought included information/education, advice/guidance, counselling, support groups—and families generally described these types of support as useful. Family members described their relief when they contacted a supportive service. The three service types reported as being of most help were drug and alcohol services, self-help groups and telephone crisis services. At these services families generally found the workers’ attitudes helpful and described community health services as those with the most helpful attitude.

Families also requested information which would assist their understanding of the effects of addiction, services/treatments for their family member with a drug related problem and emotional support. With regard to service delivery, the approach most commonly endorsed by families included a non-judgmental style, quality of service, information and community education and support for siblings.

Most families reported being involved in their young family member’s treatment process and emphasised the importance of this for both the user and the family. The ways in which families became involved was usually external to the service process and included offering encouragement and moral support, offering to do the research around rehabilitation programs and other treatment services available, encouraging and supporting the user’s progress, encouraging and supporting other family members’ involvement. In a few cases parents had become directly involved in the treatment process through an in-home withdrawal program. Participating in counselling sessions and attending support groups, such as Families Anonymous, were often ways in which family members became involved.

In the consultation with young people the general feeling was that participants wanted the support of their family. All of the young people identified in some way with their family and many were still living at home at least some of the time. The connection to family was felt by the young people as they identified their family as being a vital part of their treatment process. The focus groups with young people showed that substance users wanted and needing the support of family in one way or another.
Families who were not involved in the treatment process failed to do so mainly because their involvement was discouraged by the user or the service. For instance, the user was not being encouraged by service workers to talk to family members due to confidentiality issues, or the user themselves wanted no involvement with family.

In addition, other family members, such as brothers or sisters, were not usually involved in the young person’s treatment program because they were too busy with their careers, school studies, or had lost interest because of too much hurt and disappointment. Sometimes this was the case for parents also, who chose not to be directly involved.

The overwhelming majority of families would like to support their family member and view this involvement as a crucial part of the young person’s treatment. The most significant ways described by the families for supporting their child included offering emotional support and encouragement, helping them to access quality services, helping to improve community attitudes and offering financial assistance.

Regardless of whether families were seeking direct involvement in the treatment process, all families wanted to know what was happening and how to behave appropriately to support the treatment.

Generally, families wanted to be seen as part of the solution and not as the ‘enemy’ and acknowledged they needed to acquire a greater and deeper understanding of drug and alcohol issues in order to be in a position to provide the appropriate support to their young family member. The consultations with young people indicated that young people needed their family’s support while undergoing treatment, however, they sometimes discouraged it because their families lacked the knowledge and understanding needed to support them effectively.

In summary, families need to be in a position where they can make more informed choices when dealing with issues around their young family member’s addiction, because their support and understanding is very much needed, and is considered crucial, by the young people at this time in their life.
4. Survey of Current Practice

In an attempt to gain a clear picture of current practice, a total of 45 services currently providing a drug treatment service to young people in Victoria were interviewed. The range of services included nineteen community health services, thirteen specific drug and alcohol services, five family and welfare, three Aboriginal services and five hospital units (see Appendix 2). Those services that demonstrated family inclusive models have been written up as case studies. Further examples of interstate and overseas service models have also been documented (see Appendix 3).

In addition to service provider interviews, a series of workshops were held in Benalla, Fairfield, Dandenong, Bendigo, Footscray and Geelong, with a total attendance of 52 workers. Two workshops were also held for ethno-specific and Aboriginal service providers with an attendance of eight and twelve providers respectively.

The aim of the interviews and workshops was to identify current family involvement in drug treatment services for young people and the key issues that have emerged in engaging young people and their families. As there were consistent themes emerging from the interviews and workshop responses in relation to key issues and support needs of families, responses have been integrated. Key issues emerging from the ethno-specific and Aboriginal workshops are reported separately.

All divisions of General Practice across the State were also contacted by letter to identify whether they are currently or have in the past undertaken any work in relation to family involvement in drug treatment for young people. Nine GP Divisions responded out of a possible thirty-one. Generally, the divisions that responded were involved in more health education drug prevention initiatives, with the exception of Western Melbourne and Hume Divisions, whose work is reported later in this chapter.

4.1 Treatment Services Provided to Young People

All of the services interviewed reported that they provide drug treatment service to young people, although the numbers of young people accessing the service varied from being 100 per cent youth focused (such as YSAS, Open Family Streetworker, Youth Projects, Connexions Outdoor Program), to working with approximately 20–30 per cent young people. There were also groups which predominantly worked within an adult model (for example, Odyssey WestADD, Palm Lodge). A number of services reported that they have only recently received funding to work with young people and have had a D&A youth counsellor/outreach worker positions allocated.

It is interesting to note that at the time of writing the Young People and Drug Needs Analysis Report (Success Works, 1998), there were few services providing a drug treatment service to young people.
Table 5 shows the main types of treatment service provided to young people with problematic substance use, by organisational type and as reported by the organisations. As shown in Table 5, counselling, information, referral and outreach are the main forms of drug treatment provided to young people with problematic substance use. In particular, all community health services interviewed reported providing one-to-one counselling for young people. Twenty-one service providers reported providing outreach to young people in their homes, Juvenile Justice settings, schools and the streets. An outreach model is a particular feature of the Youth Substance Abuse Service. Eleven of the 45 services reported providing home-based withdrawal to young people, while nine reported providing residential withdrawal. There are very few methadone programs and self-help groups conducted specifically for young people.

Table 5  Treatment Services Provided by Organisational Type

<table>
<thead>
<tr>
<th>Service</th>
<th>CHSs</th>
<th>D&amp;A</th>
<th>Family focused</th>
<th>Hospital Units</th>
<th>Aboriginal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach</td>
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<td>1</td>
<td>3</td>
<td>2</td>
<td>21</td>
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<tr>
<td>Short-term counselling</td>
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<td>6</td>
<td>4</td>
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<td>33</td>
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<td>Medium term counselling</td>
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<td>5</td>
<td>4</td>
<td>2</td>
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<td>33</td>
</tr>
<tr>
<td>Referral—all services</td>
<td>19</td>
<td>11</td>
<td>5</td>
<td>5</td>
<td>3</td>
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<td>Case management</td>
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<td>1</td>
<td>1</td>
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<td>Home-based withdrawal Service</td>
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<td>Self-help groups (peer support)</td>
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<td>5</td>
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</tr>
<tr>
<td>Information (health info, drug education)</td>
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<td>10</td>
<td>3</td>
<td>4</td>
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<tr>
<td>Other*</td>
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<td>7</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>29</td>
</tr>
</tbody>
</table>

Note: This table does not represent the whole Youth Drug and Alcohol Sector. It is only representative of those organisations which responded to the survey.

* ‘Other’ treatment services provided to young people and their families as reported by service providers included those listed below.
Supported accommodation (Self-Help Addiction Resource Centre; WestADD; WRAD; Barwon Health Drug Treatment Services; Grampians CHC; and Sunraysia CHS).

Information telephone line for parents (YSAS).

Garden Arts Program (Buoyancy Foundation).

Drug and Alcohol service specifically for women (WestADD).

Parent Training Program (Odyssey).

Family Support/Work (Victorian Aboriginal Health Service, Central Gippsland Aboriginal Health and Housing Cooperative, Anglicare Werribee, Eastcare D&A, Banyule CHS, Benalla and District CHS).

Outdoor Wilderness Journey for young people (Connexions).

Needle Exchange (Box Hill Hospital—D&A Unit).

Alternative therapies, such as kinesiology/ massage/ relaxation classes (Buoyancy Foundation; Dandenong Hospital D&A Unit) and recreation sessions (Dandenong Hospital D&A Unit).

Training and/or secondary consultation (Western Hospital, Voyage, Monashlink CHC).

Special programs, such as Mocktails, ‘Beat the Binge’ (Maryborough CHS, East Gippsland D&A).

Advocacy (Inner South CHS, Voyage, Central Gippsland D&A).

In relation to drug and alcohol services provided to young people by the Divisions of General Practice, the Western Melbourne Division of General Practice is in the early stages of developing a program to address illicit drug use in the Western Melbourne area which will link GPs with other key service providers. The program will target Indo–Chinese young people in Footscray and is expected to have an outreach and home withdrawal component and community and GP support for people who have come through withdrawal and are at risk of recidivism. The program will work closely with senior community members from the Footscray Vietnamese community.

The Hume Division of General Practice has three main targets areas of adolescents, mental health and drug and alcohol and as such have undertaken considerable work in relation to young people. Currently the Division has a visiting program where an expert from St Vincent’s hospital comes to the Hume region four times a year to provide consultation to providers and clients. The Division is also running a series of workshops for GPs and young people to increase service access for young people living in the region.
4.2 Involvement of Families in the Treatment Process with Young People

Service providers were asked to comment on whether families were involved in the treatment process with young people and in what way. All services interviewed reported that they have contact with family members, although the estimated percentage of direct involvement in counselling or withdrawal varied considerably from ten per cent to 100 per cent in services, such as RAFT and Anglicare Werribee. According to many service providers, family involvement is not generally counted in the client data, that is, the family may be counted as a client but not identified as a family, therefore making it difficult to gather statistics on their involvement.

An analysis of the interview responses revealed a number of common themes in relation to family involvement currently occurring in the service system. The majority of services (13 CHSs; five D&A; four family/ welfare; one hospital) reported providing counselling to family members on a one-to-one basis separately from the young person.

Generally, the young person is seen as the primary client and if they provide consent, the family is then invited to attend the session and link into counselling. The majority of services also reported that family involvement was in the form of information and advice on how to deal with the young person’s behaviour.

Family involvement was reported to be high in home-based withdrawal programs (when the young person was withdrawing at the family home) and parents were often provided with 24-hour crisis call support.

A total of eight services reported that they engage the family as a unit (four CHSs utilising general family therapist not D&A; one D&A; two family/ welfare; one Aboriginal). Another three community health services reported that they provide family counselling through a family therapist at the centre, while the young people see a D&A counselor. Two services reported that the family is involved in the development of the young person’s case plan and discussing treatment options.

Four community health services reported that they refer the young person and family to another service for mediation/ therapy, while two drug and alcohol specific organisations reported that in the residential programs, there is a no visitation policy with regard to families, thus excluding family members.

Further, the extent to which the family is involved in the treatment process was reported to vary according to the young person’s age. In many cases, when the young person is below 14 years parents or other workers tend to be more involved, however when the young person is over 18 years the family appears to be less involved.

Relationship to the Young Person

According to the majority of service providers interviewed, the young person’s mother tends to be the main family member contacting the service for support and advice, followed by both parents together. Service providers reported that it is rare to see a father attend the service by himself. Siblings were generally not reported as being involved to a great extent. A number of services reported that they often see the young person’s ‘significant other’, which may or may not be an immediate
family member. It is not uncommon for young people from culturally and linguistically diverse backgrounds to have extended family members attend a treatment service with them.

4.3 Models of Service

Services were asked to comment on the model underpinning the treatment work they undertake with young people and their families. The tables on the following pages report the specific service models used by individual services in each category.
### Table 6 Community Health Services

<table>
<thead>
<tr>
<th>Name of Service</th>
<th>Service model for working with young people and their families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ballarat Community Health Centre</td>
<td>Case management. Individual counselling and youth outreach model.</td>
</tr>
<tr>
<td>Banyule Community Health Service</td>
<td>Harm minimisation, individual counselling model, Four Cs.*</td>
</tr>
<tr>
<td>Barwon Health—Drug Treatment Services Geelong Community Health Service</td>
<td>Harm minimisation, Prochaska and Declemente Stages of Change. Youth outreach based model.</td>
</tr>
<tr>
<td>Benalla and District Memorial Hospital/Community Health Service</td>
<td>Social work and general family therapy model using cognitive, narrative and short-term solution focus therapies (Not D&amp;A specific).</td>
</tr>
<tr>
<td>Berwick Community Health Service</td>
<td>Individual counselling model, mainly adult focused.</td>
</tr>
<tr>
<td>Cobaw Community Health Service Inc</td>
<td>Social development, case management and youth outreach model.</td>
</tr>
<tr>
<td>Colac Community Health Services</td>
<td>Individual counselling and case management model. Linked to withdrawal through hospital.</td>
</tr>
<tr>
<td>Echuca Regional Health, Community Health Division</td>
<td>Eclectic counselling model based on individual need.</td>
</tr>
<tr>
<td>Frankston Community Health Service—Peninsula Drug and Alcohol Program</td>
<td>Client centred/individual focused cognitive behavioural counselling. Youth specific outreach.</td>
</tr>
<tr>
<td>Gippsland Southern Health Service South Gippsland Drug and Alcohol Service, Grampians Community Health Centre</td>
<td>Not specified.</td>
</tr>
<tr>
<td>Inner South Community Health Service</td>
<td>Operate on an adolescent developmental and youth outreach model.</td>
</tr>
<tr>
<td>Isis Primary Care—Voyage Program</td>
<td>Holistic and client centred approach using narrative therapy, systems therapy, psychodynamic and cognitive behavioural techniques.</td>
</tr>
<tr>
<td>Lakes Entrance Community Health Service—East Gippsland Drug and Alcohol Service, Latrobe Community Health Service</td>
<td>Four Cs, holistic harm minimisation, home detox model.</td>
</tr>
<tr>
<td>Maryborough and District Community Health Centre</td>
<td>Collaborative goal model with parents, other family members and friends. Youth outreach model.</td>
</tr>
<tr>
<td>Monashlink Community Health Centre—Eastern Drug and Alcohol Service</td>
<td>Client centred/individual focused counselling model.</td>
</tr>
<tr>
<td>Ovens and King Community Health Centre</td>
<td>Harm minimisation and youth outreach model. Individual client case plan, with family involvement.</td>
</tr>
<tr>
<td>Sunraysia Community Health Service</td>
<td>Systems family therapy, Solution focused therapy and harm minimisation.</td>
</tr>
<tr>
<td></td>
<td>Client centred/individual focused counselling model, predominantly adult focus. Task centred cognitive model, motivational interviewing.</td>
</tr>
</tbody>
</table>

*Four Cs: counselling, consultancy, continuing care.*
### Table 7  Drug and Alcohol Specific Organisations

<table>
<thead>
<tr>
<th>Name of Service</th>
<th>Service model for working with young people and their families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buoyancy Foundation of Victoria</td>
<td>Holistic case management model. Alternative models, that is, homoeopath, artists.</td>
</tr>
<tr>
<td>Moreland Hall Drug and Alcohol Centre</td>
<td>Predominantly adult focused model.</td>
</tr>
<tr>
<td>Northern Region Drug and Alcohol Youth Outreach Service—Youth Projects</td>
<td>Outreach model. Harm minimisation focus.</td>
</tr>
<tr>
<td>Odyssey House Victoria</td>
<td>One-to-one counselling model.</td>
</tr>
<tr>
<td>Odyssey House Parent Program/Centre of Adolescent Health—Behavioural Exchange System Training (BEST)</td>
<td>Parent group-training model combining family therapy and skills in behavioural contracting.</td>
</tr>
<tr>
<td>Open Family Australia Streetworker Outreach</td>
<td>Home detox model, family incorporated into detox plan.</td>
</tr>
<tr>
<td>Palm Lodge Rehabilitation Centre</td>
<td>One-to-one counselling model. Egan model.</td>
</tr>
<tr>
<td>Self-help Addiction Resource Centre</td>
<td>Supported accommodation, individual case plans. Peer support model.</td>
</tr>
<tr>
<td>Task Force</td>
<td>Client focused/one-to-one counselling model.</td>
</tr>
<tr>
<td>Western Region Drug and Alcohol Centre (WRAD)</td>
<td>Youth specific model, focusing on developmental stages.</td>
</tr>
<tr>
<td>WESTADD Women and Children D&amp;A service</td>
<td>Social and gender specific model.</td>
</tr>
<tr>
<td>Youth Substance Abuse Service</td>
<td>Individual case work model. Family involvement built into withdrawal program.</td>
</tr>
</tbody>
</table>

### Table 8  Family Specific and Welfare

<table>
<thead>
<tr>
<th>Name of Service</th>
<th>Service model for working with young people and their families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anglicare (Werribee)</td>
<td>Family systems and cognitive behavioural model.</td>
</tr>
<tr>
<td>Ballarat Parish Mission</td>
<td>Youth specific outreach and case management model.</td>
</tr>
<tr>
<td>Jesuit Social Services, Connexions Outdoor Program</td>
<td>Outdoor wilderness program.</td>
</tr>
<tr>
<td>Rehabilitation and Family Therapy—RAFT</td>
<td>Family systems/therapy model of counselling.</td>
</tr>
<tr>
<td>Salvation Army Eastcare Hawthorn Primary Care Project</td>
<td>Client focused/one-to-one counselling model/case management.</td>
</tr>
</tbody>
</table>

### Table 9  Aboriginal Services

<table>
<thead>
<tr>
<th>Name of Service</th>
<th>Service model for working with young people and their families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Gippsland Aboriginal Health and Housing Cooperative</td>
<td>Predominantly one-to-one counselling and advocacy model using Prochaska and Declemente stage of change and motivational interviewing.</td>
</tr>
<tr>
<td>Victorian Aboriginal Health Service</td>
<td>Model determined by need and case plan developed. One-to-one counselling. Family oriented and holistic spiritual health model.</td>
</tr>
<tr>
<td>Wathaurong Aboriginal Cooperative</td>
<td>Holistic and harm minimisation model. Focus on outdoor programs.</td>
</tr>
</tbody>
</table>
### Table 10  
**Hospital Units**

<table>
<thead>
<tr>
<th>Name of Service</th>
<th>Service model for working with young people and their families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austin and Repat Medical Centre</td>
<td>Specialist methadone program. Predominantly adult model.</td>
</tr>
<tr>
<td>Box Hill Hospital Drug Services Unit</td>
<td>Primarily adult withdrawal model. Harm minimisation and abstinence focus.</td>
</tr>
<tr>
<td>Drug Withdrawal Unit, Dandenong Hospital</td>
<td>Medical and non-medical withdrawal. Harm minimisation focus.</td>
</tr>
<tr>
<td>Westernport Drug and Alcohol Service, Dandenong Hospital</td>
<td>Client centred counselling. Youth outreach and home residential model.</td>
</tr>
<tr>
<td>Western Hospital, Drug and Alcohol Services</td>
<td>Client centred counselling solutions based model. Youth outreach and home withdrawal.</td>
</tr>
</tbody>
</table>

Client focused individual counselling was reported by CHSs as a major component of their service model. This was usually in the context of the ‘four Cs’; counselling, consultancy, continuing care. Six CHSs identified their service as incorporating family focused treatment in their service model. Seven services specified a youth outreach model.

Drug and Alcohol specific organisations predominantly adopted a one-to-one counselling model, however several organisations reported involving the family and/or family therapy into the withdrawal process particularly in-home-based/outpatient withdrawal programs.

Family specific and welfare organisations generally indicated working within a family systems model, incorporating case management and counselling models. In contrast, hospital units were client focused, utilising both medical and non-medical withdrawal programs, with a harm minimisation focus. Two hospital units reported being primarily adult models, while two used a youth outreach and home withdrawal model.

Aboriginal services reported utilising a holistic model that addresses spiritual, mental, social and physical health needs. Two services reported one-to-one counselling model, with one reporting family involvement. One service reported using an outdoor program model.

### 4.4 Key Issues in Working with Young People and Their Families

The involvement of family members in the treatment process was found to be dependent on a vast number of variables, highlighting the complexity of working with young people and also the diversity of families that services come in contact with. From an analysis of interview and workshop responses a number of trends and patterns in the service system and experience of families emerged, which are summarised in the headings below.
Issues Related to the Service System

Who is the Client?

According to the majority of services interviewed, along with those participating in the workshops, direct involvement of the family in the treatment of the young person is generally determined during assessment and usually based on the consent of the young person, who in most cases was reported to be the primary client. In the workshops particularly, there appeared to be doubt amongst some service providers of the value of working with families.

There was a common view amongst service providers that if a request to have the family involved is considered to prevent the young person from attending individual counselling then this is generally not pursued further because of a duty of care to the young person. This was considered particularly important in relation to protective issues in instances of sexual and physical abuse. Maintaining confidentiality and trust of the young person was considered a critical factor in keeping the young person engaged in treatment, as the following quote reflects:

... sometimes it is really difficult to be there for the young person and the family —there are often different agendas. Sometimes I will have to draw back from working with families as the trust and work with the client has to be number one. The family scenario doesn’t always work (community health service provider).

In contrast to this point, one service provider maintained that:

... a lot of services hide behind confidentiality issues, where I found that it’s quite easy to get around that and come to an agreement with all parties. There are agreements you can make with both parties that satisfy everyone’s needs—education in treatment services, training to learn to work in rather than fobbing them off (community health service provider).

Services Not Set up for Family Therapy

There was a view by some providers that D&A services are not generally set up for family therapy and working with parents and family members requires specific skills and knowledge. Frustration was expressed about the lack of referral options for families, particularly in rural areas. There was a common view that working with families is very resource intensive and there was a feeling that much of the support provided to family members and the extra time required to work with families, is not taken into consideration, as the following quote reflects:

Working with family members and significant others is very time consuming in regards to the needs of the family unit and meeting the numbers required by the Department—but if you don’t work with the family you don’t have much hope (D&A service provider).
Clients Resistance to Family Involvement

An overriding theme from the service providers was that young people generally report that they do not want their family involved, or to know about their drug use and ‘a lot of young people are resentful of being pulled into family work’. Further, there was a view that in some instances family members did not want to be engaged in treatment with the young person because of the trauma that the ‘young person has caused the family’. Service providers report that sometimes the families are too angry and conflictual to sit down together in counselling.

Sometimes the parents have had enough and they don’t want to be involved (D&A service provider).

Service providers reported that families are a difficult population to engage in treatment as they come to the service at a time of crisis and it is difficult for them to make a commitment to the process. Protective issues for the young person who has been abused within the family is also a concern when involving families in the treatment process; for the young person themselves and the service provider. In addition, the young person may have lost contact with, or may be living away from the family.

Moving from Adult Model to Youth Specific in Drug and Alcohol Treatment

A number of the services that are not youth specific reported that they have only recently moved towards working with young people with specific youth D&A workers being appointed to staff and the establishment of youth D&A outreach positions. These services are still in the process of change from working within an adult model to incorporating youth specific approaches, particularly within specific drug and alcohol services and many community health services. Some services reported the existence of rules and regulations that exclude involvement in the withdrawal process because the program is based on an adult model.

Service providers identified a number of difficulties working with young people as clients, as reflected in the following quotes:

- The psychological issues faced by young people are extreme and it takes a lot of time and resources to address it (community health service provider).
- With young people and drugs it is difficult to determine what is a natural progression and what is a crisis (community health service provider).
- Young people often do not think they have a drug problem and to engage them you need to look at the other issues, such as housing (community health service provider).

There was also a view that it is critical that management understands the differences in working with young people as opposed to adults and that the philosophy and approach of workers is ‘youth friendly’.
Diversity of Families

The definition of families is often interpreted very broadly in D&A services and ‘significant others’ is often included in this definition. A clear example of this is in the Aboriginal population where ‘family’ is different from ‘mainstream’ notions of family. According to one Aboriginal service provider:

All Aboriginal people are considered ‘sisters’ (or) ‘brothers’ and what is referred to as ‘family’ often includes distant extended family members. Family is considered very important in Aboriginal culture (Aboriginal Drug and Alcohol Worker).

There was a view by some service providers that the diversity of families is an issue that needs to be acknowledged when involving families in the treatment process. Service providers were concerned about the ‘one size fits all’ approach of government policy, which ignores the special needs of families. There are differences between rural and urban families, socio-economic and cultural differences across families. The problem of working with diverse families is, according to one service provider, demonstrated by the lack of multilingual workers and the Anglo orientation of funding models.

Further family differences that need to be acknowledged as identified by participants at the workshop include the following:

- The extent of sibling involvement in substance abuse.
- First-time/generation substance abuse to multi-generation substance abuse.
- Family mental illness to no mental illness.
- Extensive physical/sexual abuse to no abuse.
- Employment (individual/family) to unemployment.
- Recreation/leisure skills/involvement to an absence of these skills/involvement.

Family Dynamics and Conflict

While there was general acknowledgment that working with young people in the context of a family system contributed to effective outcomes, numerous factors relating to family dynamics and conflict were identified by service providers as a hindrance to bringing the family unit together. Service providers reported that there are often extremely difficult family issues beneath the drug use that must be dealt with before all parties can move on.

Service providers also noted that they often need to complete considerable individual work with the young person before introducing the family to the treatment process because of the past patterns of interactions within the family. In addition, concern was expressed about instances where the parents are also using drugs. In some cases, service providers reported that clients’ family relationships had already broken to the extent that the young person was either homeless or living in refuges.
It was reported that problematic drug use amongst young people places incredible stress on the family unit and can consume the family to the detriment of other siblings as the parents focus their energies on the child with the drug problem. There was a view that assisting families to share the responsibility for family breakdown is often very difficult.

Another difficulty encountered by service providers is the issue of responsibility for the drug problem. Sometimes the families presenting believe the responsibility lies with the young person and feel some resentment at their child for the drug use and abuse of trust. On the other hand, sometimes the young person will blame the family for their drug problem.

... when we see young people there is huge family breakdown that is, stolen from family, parents don't know about their use. It is extremely difficult to bring them together (D&A service provider).

Additional key issues in relation to family dynamics and conflict identified by service providers included the following:

- Young people often have different relationships with different members of the family, for example a difficult relationship with stepfather.
- Sometimes the mother of the young person using feels lonely and isolated because others often wash their hands of the problem. Often the mother has to keep the drug problem secret from the husband.
- Unclear, inflexible or closed ways of communicating within the family, so that families have to be able to learn to trust and learn to be responsible for their own feelings.
- Boundaries and limit setting, such as issues revolving around over protection/ or under control of the young person.
- Lack of understanding between the two generations.
- Individuals within the family that have abused the young person.
- Young person struggling with two cultures in ethnic families.
- Families views and values about drugs.

**Broader Social and Legal Context of the Families**

There are also many issues within a broader social and legal context that influence young people and their families' involvement in treatment. It was reported that legal issues could complicate the treatment of drug use in young people and present a particular barrier when involving families.

Service providers reported that young people are sometimes reluctant to seek help due to fear of legal and moral repercussions and even more reluctant to involve their parents. It was also reported that some parents might have misconceptions about drug use and forms of treatment and fear their children's experience in the legal system.
There was particular concern expressed about the perpetuation of myths surrounding drug use through the media and general negative community attitudes that young people who use drugs problematically are ‘scum’. This attitude was considered to contribute to the ‘shame’ families felt and in turn prevented families from wanting to be identified as having a son or daughter with a drug problem, particularly in families from culturally and linguistically diverse backgrounds.

4.5 Specific Issues for Aboriginal and Torres Strait Islanders

The issues summarised below were identified by Aboriginal D&A workers in a specific workshop.

**Key Issues**

Young people often return to a negative environment, after treatment or intervention. The service providers believe that, unless the whole family can be treated, then essentially the chances of success with a young person are minimal. This is particularly so as they find that, where a young person is abusing substances, it is almost certain that many other family members will also be abusing. Further, even adults who have successfully withdrawn will be encouraged to return to drinking and this needs to change.

Service providers regard ‘the family’ as those people living in the immediate household of the young person—otherwise one would be going so wide in the definition of family as to become meaningless.

A whole community approach was considered the only way that Aboriginal D&A workers can operate, working with a wide range of problems well beyond D&A issues.

**Strategies and Initiatives**

Geelong Cooperative has set up a Men’s Group, particularly to focus on the dealers in the community and to confront them. They have also banned alcohol at all Co-op functions.

There was a view that cooperatives need to develop a vision and a ‘whole of community’ approach to this issue. It is not a matter of dealing with the family alone, but as part of an overall community approach to the problems facing them.

Service providers reported that they have used parent groups in the past, although they usually have called them another name, otherwise parents feel that they are being ‘told’ that they are not good parents.

There was a common view that a family treatment unit, where the whole family could come in for help, would be valuable.

Service providers felt that the co-ops should be putting pressure on such programs as ‘Strengthening Families’ to ensure that they have a Aboriginal focus and are able to use Aboriginal workers to help families.
A further crucial development would be a transition support program, to help a young person reintegrate back into the home environment.
4.6 Issues for Cultural and Linguistic Diversity

Again, a specific workshop was held for workers from specific ethnic services who identified a range of issues and some possible initiatives.

**Key Issues**

- It is crucial to identify that issues of substance abuse in migrant communities cannot be separated out from the general problems of migration and the lack of support in Australia for migrants and the disincentives from the Government.

- It was reported that the key problem in migrant communities is that parents often do not speak English and can lose contact with their young people, who themselves become confused as to their identity.
  
  They want to fit in to Australian society, but often their skin colour does not allow this. But they also do not want to simply follow ‘the old ways’ of their parents. Also, families are very reluctant to ‘air their dirty washing’ in public, hence it is very hard to get them to use a service.

- It is crucial to give support to families to cope with this cultural and identity crisis, for this is at the heart of many substance abuse problems with young people.

- The concept of ‘counselling’ is often meaningless to migrant communities and they do not understand why ‘the experts’ can’t just ‘fix the problem’.

- Some of the substances which are illegal here in Australia are standard for social usage in home cultures.

- There is great ignorance of harmful effects of abuse, hence many parents are unable to educate their young people.

- Many families have lost the extended family support they were used to in their home country.

**Strategies and Initiatives**

- The Vietnamese Welfare Association, together with a number of CHSs, have run sessions for parents of young people with a drug problem and from this emerged that the critical need for these families is information and access to resources.

- Very little support is currently offered to families, for example, the African Association had its funding for its community development worker withdrawn earlier this year. Yet such workers are considered crucial, as the mainstream services do not focus on culture and do not understand the cultural issues or aspects of substance abuse.

- Information sessions, such as those run by the Vietnamese Association, are crucial. There is also a need to allow families to talk about their fears of what is happening and talk through some of the myths.
There is a need for clear information in community languages and to link with school—many parents don’t see the need to be involved with school, who are the ‘experts’ and should know what to do. Focus on spirituality and religious aspects; help young person to cope with parental pressures; help for siblings.

The are two known successful projects: City of Port Phillip, ‘Building Healthy Communities’ Project was a very successful cross-cultural Project; and a Coordinated Project by McFarlane Burnett, MCM.

Migrant Resource Centres need to be used for more support.

4.7 Supporting Young People’s Families

The range of emotions families’ experience when a family member is using drugs problematically is intense. Service providers frequently used words, such as ‘powerlessness’, ‘hopelessness’, ‘helplessness’, ‘fear’, ‘frustration’, ‘shame’, ‘guilt’ and ‘stigma’ to describe the desperation families’ experience. Anger is one of the primary emotions experienced by the family, which may be directed towards young people for using, the supplier, anger at services who may be unable to help and at themselves for being unable to stop their children. They experience fear that their child may die or face legal repercussions and most of all feel helpless to do anything about the situation.

Many families, particularly ethnic families, feel shame and guilt at being identified as having a young person with a drug problem and service providers commonly talked about the stigma attached to this and thus the associated stigma of attending counselling or a support group. This is a particular issue in rural settings where there is little anonymity.

Further, it was commonly reported that families want services to provide an instant solution to the problem and have unrealistic expectations of treatment outcomes. Consequently they may experience confusion and dissatisfaction at the treatment process.

Key Support Needs of Families

From the issues that emerged in relation to engaging families, it is increasingly evident that families have many needs, which were acknowledged by all service providers interviewed and by the workshop participants. One service provider advocated that:

... the families need to be empowered. The message they get is to kick the young person out. Families feel hopeless, helpless—and they need strategies to overcome these feelings and to help them through the process. Families are not resourced, they need correct information—they get so many conflicting messages. There needs to be a shift in the way we understand families. D & A services generally focus on the substance and don't look at the family dynamics (welfare/family service provider).

There was a view that it is important that families are assured that it is acceptable for them to have feelings too and that the drug users needs are not the only ones in the family system.
Information and Education
One of the major obstacles to positively involving families in treatment of drug use is the misinformation surrounding drug use. As such, one of the challenges facing service providers is demystifying drug use. Those services interviewed and participating in the workshops identified several key areas where families need more information and education:

- Understanding developmental issues of the young person
- Accurate information on drugs, culture, effects, treatments and trends
- Realistic information about treatment process in terms of duration and outcomes
- Clear information about the treatment system, services available for the young person and themselves
- Legal information regarding going to court and advocacy
- Information available in different languages.

Access to Counselling and Support
Providing support to families is also perceived as difficult, as some families may feel reluctant to access such support or do not know how. According to service providers interviewed and workshop participants, there are specific areas where families need support, including:

- Grief counselling for those families who lose a child to a drug habit, or even death
- Supported accommodation for young people to provide respite for parents
- Therapeutic support to deal with feelings
- Staff with specialist skills and knowledge of drug use and in working with both young people and families
- Greater immediacy of access in rural areas, where direct support is often an hour away
- Ethnic specific services
- Support/peer support to normalise the experience
- Skill building (communication, parenting skills, coping style, anger management and boundary setting)
- Referral options to other services
- Involvement with the treatment process.

Current Programs to Support Young People’s Families
As part of profiling current practice in relation to family involvement in drug treatment, services were asked whether their organisation provided a specific program to support the young person’s family.
The following services appearing in Tables 11 to 14 below a reported providing a specific service to support a young person’s family. Fifteen services have been able to establish specific programs to support parents of young persons using drugs. This generally takes the form of family support groups, or family education programs.

### Table 11 Specific Programs Currently Provided by Community Health Services

<table>
<thead>
<tr>
<th>Name of Service</th>
<th>Specific program to support parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Banyule Community Health Service</td>
<td>PEIS—Parent Education Information and Support runs once a month.</td>
</tr>
<tr>
<td>Barwon Health—Drug Treatment Services Geelong Community Health Service</td>
<td>Two family therapists on staff.</td>
</tr>
<tr>
<td>Inner South Community Health Service</td>
<td>General family programs.</td>
</tr>
<tr>
<td>Maryborough and District Community Health Centre</td>
<td>Have general parenting skills program with D&amp;A component.</td>
</tr>
<tr>
<td>Monashlink Community Health Centre—Eastern Drug and Alcohol Service.</td>
<td>Women’s support group.</td>
</tr>
<tr>
<td>Ovens and King Community Health Centre</td>
<td>Beginning stages of implementing a parent support group.</td>
</tr>
</tbody>
</table>

### Table 12 Specific Programs Currently Provided by Drug and Alcohol Specific Organisations

<table>
<thead>
<tr>
<th>Name of Service</th>
<th>Specific program to support parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buoyancy Foundation of Victoria</td>
<td>Family and friends support group.</td>
</tr>
<tr>
<td>Odyssey House Victoria</td>
<td>Parent support—8 weekly seminars.</td>
</tr>
<tr>
<td>Odyssey House Parent Program/Centre of Adolescent Health—BEST</td>
<td>9 session parent training group.</td>
</tr>
<tr>
<td>Open Family Australia Streetworker Outreach</td>
<td>Specific home detox program—formalised education and support to families.</td>
</tr>
<tr>
<td>Youth Substance Abuse Service</td>
<td>Home visitations.</td>
</tr>
</tbody>
</table>

### Table 13 Specific Programs Currently Provided by Family Specific and Welfare

<table>
<thead>
<tr>
<th>Name of Service</th>
<th>Specific program to support parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anglicare (Werribee)</td>
<td>Specific family program.</td>
</tr>
<tr>
<td>Rehabilitation and Family Therapy—RAFT</td>
<td>Are a family agency.</td>
</tr>
<tr>
<td>Salvation Army Eastcare Hawthorn Primary Care Project</td>
<td>Family and friends support group.</td>
</tr>
</tbody>
</table>

### Table 14 Specific Programs Currently Provided by Hospital Units

<table>
<thead>
<tr>
<th>Name of Service</th>
<th>Specific program to support parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Westernport Drug and Alcohol Service, Dandenong Hospital</td>
<td>Have family education sessions once a month.</td>
</tr>
</tbody>
</table>

A number of services reported that they have attempted to set up specific support programs for parents which have been unsuccessful, mainly due to parents
unwillingness to attend a formal group and desire to avoid the stigma of accessing drug treatment services.

Overall, for the majority of services interviewed, support for families tends to be an informal process involving families contacting the service by phone for information and advice on the young person’s substance use. Services, such as the Youth Substance Abuse Service reported having a specific parent information line that families could call.

Other forms of support offered to families were:

- Family therapists at the service (often on a one-to-one basis and linking in with D&A counsellor)
- Parent skills training group
- Home visitations
- Specialised home detox program
- Family education programs.

### 4.8 Case Studies of Service Models that Engage Families and Young People

In reviewing the current practice of working with young people and their families, four services in Victoria, nine interstate and two overseas were selected and written up as case studies. These case studies have not been formally critiqued as being models of best practice, rather they have been documented on the basis of having components of Family Inclusive Practice which assisted in identifying common themes. What is clear from the case studies is that there is a number of different levels of intervention. These include:

- Support and information telephone lines
- Parent support groups
- Family counselling and mediation with the young person
- Individual counselling for young people and families
- Integrated family service models that contribute to effectively working with young people and their families.

Following is a brief discussion of the main service types documented in the case studies and the identified benefits of each approach (for detailed discussion on services see Appendix 3).

**Support and Referral Lines**

There are a number of generalist and specialist drug and alcohol support and referral lines that families are reported to utilise, including: Direct-line, Lifeline and Care Ring (formally Crisis Line). What makes these services suitable for some families is their anonymity and immediacy of response. This type of service is aimed at dealing with a crisis situation on a 24-hour basis and is often the first point of
Contact for people entering into the service system and wanting to be linked into other services. Specialist drug and alcohol lines also provide drug and alcohol information for parents. As a 24-hour statewide service, support and referral lines are able to provide access for a large number of people.

**Parent Education and Support Groups**

Generally, structured programs of family involvement occur through parent support groups. Parent support groups are usually for family members, or significant others who have a young family member with problematic substance use who are either currently receiving treatment for their drug use or are not in any form of treatment. The theoretical framework adopted varies from an empowerment approach (Banyule CHS Parent Education Information and Support; Queensland Community Drug Awareness Council), to adult learning (Grove Street Service—Making a Difference; Elura Outpatient Counselling Clinic—SA), family systems/therapy and developmental models (Odyssey House Behavioural Exchange Systems Training (BEST); Hot House Youth Community Team Parent Education and Support Group), to solution focused, cognitive behavioural and ‘tough love model’ (Dunsmore House —Sydney).

The groups vary from structured educational programs, such as Odyssey BEST program, Hot House Youth Community Team and Grove Street Tasmania, to ongoing informal support to enable newcomers to benefit from older participants, such as Banyule CHS (PEIS). Evaluation of the support programs usually occurs informally through participant feedback. The Odyssey BEST program and the Making a Difference: A Drug Awareness Program for Parents programs are based on a strong research base and on fully evaluated presenters’ manuals.

While the approaches to parent support varied across the programs reviewed in the case studies, common principles underpinning outcomes include the provision of information and support through shared experience and providing skills and strategies to cope with and manage the young person’s drug use. The majority of these support groups were developed in response to the acknowledgment of the unmet needs of families of young people with problematic drug use.

**Family Drug and Alcohol Counselling**

As previously mentioned in this chapter, very few services provide a specific family drug and alcohol service. In the Victorian context, two programs stand out as having family inclusive approaches: Rehabilitation and Family Therapy (RAFT) and Anglicare Werribee—Family D&A Clinician. Both models are based on a family systems approach. The Anglicare Project is a twelve-month funded pilot project and specifically targets young people between twelve and seventeen years, while RAFT is a service that targets any age group with problems with addictions.

Both services were developed in response to an identified gap in drug and alcohol service provision and share the intended outcomes of changing destructive family patterns and preventing family breakdown as a result of addictive behaviour. The Anglicare Project also has a parent support group component.
Generalist Adolescent/Family Mediation and Therapy

Adelaide Central Mission provides an example of a further service intervention that crosses into the area of problematic substance use and family involvement. This service provides adolescent family mediation for families of young people who are homeless and are at risk. The service also runs a parent support group for young homeless people in their shelter.

Invariably many young people attending the service have drug related issues and the generalist family mediation provides a useful means in which to engage young people and their families. The program generally targets the family as a whole unit and adopts a family systems approach in conjunction with narrative therapy, problem solving and behaviour modification. The program is funded by Legal Aid and Family Services and has been formally evaluated.

Adolescent Residential Support

Thunder Road Drug Rehabilitation Program in Oakland and Odyssey House, Auckland Youth Services—Day, Residential and Evening Program, are two overseas examples of residential treatment services specifically for young people with family inclusive models. Family involvement is a significant component of both these services. For instance, at Thunder Road, as part of the rehabilitation process, family members are required to attend meetings and group sessions at least twice per week throughout the year of treatment and after the young person has returned home. Odyssey House, Auckland, provides an 18-week evening program for young people and their families consisting of three phases. Both agencies have a therapeutic community approach.

Integrated Service Model

Western Australia Drug Strategy Office ‘Working in partnerships with parents program’ outlines an integrated service model for working with families of young people with problematic substance use. This strategy involves a number of interventions at a number of levels, including: 24-hour parent drug information service; support to police for provision of intervention packages to parents; practice development projects enhancing parents access to mainstream services; school drug education program involving parents; provision of training to other service providers; and local drug action groups. Eleven Community Drug Service Teams work with local communities and agencies in providing facilitated support groups. This strategy is overseen by a reference group of eight parents. The expected outcome is a state-integrated strategy to involve families in dealing with young people problematic drug use.

4.9 Organisational Features that Contribute to Successful Interventions

Service providers were asked to comment on the organisational features that contribute to successful interventions with young people and their families. These features have been summarised in point form below.
Youth Specific Features

For drug intervention services to be successful in dealing with young people with problematic substance use, it is important that the service is organised in such a way as to be accessible for young people. The main features that service providers considered essential include:

Attitudes and Approach
- A non-judgmental attitude towards young people
- Developing a trusting relationship with the young person
- An adolescent development perspective.

Service Style
- Linkages with youth specific services and organisations
- Being co-located with other services and networking with other services
- Being centrally located
- ‘Youth friendly’, that is, access to pool tables, activities
- Safe and secure environment for the young person to withdraw from drugs
- Option of home-based withdrawal with appropriate support for the young person and family
- Drug free environment in supported accommodation
- Being able to see young people and their own environment, through outreach and home visitations.

Worker Skill
- Wide variety of personalities, skill and resources
- Drug and alcohol counsellors with specific expertise in working with young people.

Program Approach
- An emphasis on self-help and mutual support to enable the young person to live drug free after leaving a drug and alcohol service
- Youth team building activities, such as wilderness programs
- Active involvement of young people in the decision making, that is, alcohol free events involving young people on the committees.

Organisational Features
- Management support and understanding of the issues involved in working with young people
- Flexible service provision and being able to respond within 24 hours
Family Specific
The main family specific features within the organisation that service providers believed contributed to successful interventions with young people and their families include:

Attitudes and Philosophy
- An understanding that family are players in the young person’s life and that people live in a family system.
- An appropriate theoretical framework in place, such as action based family interventions/ family system therapy.
- Commitment to and valuing families at the organisational level.
- Trust and honesty both with the worker and within the family (the worker cannot engage the family unless there is honesty).

Organisational Features
- Infrastructure to recruit, appoint, train and support workers.
- Facilitation of learning through supervision/ action learning approach.
- Appointment of staff with the necessary knowledge (for example, family forms, NESB issues drug issues), values (respect for families) and skills (family counselling and engagement).
- Accessible parent support programs.
- A proactive approach in trying to engage the family and identifying the key people involved in the young person’s life.
- Flexibility for immediate response to the family and the young person, that is, in appointment times and waiting lists.
- An understanding of staff and organisational limitations, that is, they should know when to refer on when there are issues of abuse, or psychiatric issues.

Service Features
- A welcoming and warm service environment and having the right context for family meetings.
- Culturally specific approaches accepted by the community, that is, run by aboriginal people for aboriginal people.
- Opportunities to reflect on practice.
- Flexibility to work co-jointly with the young person and the family or on a one-to-one basis, depending on needs of each individual family.
- Developing contracts between the parent and the young person of what goals and expectations each has of each other.
Increasing early intervention work.

4.10 External Factors which Assist Successful Intervention

Service providers were also asked to comment on the factors outside their organisation that can contribute to successful interventions with young people and their families. While there are unlimited external factors that can contribute to successful interventions, the main factors identified by service providers are summarised below.

Resources and Appropriate Funding Models

There was a common view amongst service providers that to involve family members in the treatment process there needs to be a ‘political environment that overtly, rather than just implicitly, encourages family involvement’. A number of service providers reported that the funding models need to reflect the time and complexity in working with young people and their families.

Concern was expressed that a lot of services are still funded on an adult model and have now been told to work with young people without changing targets, rather just the name of the worker.

Training for Workers

Involving young people and their families in treatment is also dependant on the services and staff that have specific skills in working with young people and the families when problematic drug use is involved. Many service providers considered the availability of training in family systems therapy for staff providing drug treatment service to young people and their families critical. There was a view by one service provider:

...we shouldn’t assume that people will automatically think of family involvement (service provider).

Service Linkages and Networks

Development and maintenance of services linkages and networks was also considered important, particularly in the following areas:

- Access to skills and knowledge from outside services who have skills in working with the family.
- Linkages with treatment centres, that is, withdrawal services.
- Knowledge of the system—keeping up with the street names of drugs and the networks for referral and latest treatment programs.
- Coordinated and comprehensive support where necessary for the young person and family (with minimum amount of agencies/ workers involved in their direct care).
• Support networks of other professionals who have a similar approach of involving families where possible.

• Provision of practice forums where workers can get together, have post-training support and peer supervision.

**Education and Information**

The provision of individual, family and community-based education and information was another key area that was considered to contribute to successful interventions with young people and their families. In particular, there was a view that schools should be more proactive rather than reactive to young people’s drug use by introducing parent information nights around D&A issues, providing education and information for students, parents and staff so parents have the support of the whole community. A further key area for targeting information and education that was identified is changing community understanding and breaking down the ‘taboo’ factor of drug use so that families are able to talk about the drug use without being ostracised.

Additional external factors reported by service providers include the following:

• Acknowledgment of the multicultural aspects

• Stable and secure place for the young person to live

• Recreational and educational opportunities and the development of new peer networks for the young person

• Transport, particularly in rural areas

• Support for single parent families

• Support network within the family.

• Supported extended families to support the parents of the user—to educate other members of the family.

**4.11 Summary**

To identify current practice and the key issues in involving families in the drug treatment process, 45 service providers currently providing a drug treatment service to young people in Victoria were interviewed and eight workshops were held across the state (including one ethno-specific and one Aboriginal) with a total attendance of 72 service providers. All GP divisions in the state were also contacted, however their main area of focus reported in relation to young people and drugs was generally of a health education nature and increasing service access.

All services interviewed reported that they have contact with family members, although the estimated percentage of direct involvement ranged from an estimated ten per cent to 100 per cent. Family involvement in the treatment process was mainly in the form of one-to-one counselling and provision of information and advice separately from the young person, who is generally considered the primary client. The majority of organisations interviewed operated on a client focused one-to-one counselling and harm minimisation model.
The involvement of family members in the treatment process was found to be dependent on a vast number of variables both within the service system and within individual families, highlighting the complexity of working with young people and their families. In particular it was identified that the key issues in relation to family involvement related to:

- Clarification of who the primary client is and where confidentiality and duty of care rests.
- Individual client focused models of service.
- Client’s resistance to family involvement.
- Process of moving from an adult model to youth specific work.
- Diversity of families.
- Family dynamics and conflict.
- Broader social and legal context of the families.

From the issues that emerge in engaging families it is increasingly evident that families have many support needs, which were acknowledged by all service providers interviewed. While fifteen of the 45 services interviewed reported that they currently provide a specific program to support the families of a young person using drugs, there was a view that there are still many gaps relating to information and education surrounding drug use and access to counselling and specific support groups.

In reviewing case studies in Victoria, interstate and overseas, it is clear that there are a number of different levels of interventions to provide support to and involve families in, the treatment process including: support and information telephone lines, parent support groups, family counselling and mediation with the young person, individual counselling for young people and families; and integrated family service models responses.

From the service provider interviews, a number of organisational and environmental factors that contribute to effectively working with young people and their families were identified. Organisationally, not only a youth specific focus was perceived to contribute to successful interventions, but also an understanding of families. Externally, the main factors that were considered to contribute to successful interventions included:

- Resources and appropriate funding models
- Training for workers
- Service linkages and networks
- Education and information, particularly in relation to community attitudes.
5. Approaches to Working with Families

Reviews of the literature, site visits and interviews indicate a number of approaches which can support and/or engage families who have young people involved in treatment for a drug and/or alcohol problem. There are two broad approaches which focus predominantly on providing support to family members:

- Self-help groups which largely are self-organising
- Facilitated groups which may have an educational and/or therapeutic approach. These groups focus their attention on the family and in particular the parents.

The second approach more actively engages the family in the treatment process and includes:

- Family focused/centred counselling
- Home-based withdrawal
- Integrated treatment approaches including family conferencing, mediation and counselling.

In addition to specific programmatic approaches, the findings of this Project indicate that all services could be more effectively engaging young people through working with their families. This approach is based on an automatic assumption on the part of the organisation and staff that any young person presenting for a service is part of a family and that this must be taken into account.

This chapter will discuss three approaches or models which can be used in drug treatment services working with young people:

1. Family inclusive practice which provides a framework for all services that work with young people.
2. Facilitated support for family members.
3. Engagement of families in the actual treatment process with young people.

Implementation of the various approaches/models depends on a number of factors including the philosophy and beliefs of the organisation, the skill and experience of the workers, broader community resources, the interest of the family members and the situation or status of the young person themselves. The theory and practice outlined in this chapter provide a starting point for services to consider. Clearly any implementation would require a detailed analysis and further development by agencies.

Figure 2 below illustrates the range of options available to young people and their families through the range of options to be explored in this chapter:
Figure 2  Range of Options

Notes:
The first line indicates the ways in which families might be involved ranging from ‘disengaged’
through to ‘full engagement in treatment’.
The third line shows the situation or status of the young person as to whether they are still
connected to family and school/employment (see Chapter 2) or are disconnected from both.
Clearly there are more options along this line which could be considered.
The second line shows the key treatment options and the points at which families and young
people can connect in the process.
The dotted lines represent indirect connections while the full lines represent complete and possibly
formal connections.

Defining ‘Families’
One of the barriers to working effectively with young people and their families is the
narrowness of understanding about what constitutes a family.

‘A Family’:
Relatives and/or significant others. Most of the literature seems to indicate that
greater success is achieved if those involved are from the immediate family,
however extended family members and other significant others, such as family
friends, can substitute when immediate family members are not available,
unsuitable, or unacceptable to the young person. The key issue is that the young
person is able to make a strong ongoing connection with this person(s).

If programs are going to involve parents they first must assess whether there are
parents that can be constructively involved. For example, often youth[s] have
not lived with a parent for a number of years. Further, parents who abuse drugs
themselves or engage in criminal activity are not likely to be productive
elements in a treatment plan. In these cases it may be more appropriate to
involve a responsible significant adult in the parental support role (Catalano et
If concerted efforts to work with parents show them to be unable or unwilling to be a constructive resource, the systemic view would lead to treatment professional to look for alternative family-like supports for the young person (Snyder and Ooms, 1996:1).

In exceptional situations, attempts to involve parents in the adolescent’s treatment may reveal such intense longstanding abuse, hostility, or indifference that the parents cannot realistically be seen as a resource to the youngster. Even then the treatment professional must recognise the impact of the family in the adolescent’s life. They must help the youngster to deal with the limitations of the family as a resource and look to the extended family or the community for the support so vital to the youngster’s healing (Snyder and Ooms, 1996:1).

5.1 Family Inclusive Practice

As documented earlier, researched data from around the world supports the fact that services inclusive of the family produce more sustainable and effective outcomes for young people. An approach which could be described as Family Inclusive Practice could be adopted by all drug and alcohol services which work with young people. It does not require additional resources as it is a way of thinking about the young person and the systems which surround them.

In Family Inclusive Practice there is an automatic assumption on the part of the organisation and staff that any young person presenting for a service is part of a family and that the service will acknowledge the significance of this connection.

In fact, it is suggested that Family Inclusive Practice is the overarching framework in which all other approaches and models are located and that it is adopted regardless of the organisational or worker context.

Clearly, the nature and level of any approach will be influenced by the context within which it occurs. For example, a lone worker in a general health setting will have resources and a mandate that are significantly different from that of a team worker in a youth specific substance abuse service. The age of the young person and associated legal status will vary. It would be expected, then, that there will be some variation between services in the level of active family involvement. Whatever that level is, the style of the family’s inclusion will be determined by the way in which it can assist the young person now and in the future.

It should also be noted that family inclusiveness does not necessarily mean that family members will be physically present; their contribution can be accessed by the young person through conversations with a staff member. These conversations can reinforce a sense of belonging, clarify conflicting aspects and assist in overcoming barriers, like guilt and disappointment, which may be reducing the young person’s capacity to use support available from family members.
Principles

The principles of Family Inclusive Practice provide an overarching framework under which a number of practice models are valid. Each model, however, should be able to demonstrate that it is working within the following assumptions:

- Young people have the right to be treated with respect and dignity.
- The family is the most important resource to young people.
- Families go on forever and services are short term.
- Young people ‘carry’ their family with them regardless of the level of current contact.
- Family members can grow and adapt.
- Family members have an intimate knowledge of each other.
- All family members have needs and rights that should be respected.
- Intervention should be aimed at building and strengthening constructive family bonds.
- Services should avoid interventions that displace the potential resources in the family.
- Young people have the right to Family Inclusive Practice.
- Family inclusive practice and client confidentiality are not mutually exclusive.
- It must be remembered that, at times, the behaviour of some family members might be dangerous to the young person.
- Young people belong to interconnecting systems in society.
- It is less marginalising to resource these systems, including family systems, to support the young person, than it is to provide a tertiary service.

Because Family Inclusive Practice is a framework rather than a model, its application can not be described in a predetermined step by step structure. However it is possible to establish some of the processes, based on the above principles, to be considered organisationally and at each phase of all interventions.

Worker Skills

Family Inclusive Practice does not require workers to be family therapists. The principal skill is being able to relate comfortably to a variety of people of different ages, stages, backgrounds and family structures. If there is a principal skill it is the ability to trust that family members are the experts on their own lives.
All staff members in the service should be considered ‘family workers’. Techniques and skills will be more specific according to the role a staff member is taking in assisting a particular family to reach identified outcomes. A receptionist will not require the technical skills of the workers undertaking the assessment phase, however, they will need to understand that family members are welcome and supported. A residential worker might need to build a strong partnership relationship with a parent in order to encourage and coach that parent to ‘hang in there’ with an adolescent whose current behaviour is dangerous.

Within a family inclusive approach there may be a need for family mediation skills — the skills used in family and adolescent mediation services and in family group conferencing are applicable here. If formal family therapy is required, specific skills in working with family dynamics are necessary and this specialist skill may only be available on a sessional or referral basis. Work in the family home requires a high level of flexibility and accommodation to a family’s own culture and an understanding of cultural diversity is essential.

In a service designed around the resources already existing in the young person and their family, the complementary resources and roles of the agency and others will be determined by how they directly contribute to strengthening the family’s capacity to reach its desired outcomes. In this sense the service is client-driven, not bound by specific program responses.

The size, structure and flexibility of the organisation will determine whether staff are recruited to do specialised tasks for which they will require specific skills or whether they are recruited into more generic teams, which might require them to undertake a variety of roles, determined by the way the organisation ‘packages’ around a particular family. The baseline is that tasks should not be undertaken unless staff skill and the agency structure is adequate to support that process.

A Family Inclusive Organisation

When a service adopts a family inclusive approach there are a number of organisational issues which need to be addressed, such as those listed below:

Cultural Change and Vigilance

Publicly funded health and welfare services usually develop because of community discomfort. If the level of discomfort is high, as it is with adolescent problematic substance use, it is likely that workers will feel pressured to produce cures. There may be an expectation that they, as ‘experts’, will know best what has to happen. To work within a family inclusive framework the role of ‘expert’ needs to be handed to the family. The workers’ expertise is in resourcing the family to do the ‘treatment’.

The culture of diagnosis and treatment is replaced by a culture of learning. Family inclusive practice values interventions and techniques which do not marginalise family members by not assuming that professionals hold the answer to reduced problematic behaviour.

Organisational Structures

Family inclusive service delivery is most feasible if it is located within an organisation that values families. Such an organisation will provide family sensitive physical settings and resources for staff to visit family homes. More particularly, the organisation will
acknowledge the added complexities of working with a family system and employ and train staff accordingly. Professional supervision would be based on a support for Family Inclusive Practice.

Staff working in organisations that are not family inclusive will have a reduced opportunity to service families but could still attempt to operate as much as possible within the family inclusive principles. Funding agreements might also determine that an organisation will be providing a specific resource to a whole family or just to one member of the family.

What is being suggested is that all drug and alcohol services working with young people review their current philosophy and practice and develop an approach which views the family as a basic resource to the young person and to the agency. This is a major shift for many workers and services will require some effort at all levels of the organisation. A set of resources has been developed to assist workers and their organisations in this change process (see Appendix 4).

5.2 Facilitated Support Groups

While it is expected that all drug and alcohol services which work with young people will take a family inclusive approach, it is envisaged that facilitated support groups will only be conducted by some agencies. The reason for this assumption is that there are specialist skills and resources required to put this model into practice.

The Facilitated Support Group model provides education, support and direction to family members where there is an adolescent, or young adult engaged in problematic substance use. The focus of the group is predominantly on the family members who are encouraged to direct their concerns to improving communication with the young person. Change is advocated as an evolutionary process, seeking incremental rather than dramatic change. Emphasis is placed on the importance of family members, ensuring they are taking adequate care of their own health and welfare.

The model proposed for facilitated groups with family members draws significantly from the Behavioural Exchange Systems Training (BEST) program, which was initiated by Odyssey House (See Appendix 3). In addition, the model draws from material provided by services in Australia and overseas, particularly as it relates to sessions for the broader family. In terms of programs for parents, the findings of this Project indicate that BEST is the most appropriate package currently available in Australia, as it has been thoroughly tested and evaluated over some years.

Rationale

As has been described in Chapter 4, services working with young people have increasingly come to acknowledge the importance of engaging the family members of young people who have a problem with the use of drugs and/or alcohol. There are a range of reasons why families want this support, including:

- Family members themselves need support either as individuals and/or as a family system which has come under increasing pressure and stress.

- The young person may not be willing to seek help for themselves and the family may be able to support them in a number of ways.
If the young person is in treatment the family members may require support.

At the end of a treatment episode the young person may be returning to the family home and the transition will require new behaviours and approaches from family members.

Family dynamics may be at the base of the problematic use and this will need to change if any change in use is to occur.

Research in Australia and overseas indicates that those young people who were most successful in transition from problematic substance use were able to utilise a family or social support network. The family is therefore a crucial point of intervention, in particular for young people who would not themselves want to attend a treatment service.

Many young people will engage in experimental or recreational substance use without harm occurring, however for this particular group there are associated harms arising for the young person from their use of drugs. Problematic substance use is seen as occurring within a cluster of associated behavioural or emotional difficulties and the model outlined here draws on a number of interrelated theories, including:

- A developmental view of adolescence and the importance of age-appropriate challenges and opportunities to be offered in the family as a precursor to the assumption of adult responsibilities. Having an adolescent in the family is also a period of transition for parents as they are required to make their own paradigm shift from parenting a dependent child to a parenting stance which takes account of the adolescents striving for autonomy and ultimately to a relationship of mutuality.
- Family therapy (Stanton and Todd 1982).
- Attachment theory (Catalano and Hawkins 1996).

**Adult Learning Principles**

In addition, the following key concepts of adult learning should underpin all the work undertaken in the facilitated groups:

- Adults need to know the benefits of learning something before being motivated to learn it. Facilitators must emphasise the improvement in the participant’s performance as a family member, and the enhanced quality of life that will come from strengthening the family in this way.

- Adults are responsible for their own decisions and for their own lives. They resent imposition and often associate previous bad experiences at school with any educational situation. Therefore, the facilitator must treat participants as self-directed learners and engage them in mutual enquiry, rather than transmit knowledge and evaluate conformity with it.
- Adults carry the resources for learning within themselves, based on their life experiences. For this reason a range of experiential techniques, group discussion, problem-solving and peer-exchange activities are appropriate. However, experience is not always positive and can cause biases and habits that block out fresh ideas. This makes way for values clarification and sensitivity training.

- Adults derive their self-concept mainly from their experiences. Thus, if their experiences are ignored or devalued, their identity is diminished. Therefore, the core methodology for adult education is the analysis of experience, and this is broad and varied within any one group of adults.

- Adults are task-and problem-centred in their approach, particularly to the problems which they encounter in their everyday lives. Therefore, the appropriate way to organise adult learning is according to life situations and not subjects.

- Adult motivation tends to come from intrinsic factors, such as quality of life, self-esteem and job satisfaction. Adult receptiveness and ‘teachable moments’ peak at the point where a learning opportunity coincides with the recognition of a need to know. All questions are opportunities for learning and individual differences increase with age. This means adult education must accommodate differences in style, time, place and pace of learning (adapted from Bruns, 1995).

**Program Objectives**

The objectives of these programs are to:

- Reduce the stress, anxiety and guilt experienced by family members as a result of adolescent substance use.

- Increase the capacity of the family to respond effectively and consistently to the young person.

- Increase the repertoire of communication and negotiation strategies available within the family.

- Increase awareness of the relationship implications of adolescent development.

- Where appropriate, advise families on strategies to encourage the adolescent to maintain or reduce substance use to levels which reduce harmful consequences.

- Promote a solutions-focused approach to problem solving.

**Target Group**

In some programs the target group is parents only (See the Odyssey BEST program). Others see the need to have a wider range of adult family members as appropriate. If the children in the family are themselves adolescents, then it may be more effective for them to have a separate group.
Timeframe
The various programs that were considered in the development of this model have at least a weekly session for two to three hours for a minimum of eight weeks and up to sixteen weeks. In addition, some programs recommend a follow-up session after six to eight weeks. In some cases a monthly follow-up program and/or individual sessions are conducted to provide ongoing support.

Example of a Program Outline
- **Week 1** Introduction and Orientation
- **Week 2** Understanding Drugs
- **Week 3** Adolescent Development
- **Week 4** Identifying Risk and Building Protective Factors
- **Week 5** Understanding Family Dynamics
- **Week 6** Communication and Negotiation Skills
- **Week 7** Developing Positive Support Networks
- **Week 8** Understanding the Treatment System.
- **Week 9** Developing a Positive Approach to Health
- **Week 10** Evaluation and Review Staff and Organisational Issues

Staff Team
As has already been stated, the skills and expertise required to conduct Facilitated Support Groups are specialised, and the staff team will need a mix of skills, including:
- General counselling and group facilitation skills
- Knowledge of adolescent development
- Familiarity with family systems concepts and techniques
- Knowledge of behavioural communication strategies
- Knowledge of substance dependence
- Skill and expertise in adult education
- Cultural awareness
- Awareness of broader community resources and referral networks.

The organisation will require the capacity to manage the range of issues which will emerge as a result of the facilitated group, since it is possible that family members will require support outside the group.
A publication by Odyssey on the BEST Program details how to conduct a facilitated support group for parents. Use of this manual is recommended to agencies and workers who intend to implement this model in addition to their Family Inclusive Practice.

Follow-up

As a result of participating in a Facilitated Support Group, family members may wish to maintain some ongoing contact with other members of the group. This may evolve into a ‘self-help’ process which requires little support from workers other than provision of space, administration and ongoing encouragement. In other cases, the members of the group may want to connect with an already established self-help group.

5.3 Family Engagement in Treatment

Actively engaging family members in treatment process has been demonstrated as being highly effective in terms of treatment outcomes. It does, however, require the specialist services of dedicated agencies in the drug and alcohol field to implement it. Therefore, initially it will be the least frequently implemented model, but agencies should gradually build towards this end of the spectrum of available approaches.

The concepts and approaches outlined in this section are drawn from a number of sources which provide a theoretical framework and model for working with young people within the context of their family. These models are well documented and evidence based. However, they are from the USA, and require detailed translation and adaptation into the Australian setting.

The three major theories which underpin this model are family systems theory; behavioural therapy; and multi-dimensional family therapy. Each of these theoretical frameworks provides a valid base for this work however, there is some evidence (Liddle, 1996) that the multi-dimensional approach is achieving more effective results.

Family Systems Theory

Family systems theory proposes that adolescent behaviour can best be understood by studying the characteristics of the family system in which the young person is located. The approach, then, is to change these family characteristics, by:

- Gaining access to and influencing the family system.
- Interrupting the relationship between the dysfunctional characteristics in the family system and the adolescent’s problematic behaviour.
- Establishing new family characteristics to interact with new adolescent behaviour.
Behavioural Therapy

In contrast, behavioural theory focuses on learning theory and proposes that changes in the young person are dependent on parental change. This means that the focus is on parents learning new behaviours, such as parental management, communication, problem solving, self-management and reinforcement. Interventions would include providing reading material, informal instruction, modelling new behaviours, role play and reframing behaviour.

Multi-Dimensional Family Therapy

The multi-dimensional family therapy (MDFT) model was developed by Howard Liddle (1996), within the framework of a research project on drug and alcohol treatment options for young people. According to Liddle, the Multi-dimensional Family Therapy model is based on some key assumptions:

- The overlapping domains of human existence include the affective, behavioural, temporal, moral/ethical, spiritual and interpersonal.
- Human problems are accessed through these domains and solutions can be developed by working in any one or all of them.
- The effectiveness of any intervention is diminished if any one domain is considered primary or dealt with to the exclusion of others.

...poor relationship skills, learning and behaviour difficulties in school, poor self-esteem, family disorganisation or dysfunction and movement in a trajectory of failure that places them outside the mainstream of their peer culture are typical patterns in these youngsters (Liddle, 1996:92).

The MDFT sees the importance of the engagement of both the young person and the family in the treatment process and places equal emphasis on both approaches. In addition, while the problematic use of drugs and/or alcohol is addressed, it is seen as ‘one problem within a complex of problems’ and conceives all problems as being multi-dimensional (Liddle, 1996:94).

In addition the MDFT is solutions focused.

- In a family focused/centred model there is an acceptance of the critical role of the family in adolescent development and as the major resource for the young person.

  The fundamental assumption of family-centred treatment is that the best way to help a troubled adolescent is to support, strengthen and empower their family (Synder and Ooms, 1996:1).

The two levels at which an organisation needs to work in a family focused/centred model are:

1. At the clinical level, viewing the family as the unit of care.
2. At the organisational or program level, ensuring that all policies and procedures support a totally integrated approach to families.
Rationale

The rationale for engaging the family in treatment is research based and draws from studies in both adolescent development and drug and alcohol treatment.

As has been explored in some detail in Chapter 2, while early approaches to adolescent development maintained the need for young people to achieve separation from their family, more recent research challenges this belief. In fact, it is now thought that negotiating and maintaining positive family relations is a critical step in the maturation process.

In sum it seems clear that adolescent development and problems are very much a family affair... (Liddle, 1996:92).

The work undertaken by Catalano et al, which was reported in detail in Chapter 2, stresses the need for young people to maintain family connectedness and considerable work in the youth welfare field now supports this approach.

The research on drug and alcohol treatment outcomes is still relatively limited, however Catalano et al (1990) conclude that:

- Some treatment is better than no treatment.
- Few comparison studies of treatment modalities demonstrate that one method is superior to another.
- Maintaining abstinence is difficult.
- Post-treatment relapse is high.
- Family involvement is regarded as a key aspect of effective treatment and has a positive impact on relapse.

As has already been reported, there are now a number of studies which indicate that:

Findings on family-based treatments of adolescent drug use are also encouraging. Studies consistently report that family involvement in the treatment of adolescent drug use is critical to engaging and retaining adolescents in treatment, as well as to successful treatment as defined by reduction of drug use, decrease of behaviour problems and affiliation with the family and the pro-social peers (Liddle and Dakof, 1995:218).

Structured cognitive-behavioural and skills-based approaches consistently show better results, along with approaches which address the educational and vocational needs of the family.

Family engagement (participation, therapy, training, etc) is regarded as an essential ingredient in effective treatment intervention, and reduces dropout. Early staff–family connection may be predictive of positive outcome and attendance. It can also reduce attempts by family—consciously or unconsciously—to sabotage treatment (Howard, 1998:96).
Another finding from the drug and alcohol research is that the 'disease model' is an inappropriate construct for young people (Liddle, 1996:94). A number of researchers and practitioners suggest that while the disease model has traditionally been applied to young people this has been because there has not been another alternative. What is now proposed is an approach based in adolescent development theories which specifically addresses the needs of young people.

The capacity and willingness of staff to engage the family at all points in the treatment process has also been found to be a critical factor in success.

It should be noted that most of the research on effective models of intervention with young people and the engagement of their families in the treatment process is from the USA. This does create some problems for the Australian setting, as the theoretical underpinnings of many of these models is abstinence and the Twelve Step program. Concepts of harm minimisation need to be examined in relation to this age group and local research will be required as programs are established.

**Timeframes**

As has been indicated in much of the previous material, most of the organisations which have undertaken research and in-depth evaluations in this area suggest that it is preferable to keep the young person at home if at all possible. Where this is not possible, the same principles of involving the family apply, while the logistics may differ.

Most of the successful programs have at least a twelve- to sixteen-week program which involves both the young person and family members on at least a weekly basis (The research now seems to indicate that it can take between three to six months to change social patterns).

In some cases the involvement is even more intense with the young person attending full day sessions during the week and the family members at least three times a week on evenings and/ or weekends.

Clearly the level of intervention and the length of time required are dependent on the severity of the situation and would be considered in the assessment process.

**Age Groupings**

The approach that will be taken will depend in part on the age of the young person involved, however, it is more important to look at the behaviour and development rather than the specific age. There are some specific duty of care issues for young people under 16 years of age which do not apply to older age groups.

It is also more appropriate to have groups for young people from similar age ranges, as the developmental and social issues for younger groups are significantly different from those of older groups.

**Steps in the Process**

It is acknowledged that the capacity of services to engage both young people and their families will vary enormously and will depend on the level of connectedness between the young person and members of their family. The experience of those services which have decided on a family focused approach has been that there are
always some members of the extended family and/or significant others who will be engaged. It has also been the experience of these services that the majority of young people would prefer to keep some connection with the family and see it as appropriate for the family to be involved.

Engaging the Young Person

For some services the young person will be the first contact, while for others it will be a member of the family. In either case there is a clear mandate to maintain the motivation of the young person throughout the treatment process and to ensure that adequate individual time is allocated.

At the outset the young person is helped to feel that the treatment process can address their own concerns. At all points they are encouraged to clarify and articulate their thoughts and feelings about their family and gradually express this to their parents/family members.

Young Person's Program

A number of components are suggested for inclusion in the young person's program, including:

- Social skills development
- Developing a positive peer culture
- Group work and support
- Addressing problematic substance use

Engaging the Family

A non-blaming approach is critical.Motivating the family to become engaged will require developing a rationale which includes the importance of significant others in the process.

In the MDFT model the parents/family members are encouraged to understand the developmental process and the interdependence of family members.

Interdependence and the necessity of both parents and adolescents negotiating the [young persons] transition to adulthood (Steinberg, 1991) become content themes and goals of the therapy (Liddle, 1996:94).

In addition, parenting styles and belief systems are explored and reassessed.

Family Program

A number of components are suggested for the family program, including:

- Education about drug use, problems and treatment approaches
- Parenting skills: boundary and rule setting, monitoring, discipline and problem solving
- Communication skills
- Counselling
- Group work on family issues
- Parent support group.

**Joint Sessions**
Throughout the treatment process the young person and family members are seen separately and together. In the MDFT model the therapist does not just work with the family system but also addresses the multiple systems within which the young person operates. This would include the school, Juvenile Justice system and peer group.

To accomplish interventions in these various systems, the therapist must be active, persistent and upbeat about the possibilities for change (Liddle, 1996:95).

The following components are suggested in the joint parts of the treatment process:
- Family therapy
- Family Group Conferencing
- Mediation
- Recreational activities to encourage pleasurable interaction.

**Clarity of Purpose**
Some of the family focused approaches maintain that it is important to hold in mind that the purpose of the treatment process is to address the problematic use of drugs and/or alcohol, even if there are a number of other issues in the family context which would benefit from family therapy or other interventions. However, the MDFT model suggests that, while this may be true, on occasions when the drug use is advanced, it is critical to deal with the whole system.

A key step is to ensure that all parties are clear about the reason that they are engaged in the treatment process and what they can expect to achieve from their involvement. In addition it is critical that they contract to remain in the process. For this reason, many services have an agreement or contract which all parties sign.

**Goal Setting**
For many family members, the only goal is to find a cure for the young person and to stop them using drugs. While goals need to be set in relation to the problematic use of drugs, goals are also needed in regard to broader family systems and relationships issues.
**Building Protective Factors**
Perhaps a core goal of the treatment program should be building the protective factors to support the young person, which include:

- Ordered home environments
- Effective parenting
- Strong family bonds
- Clear and consistent family rules
- Parental involvement
- Mutual attachments and nurturing
- Connectedness to school.
- Social coping skills
- Positive peer connections and affiliations
- Clear and unambiguous messages about the misuse of drugs.

**Assessment and Data Gathering**
In a family focused program, the assessment procedure would include all members of the family/ significant others. The data which is collected in this process would include:

- Drug using history
- Family responses and approaches
- Impact on family members
- Role of various family members in the creation of the ‘problem’
- Peer group involvement and support
- Connectedness to school and other community groups
- Other interventions and organisations which have been involved
- What helps to maintain the current situation and what purpose is served.

**Monitoring Questions**
- Is the young person demonstrating improved problem solving ability?
- Have the relationships in the family improved?
- Has the family process for dealing with conflict and difficult situations changed?
- What is happening in the broader social systems for the young person and the family?
5.4 Summary

The literature and case studies have identified a number of approaches which could effectively be introduced in the drug and alcohol service system. The critical role of families in assisting both the young person and the service is underdeveloped in the sector and much could be learned from allied fields such as Child Protection and Juvenile Justice about child inclusive practice.

This Project has found a desire in the sector and evidence in the literature, that would support all services adopting what could be described as Family Inclusive Practice. This approach works from the fundamental assumption that the family is a resource to the young person and the agency and that the involvement of family members is fundamental to an ongoing solution. The adoption of this framework for service delivery will require services to review their current organisational philosophies and service models as well as ensuring that a range of skills and supports are available to workers and families alike. A resource for this process is provided in Appendix 4.

In addition to a general re-orientation of all services, in terms of the inclusion of families when working with young people, there is an identified need for Facilitated Support Groups for family members. Currently there are some services providing these on an ad hoc basis although, in the main, these focus on parents rather than on the broader extended family and siblings. Odyssey has conducted a well documented and evaluated program for parents which is recommended as a model for this approach.

Overseas literature demonstrates the value of engaging family members in the treatment process with young people. This is perhaps the most challenging approach for the sector in Australia and any models need to be trialed within the local context. However young people and family members stress the importance of this approach. The theoretical frameworks are well documented and there is evidence of the efficacy of many of the models.
6. Discussion and Recommendations

This Project has explored new territory in the treatment of young people with a substance abuse problem in exploring the needs of family members and the potential for involving them in the treatment process. It is only recently that there was a recognition of the need for a different treatment model for working with young people than had been developed for work with adults. The development of youth specific services and the appointment of workers with experience in working with young people were key responses to this.

The current Project has identified a number of issues which need to be addressed in relation to families who have a young person engaged in problematic substance use. Some of the findings include:

- Family members feel excluded by current approaches in the service system, from the very first contact through a telephone service or general practitioner to having their child or sibling involved in a treatment service. Generally speaking, their experience has not been positive or supportive.

- Generally, young people see the benefit of having family members included in the treatment process.

- There are a number of drug treatment services which are focusing on the needs of young people. Some of these are now either in contact with family members; are supporting the family through support groups and/or counselling; and/or are attempting to find ways of working with the family in more sustainable ways.

- Overseas research demonstrates that the involvement of family members in the treatment process increases success. In addition, there are now a number of methods and approaches which have been shown to have a significant impact.

- A shift to involving family members in the treatment of young people will require a cultural shift in many organisations and a change of approach for many workers who have traditionally seen the family as ‘the problem’.

- Training and supervision are seen as key strategies for bringing about change and workers are keen to have this provided.

6.1 Improving Family Involvement and Support

Key approaches have been explored towards improving the treatment outcomes for young people, ensuring that families are supported and actively engaging families in the treatment process. In summary, these include:

- Support for self-help groups: self-help groups are, by definition, self-supporting and require little intervention from drug and alcohol agencies. There is, however, some indication that some support in terms of basic administration would be of some assistance.
• Adoption of a sector wide approach which sees families as a valuable and even essential resource to work with young people in drug and alcohol treatment and which results in Family Inclusive Practice as the norm in working with young people.

• Development of a team of specialist workers who can conduct Family Facilitated Groups for the family members of young people who have a drug and or alcohol problem. These groups would focus on the specific needs of the family members and increase their capacity to both deal with their own issues and those of the young person.

• Development of a key service in each region which will ensure that there is a coordinated approach to working in a family inclusive way through worker training, supervision and support.

• Development of treatment models which draw on and adapt overseas evidence that engaging the family in the treatment process has positive outcomes for the young person.

**RECOMMENDATION 1**

That Drug and Alcohol services which work with young people adopt an approach of Family Inclusive Practice.

**RECOMMENDATION 2**

That Facilitated Family Support Groups be offered in each region so that family members can gain support for themselves as well as being supported to assist the young person requiring treatment.

### 6.2 Adoption of New Conceptual Frameworks

In the identification of new approaches it is important to acknowledge that some of the theories which have underpinned the work of drug treatment services might need to be re-examined. Working with families has not been an integral part of treatment in this sector. In addition, the particular issues to do with adolescent development may need to be explored in terms of their applicability in the drug treatment setting.

For some years now there has been considerable debate in allied fields, which work with many of the young people who are now accessing drug treatment services, about the role of the family in any intervention that is taken with a young person. This has lead to a number of government funded programs and non-government projects, such as strengthening families, family group conferencing, family and youth mediation and working with young people in the context of their family.

The skills and experience that has been gained in these fields may provide an important starting point in the development of new approaches. The evidence on which this practice is now based from overseas supports that working with young people in the context of their family has more positive outcomes than engaging them alone.
The work around resilience and protective factors is perhaps the most appropriate to consider as the basis for a new conceptual framework. The holistic approach which addresses the needs of young people to feel connected to family or significant adults, school, positive peers and the community is a critical starting point (see Chapter 2). In this regard there are a number of allied services in Juvenile Justice, mental health and education, such as the School Focused Youth Service, which would provide links into the school and community networks.

In addition, there is still work to be undertaken in relating these conceptual frameworks to the experience of Aboriginal young people and families as well as families from culturally and linguistically diverse backgrounds. The processes currently being applied in creating more culturally responsive services provides a sound basis for this work.

Given that the approaches and models presented here are only a starting point it is important that processes are developed to ensure that there is an ongoing dialogue between workers with young people in drug treatment services and those in the broader youth services sector. At a departmental level, the Working Together Strategy is a valuable resource and model for this process.

There would be value in each region having a lead agency which would ensure that an integrated and consistent approach is taken to developing new frameworks and practice in this area which draws on the range of expertise and skills in allied sectors. This process would ensure the ongoing identification and promotion of best practice.

RECOMMENDATION 3

That a lead agency is identified in each region to develop a process for linking drug and alcohol services with the broader network of youth focused services, to both draw on skills and expertise in these areas, and ensure that young people are supported by the widest range of services.

One of the issues which emerged in the conduct of this Project was that of the applicability and relevance of the harm minimisation model in relation to young people. While there was no questioning of harm minimisation as a philosophy, there was a suggestion that it would be advantageous to have a discussion between practitioners in drug treatment services and those working from a framework of adolescent psychology, particularly as the concepts relate to adolescent development.

RECOMMENDATION 4

That workers from drug treatment services and adolescent development psychologists explore the particular issues in developing treatment models for young people within a harm minimisation framework through a series of forums and practice workshops.
6.3 Overall Training Strategy

In Chapter 5, a framework for Family Inclusive Practice was outlined, and in Appendix 4 some tools and processes are outlined. It is acknowledged that a number of organisations which conduct programs and provide services to young people do not have a youth focus and may not have a concept of family inclusive work. This presents some challenges to both the organisation and the workers. The ways in which these workers are supported and supervised will be critical if any change is to be achieved.

The experience of working with young people in drug treatment is still relatively new and working with them in a family context will be an additional challenge which many workers will find daunting, without supervision and training, as engaging families will raise a number of personal issues for workers.

In fact, it is the very issue of workers personal experience and values which needs to be at the centre of a training strategy and of practice supervision in the sector. At a minimum, the training required to work with young people in a family inclusive way will include:

- Confronting personal attitudes and values.
- Theories and conceptual frameworks of resilience and connectedness.
- Approaches to assessment.
- Engaging young people and their families through dialogue—the experience of workers in family group conferencing and family and youth mediation is of relevance here.
- Creating a family inclusive environment.
- Team approaches to family work.
- Confidentiality, consent and record keeping.
- Creating family action plans and drawing on the family as a resource.
- Evaluation.

Because of the newness of services and workers in this area it will be necessary to draw from the expertise of allied sectors for initial training models and curriculum as well as for training for supervisors who can provide ongoing support.

**RECOMMENDATION 5**

That a training strategy is developed for supervisors of workers with young people; and that expertise is drawn from allied fields where there is a stronger base for working in a family inclusive way.
RECOMMENDATION 6
That a training program on Family Inclusive Practice for all services working in drug treatment with young people is developed and implemented.

In addition to Family Inclusive Practice being adopted by all services, a model of Facilitated Family Support was also suggested. This model was based on literature from a number of services in the USA and the work of Odyssey House in its BEST program. Full documentation of the BEST program is being published separately and this will provide a valuable resource for workers interested in providing structured support to families members.

RECOMMENDATION 7
That training is offered to workers who are planning to conduct Facilitated Family Support groups and that this training draws on the expertise already in the field.

6.4 Active Engagement in Treatment
The third approach that has been recommended is that of actively engaging family members in the treatment process with young people. While this is happening in home-based services, there has been reluctance—and even some resistance—by workers and services to see families as having a legitimate role in treatment services of any type. In spite of the evidence from overseas studies, both in drug treatment services and in allied fields (also in Australia) there seems to be a number of reasons why services cannot conceptualise the value of this approach.

As has been reported, organisations such Odyssey New Zealand and Thunder Road in the USA have developed effective models which engage the family in every aspect of treatment. In addition there are numerous models of family focused work in Victoria in services which deal with the same population group but from a different perspective. Some of these include St Luke’s Family Services and Anglicare’s Southbridge Youth Services.

RECOMMENDATION 8
That a Task Force is established, which includes drug and alcohol services and youth and family services, to develop treatment models which actively engage family members.

One of the major issues in working with families, in any field that is focused on young people and their needs, is that a paradigm shift is required which changes the focus from the family as the problem and therefore requiring exclusion, to the family as a resource which is critical to the solution. This will require addressing the issues that emerge with intentionality rather than in an ad hoc manner.
6.5 Episode of Care

There is no question that Family Inclusive Practice can be implemented immediately, even at the level of direct service to family members because a non-user can be counted as a client in Alcohol and Drug Information System.

In addition, it would be valuable to create a new treatment service type of ‘family focused’ counselling. This would require the employment of D&A youth and family counsellors (not family therapists).

The unit cost for counselling funds 110 episodes of care per annum and each episode of care is based on the achievement in of significant goals defined an Individual Treatment Plan (ITP). Consideration needs to be given to the appropriate unit cost and number of episodes of care achievable in the multi-client situation of family focused counselling. Other issues, such as whether family member would require an ITP, will have to be resolved.

**RECOMMENDATION 9**

That the Drug Treatment Services Program develops a new treatment service type of family focused counselling with appropriate key service requirements.

6.6 First Point of Contact

One of the critical issues for parents and other family members is the first point of contact. There were a number of complaints about telephone services. In particular, family members felt that their concerns were not taken seriously when they contacted these services. Another entry point into the service system is general practitioners, and again the experience has not been positive.

At a basic level, when family members approach any service for help, they need to be treated with respect; seen as a legitimate client; and referred to an appropriate service for assistance.

It would be appropriate for all telephone services to understand that family members require support and encouragement and have access to referral resources to ensure that the most appropriate referrals are made. ParentLine may have a particular role to play in providing parent support and referral to self-help and facilitated support groups.

As a service focused on the drug and alcohol sector DirectLine has an important function in ensuring that all callers feel that they have been responded to appropriately and linked to a service(s) which will respond to their needs and concerns. Given the emerging interest in working with families, this may require additional data and briefing for staff.

All telephone queries should be referred by other telephone services to DirectLine.
RECOMMENDATION 10
That DirectLine establishes a family reference group with an understanding of the issues for Family Inclusive Practice and an effective response to families who contact the service.

RECOMMENDATION 11
That DirectLine provides briefing and orientation for telephone workers on family inclusive responses and referral.

6.7 Self-Help Groups
Although not the specific subject of this Project, self-help groups were seen by many parents as the only source of support available to them. As was pointed out in the Report there is some variation in these groups depending on the current membership and leadership. It may be useful for these groups to consider linking with a service for support and referral. In addition, there would be some benefit in self-help groups working with services that provide facilitated support for family members so that there is some ongoing support when the group finishes.

One of the groups which appears to have had little attention is the siblings of young people who have engage in problematic substance abuse. As was discussed earlier in the Report this group has their own particular issues and concerns which need to be addressed.

Treatment services working with young people can assist the process of self-help in a number of ways including:

- Advertising and referring to already existing groups.
- Providing venues and administrative support to both newly emerging and ongoing groups.
- Bringing together family members to establish new groups as appropriate.
- Assisting groups which have been meeting in an educational and/or facilitated group to maintain contact on completion of this process.

RECOMMENDATION 12
That services which work with young people encourage and support the development and maintenance of self-help groups through provision of resources, referral and initial facilitation.
6.8 Summary of Recommendations

1. That Drug and Alcohol services which work with young people adopt an approach of Family Inclusive Practice.

2. That Facilitated Family Support Groups be offered in each region so that family members can gain support for themselves as well as being supported to assist the young person requiring treatment.

3. That a lead agency is identified in each region to develop a process for linking drug and alcohol services with the broader network of youth focused services, to both draw on skills and expertise in these areas, and ensure that young people are supported by the widest range of services.

4. That workers from drug treatment services and adolescent development psychologists explore the particular issues in developing treatment models for young people within a harm minimisation framework through a series of forums and practice workshops.

5. That a training strategy is developed for supervisors of workers with young people, and that expertise is drawn from allied fields where there is a stronger base for working in a family inclusive way.

6. That a training program on Family Inclusive Practice for all services working in drug treatment with young people is developed and implemented.

7. That training is offered to workers who are planning to conduct Facilitated Family Support groups and that this training draws on the expertise already in the field.

8. That a Task Force is established, which includes drug and alcohol services and youth and family services, to develop treatment models which actively engage family members.

9. That the Drug Treatment Services Program develops a new treatment service type of family focused counselling with appropriate key service requirements.

10. That DirectLine establishes a family reference group with an understanding of the issues for Family Inclusive Practice and an effective response to families who contact the service.

11. That DirectLine provides briefing and orientation for telephone workers on family inclusive responses and referral.

12. That services which work with young people encourage and support the development and maintenance of self-help groups through provision of resources, referral and initial facilitation.
Appendix 1—Bibliography


Success Works Pty Ltd (1998) Young People and Drugs: Needs Analysis, Department of Human Services, Drug Treatment Services Unit, Aged, Community and Mental Health Division.


## Appendix 2—Services Interviewed

### Table 15 Community Health Services

<table>
<thead>
<tr>
<th>Title</th>
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<tr>
<td>Coordinator, Drug and Alcohol Program</td>
<td>Ballarat Community Health Centre</td>
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<td>D&amp;A Counsellor</td>
<td>Banyule Community Health Service</td>
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<td>Youth D&amp;A Worker</td>
<td>Barwon Health—Drug treatment Services Geelong Community Health Service</td>
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<td>Social Worker and D&amp;A worker</td>
<td>Benalla and District Memorial Hospital/Community Health Service</td>
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<td>D&amp;A Counsellor</td>
<td>Echuca Regional Health, Community Health Division</td>
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<tr>
<td>D&amp;A Counsellor</td>
<td>Lakes Entrance Community Health Service—East Gippsland Drug and Alcohol Service</td>
</tr>
<tr>
<td>Youth Outreach Worker</td>
<td>Latrobe Community Health Service</td>
</tr>
<tr>
<td>D&amp;A Counsellor</td>
<td>Maryborough and District Community Health Centre</td>
</tr>
<tr>
<td>D&amp;A Team Leader</td>
<td>Monashlink Community Health Centre—Eastern Drug and Alcohol Service.</td>
</tr>
<tr>
<td>D&amp;A Counsellor</td>
<td>Ovens and King Community Health Centre</td>
</tr>
<tr>
<td>D&amp;A Counsellors</td>
<td>Sunraysia Community Health Service</td>
</tr>
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</table>
### Table 16  Drug and Alcohol Specific Organisations

<table>
<thead>
<tr>
<th>Title</th>
<th>Name of Service(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinator</td>
<td>Buoyancy Foundation of Victoria</td>
</tr>
<tr>
<td>D&amp;A Counsellor</td>
<td>Moreland Hall Drug and Alcohol Centre</td>
</tr>
<tr>
<td>D&amp;A Outreach worker</td>
<td>Northern Region Drug and Alcohol Youth Outreach Service—Youth Projects</td>
</tr>
<tr>
<td>D&amp;A Counsellor</td>
<td>Odyssey House Victoria</td>
</tr>
<tr>
<td></td>
<td>Odyssey House Parent Program/Centre of Adolescent Health—BEST</td>
</tr>
<tr>
<td>Manager</td>
<td>Open Family Australia Street worker Outreach</td>
</tr>
<tr>
<td>Director</td>
<td>Palm Lodge Rehabilitation Centre</td>
</tr>
<tr>
<td>D&amp;A Worker</td>
<td>Self-help Addiction Resource Centre</td>
</tr>
<tr>
<td>D&amp;A Worker</td>
<td>Task Force</td>
</tr>
<tr>
<td></td>
<td>Turning Point Drug and Alcohol Centre</td>
</tr>
<tr>
<td>D&amp;A Youth Worker</td>
<td>Western Region Drug and Alcohol Centre (WRAD)</td>
</tr>
<tr>
<td>Program Manager</td>
<td>WESTADD Women and Children D&amp;A service</td>
</tr>
<tr>
<td>Executive Officer</td>
<td>Youth Substance Abuse Service</td>
</tr>
</tbody>
</table>

### Table 17  Family Specific and Welfare

<table>
<thead>
<tr>
<th>Title</th>
<th>Name of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional Family D&amp;A Clinician</td>
<td>Anglicare (Werribee)</td>
</tr>
<tr>
<td>Youth D&amp;A Outreach</td>
<td>Ballarat Parish Mission</td>
</tr>
<tr>
<td>Outdoor Program Coordinator</td>
<td>Jesuit Social Services, Connexions Outdoor Program</td>
</tr>
<tr>
<td>Coordinator</td>
<td>Rehabilitation and Family Therapy—RAFT</td>
</tr>
<tr>
<td>CCCCC</td>
<td>Salvation Army Eastcare Hawthorn Primary Care Project</td>
</tr>
</tbody>
</table>

### Table 18  Aboriginal Services

<table>
<thead>
<tr>
<th>Title</th>
<th>Name of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D&amp;A worker</td>
<td>Central Gippsland Aboriginal Health and Housing Cooperative</td>
</tr>
<tr>
<td>Aboriginal Drug and Alcohol Worker</td>
<td>Victorian Aboriginal Health Service</td>
</tr>
<tr>
<td>Aboriginal Drug and Alcohol Worker</td>
<td>Wathaurong Aboriginal Cooperative</td>
</tr>
<tr>
<td>Title</td>
<td>Name of Service</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>Coordinator</td>
<td>Austin and Repat Medical Centre</td>
</tr>
<tr>
<td>Community D&amp;A nurse, Home-based withdrawal team</td>
<td>Box Hill Hospital Drug Services Unit</td>
</tr>
<tr>
<td>Coordinator</td>
<td>Drug Withdrawal Unit, Dandenong Hospital</td>
</tr>
<tr>
<td>D&amp;A Counsellor</td>
<td>Westernport Drug and Alcohol Service, Dandenong Hospital</td>
</tr>
<tr>
<td>D&amp;A worker</td>
<td>Western Hospital, Drug and Alcohol Services</td>
</tr>
</tbody>
</table>
Appendix 3—Case Studies

In reviewing the current practice of working with young people and their families, four services in Victoria, nine interstate and two overseas were selected and written up as case studies. The services include:

- Adelaide Central Mission Adolescent Services
- Anglicare Werribee—The Family Clinician Project
- Banyule Community Health Service (VIC)—Parent Education Information and Support (PEIS)
- Odyssey House Victoria: Behaviour Exchange Systems Training (BEST)
- Dunsmore House (Western Sydney Area Health Service)
- Dunlea Alcohol and Other Drugs Adolescent and Family Work Project (NSW)
- Elura Outpatient Counselling Clinic (SA): Parent Support Program
- Grove Street Service (TAS) Making a Difference: A Drug Awareness Program for Parents
- Hothouse Youth Community Team—Parent Education and Support Group
- Queensland Community Drug Awareness Council: Stepping Stones
- Rehabilitation and Family Therapy Inc (RAFT)
- Ted Noffs Foundation
- Western Australia Drug Strategy Office—Working in Partnerships with Parents
- Odyssey House Auckland Youth Services: Day, Residential and Evening program (NZ)
- Thunder Road Drug Rehabilitation Program (USA)

These case studies have not been formally critiqued as being models of best practice. Rather they have been documented on the basis of having components of Family Inclusive Practice.

Australian Case Studies

1. Adelaide Central Mission Adolescent Services
   - Parent Support Group for young homeless people in their shelter
   - Adolescent Mediation and Family Therapy.
Brief Description
Adelaide Central Mission Adolescent Services do not focus solely on adolescent drug users and their families, but they form part of the client group of the program. One aspect of their service is a shelter for homeless youth and a Parent Support Group is offered as part of this. Another program is Adolescent Mediation and Family Therapy, which provides individual and group counselling and mediation to deal with family conflict for individuals and family groups. This program works with whoever presents and in any combinations chosen by the presenters.

Target Group
Families with a young person between the ages of 12 and 25 are the official target group, but the most common age group is 12-18 years. The client is the family, but if pushed the program will adopt the young person as client because of their vulnerability.

Timeframe
Counselling and Mediation is available for as long as required. This may range from two or three sessions to 12 months.

Rationale for Program
Some trial courses for families have been conducted and these clarified certain issues that have influenced the current service model:

- The parents who attended were already the very motivated ones
- Similar programs in open discussion and parenting skills are offered by other services for example, STEP.

Theoretical Framework
Systemic family therapy is the general approach used, however an eclectic approach also allows for the use of other approaches that work well, such as: narrative therapy, problem solving, behaviour modification.

Organisational Prerequisites
According to the program coordinator, the main service prerequisites include the following:

- A flexible and experimental approach that can be adapted to particular families
- Critical examination of service provision
- A good referral network to assist the client
- Use of teamwork and a lateral approach.
Outline of the Program
Access to the program generally occurs by people contacting the service by telephone. Following contact, clients are assessed for approximately one hour. Following an assessment an appointment is then made for either counselling or mediation. It is common that families have not talked to anyone else about their situation and do not require for counselling or mediation but need assurance that what they are doing is positive.

Evaluation
- Both programs have been evaluated by their funding bodies. SAAP commissioned the evaluation of the residential service and LAFS the Adolescent Mediation and Family Therapy Program.
- Family and mediator devise an agreement on three issues, which is assessed by using a scale to rate their progress towards a resolution.
- Client feedback is sought through a general satisfaction questionnaire.

Expected Outcomes of the Program
The main outcome is that the young person returns and remains with their family.

Further Information
Michael Collins, Adelaide Central Mission Adolescent Services, Ph: 08 8202 5160.

2. Anglicare Werribee—The Family Clinician Project

Brief Description
The Family Clinician Project involves the use of family counselling and groupwork to assist families where a young person has an alcohol or drug problem. It is a twelve-month pilot Project which commenced in September 1998. Counselling is conducted at the office or in family’s homes.

The design of the group intervention is to conduct some discrete information/education sessions for a group different from those involved in the counselling, with the intention that it will develop into an ongoing, professionally facilitated support group.

Target Group
The families of young people between 12 and 17 years who are dealing with substance use issues. The sessions in either arm of the Project can include the parents, the young person and siblings, if requested. The priority is to work with families which have young people receiving treatment, whether this be drug and alcohol counselling, withdrawal or rehabilitation. Families of young people not yet in treatment are not discouraged to attend.
Timeframe
The average number of counselling sessions aimed for is eight and there is capacity for ongoing work. Families tend to come in and out of counselling as they feel the need for more assistance or as other things in their lives allow. The proposed support group will be ongoing.

Rationale for the Program
A service gap was perceived in the region and one of the recommendations in Young People and Drugs Needs Analysis (Success Works 1998) highlighted the need for the role of parents in supporting young people with a substance abuse problem to be explored. In addition, overseas literature has emphasised the value of a family focused on this problem.

Theoretical Framework
The Project is based on the following framework:

- Engage the whole family or as many members as possible in the counselling and group processes.
- Utilise Humanistic/Rogerian techniques to engage with families in the first instance.
- A systemic framework is adopted in assessing and understanding the family situation and the family dynamics in counselling.
- Specific techniques from family systems theory, such as reframing and boundary making, are utilised.
- Provision of a combined education and therapeutic focus for the group, via resource sharing, guest speakers and group counselling.

Prerequisites
The service prerequisites identified include the following:

- Sensitivity to the needs of families and the blame and stigma carried by them.
- Willingness to do home visits.
- Good communication with treatment services to prevent overlap.
- Trained counsellors who are experienced in working with families, but not necessarily psychologists or social workers.
- Team support through supervision.
Outline of the Program
The program components are as follows:

- Goals and expectations for the family are clearly articulated as part of the counselling assessment process.
- Information is provided in verbal and written forms, in response to specific questions from family members, to alleviate anxiety and to demystify the situation, in both counselling and group interventions.
- In looking at families in a holistic way many practical difficulties in functioning, communicating and managing on a daily basis are addressed.

Evaluation
To determine the effectiveness of the interventions, a coping scale is administered pre and post intervention. An evaluation form will be administered after work with the family is completed and a follow-up interview will occur approximately three months later to determine ongoing effects.

Expected Outcomes of the Program
The expected outcomes include:

- Alleviation of parental distress.
- Influencing behaviour change in parents and siblings that will lead to change in the young person.
- Assisting family in supporting treatment so that harm to the young person is reduced.
- Preventing family breakdown and homelessness.
- Through the support group, assisting parents, significant others and caregivers to manage more effectively in relation to the substance use of their young person.

Further Information
Tania Zapparoni, 2 Market Rd, Werribee Vic 3030, Ph: 03 9742 5300.

3. Banyule Community Health Service (VIC)—Parent Education Information and Support (PEIS)

Brief Description
PEIS is a facilitated, non-structured group for parents of adolescents that have problematic drug use. The program brings together parents of young people who are at the early experimental stage of use of various drugs to parents of young people that are heroin dependant. The latter group form the core of the group over time, while others drop in and out.
**Target Group**
The program generally targets parents or the spouse of the young person, or sometimes a relative or significant other, who have requested assistance and support from the Drug and Alcohol worker.

**Timeframe**
PEIS has been running for past twelve months. The group is ongoing and meets monthly.

**Rationale for the Program**
A gap was perceived in relation to the needs of parents who were coming to see the Drug and Alcohol worker. He found himself repeating information, education and support time after time to different parents, as well as using other parents’ experience as examples of hope and change. A group for a mixture of less experienced and more experienced parents seemed the most appropriate approach.

**Theoretical Framework**
The group operates on an eclectic model as the facilitator does not have a background in any particular theoretical approach. It presents a supportive framework for the empowerment of parents to develop skills to manage for themselves.

**Prerequisites**
The identified prerequisites to facilitate this program as follows:

- Personal contact between participants and the facilitator before attending the group to develop some understanding of what it is about and how it operates.
- Flexibility in structure of the sessions.
- The facilitator needs knowledge about all aspects of drug use, skills in communication and group dynamics, understanding of parental/child relationships and behaviour change.
- Workers within the organisation and in referring agencies need to be familiar with the program and how it works.

**Outline of the Program**
Participants’ information/education needs are canvassed and guest speakers are invited to the group. The longer-term parents offer the benefit of their experiences to newcomers and support and information are provided first, then behaviour change comes later in the process. In addition, the facilitator mails out relevant information in the weeks between meetings.

**Evaluation**
The program has not been formally evaluated, however feedback from participants indicates that the group has been helpful to those attending. Attendance numbers have been up to 20, but generally 8-10 parents attend.
Expected Outcomes of the Program
The expected outcomes are that parents will develop knowledge and understanding of how to deal with the young person’s drug behaviour and feeling more able to cope.

Further Information
Ross Mortimer, Drug and Alcohol Counsellor, Eltham Community Centre, 917 Mann St, Eltham VIC 3095, Ph: 03 9431 1333.


Brief Description
BEST is a nine session group parent training model developed by Odyssey House (Anne Blyth and John Bamberg) and the Centre for Adolescent Health (Dr John Toumborou). The program was originally piloted with the Australian Greek Welfare Association and has had continued development and implementation over the last three years.

The objectives of the program are to:

- Reduce stress, anxiety and guilt experienced by parents as a result of adolescent substance use.
- Increase the capacity of the parent(s) to respond effectively to the adolescent.
- Increase parents repertoire of communication and negotiation strategies.
- Increase parents awareness of the relationship implications of the adolescent stage of development.
- To ensure a consistent approach is undertaken by couples.
- Where appropriate advise families on strategies, to encourage the adolescent to maintain or reduce substance use to levels which reduce harmful consequences.

Target Group
The program targets parents of young people aged 14–22 years with problematic substance use. The program is most suitable for parents with high involvement with their adolescent.

Timeframe
The group runs for two hours per week for eight weeks, with a follow-up session in eight weeks for two hours. Currently, a monthly session is being piloted for those who have attended.
Rationale for the Program
The program was developed in response to a high number of calls for information and support from parents with young people with problematic substance use patterns to Odyssey House. A further rationale was a research knowledge base that interventions involving family and support networks contributes to more effective outcomes in the treatment process.

Theoretical Framework
The program has a strong theoretical foundation drawing on a developmental view of adolescence and combining systems and behavioural thinking, including: family therapy, behaviour therapy and attachment theory. The program is also based on experience and understanding of people with problematic drug use.

Prerequisites
There are a number of prerequisites in order to facilitate the BEST process. Staff will need to have general counselling and group facilitation skills, a knowledge of adolescent development, familiarity with family systems concepts and techniques, knowledge of behaviour change strategies and knowledge of substance dependence. While the course has a definite structure, part of its value is in the individual attention which is given to the particular family circumstances. Facilitators must have sufficient clinical depth of experience to be able to respond to parents in this way. The frequency with which mental health issues are found in parents or adolescents would suggest that clinical experience here is also an advantage.

Publications Outlining the Program


Outline of the Program

<table>
<thead>
<tr>
<th>Session Topic</th>
<th>Session Content</th>
<th>Pre-Meeting Homework Assignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1: Introduction and familiarisation with the group, exploration of problems.</td>
<td>Participants interview one another investigating their problems and goals.</td>
<td>Questionnaire assessing adolescent drug use and parental mental health symptoms.</td>
</tr>
<tr>
<td>Week 2: Investigation of drug types and their effects. Introduction to the positive functions of drug use.</td>
<td>Didactic instruction followed by participant examination of their positive motivations for alcohol use.</td>
<td>Parents invite adolescents to complete an interview regarding the positive benefits of either their own or another's drug use.</td>
</tr>
<tr>
<td>Week 3: Exploration of the challenges of adolescent parenting including the need to increase adolescent responsibilities and to plan for life post-children.</td>
<td>Adolescent interviews are discussed. Group discussion examines dangers posed through adolescent irresponsibility, the dependency of personal happiness on parenting success.</td>
<td>Parents are asked to elaborate personal goals planning for the period after their children have left home.</td>
</tr>
<tr>
<td>Week 4: The importance of adolescents experiencing consequences for decisions. The tendency of parents to take responsibility.</td>
<td>Discussion of parents' plans for the future. Exploration of parents fears. Investigation of the positive qualities of adolescents.</td>
<td>Parents are asked to meet together to determine a common stance to parenting. Sole parents are asked to investigate available sources of support.</td>
</tr>
<tr>
<td>Weeks 5: Investigation of parents' willingness to alter their parenting stance and to encourage adolescents toward more mature responsibility.</td>
<td>Parents discuss the need to change their approach to parenting. Some parental encounter regarding the consequences of taking responsibility for adolescents.</td>
<td>An inventory of household tasks and responsibilities of family members is completed</td>
</tr>
<tr>
<td>Week 6-7: Immature adolescent behaviour is identified and analysed with respect to how it could be more maturely performed. Parents are instructed how to positively reward mature adolescent behaviour.</td>
<td>Parents work in small groups to identify behavioural strategies. Parents attempt to make more of their existing support contingent on responsible behaviour.</td>
<td>Parents negotiate strategies with adolescents. Problems are noted for further discussion in the meetings.</td>
</tr>
<tr>
<td>Week 8 and Week 16: Evaluation, review.</td>
<td>Parents discuss progress. Suggestions for improvements to the program are sought.</td>
<td>Pre-intervention assessments are repeated.</td>
</tr>
</tbody>
</table>

Evaluation and Outcomes of the Program

Entry to the program is via a telephone assessment in which basic information is collected on who is in the family, what problems are being experienced and what the intended participants would be seeking by their attendance. Information is given about the program and its objectives. The General Health Questionnaire (Goldberg and Williams, 1998) and the Kansas Parental and Family Life Satisfaction Scales (James et al, 1985) are administered on entry, at week eight and at week sixteen.

The GHQ provides information relating to four scales of mental health and in addition a global psychiatric health index. The global index was conceived as a measure of the likelihood of an individual being diagnosed by a generalist service provider (such as a GP) to be suffering from a psychiatric illness. The analysis of the most recent participants will be available in early 1999. Of those participants who attended during 1996 and the early part of 1997 it was found that on program entry 73 per cent of parents were found to score 5 or higher, which represents a highly significant degree of disturbance. Primarily, parents reported a significant degree of depression. By week eight these rates dropped to 34 per cent and appeared to remain around this level to the follow-up at week sixteen. Analysis of the KPFLSS indicated marked improvement in parents’ satisfaction with their participation in
the family. For example, ratings on the item ‘How satisfied are you with yourself as a parent?’ went from 26 per cent at entry, to 57 per cent at week eight, and were maintained at follow-up.

Information is also collected on the substance use and behaviour change in the adolescent. In 36 per cent of cases drug use ceased and/or the adolescent entered treatment of their own. In a further 43 per cent drug use continued, however, improvements occurred in behavioural or other developmentally appropriate ways. Twenty-one per cent of clients reported no change. Given that this is an indirect effect, since the young person is not seen by the program, this represents a significant flow-on effect of increased parental confidence and skill in responding to their adolescent. At week eight and sixteen parents are also asked to give verbal feedback on any suggestions for program improvement.

Further Information
This program information has been provided by Anne Blyth, 1999. For further information contact Charlie Stewart, Odyssey House Counselling: Ph (03) 9510 5394.

5. Dunsmore House (Western Sydney Area Health Service)

Brief Description
Dunsmore House provides two programs involving families. The first program is a weekly Parent Support Group available to parents and siblings of young people with drug dependant issues. The program is offered both to parents of those undertaking the residential detoxification program provided by Dunsmore and families not currently involved in the treatment. The group is facilitated by a staff member and the aim is to offer information, support through sharing experiences with others and education about behaviour change. A principle aim of the Group is to prepare the families for the homecoming of the young person following treatment.

The second program is Sunday Night Group, which operates on a drop-in/ drop-out basis. It has a similar focus to the Support Group but is made up of those whom the young person in the residential facility invites, including parents, siblings and friends. The Sunday Group visit Dunsmore House to see the changes in the young person. This group can be up to 30 people, including the residents themselves and even ex-residents.

Target Group
The Parent Support Group targets direct family members, that is, parents and siblings. The target group of the Sunday Night Group is more broad and includes: parents, siblings, friends, significant others, young people currently in residential treatment and ex-residents.

Timeframe
The Parent Support Group is held weekly for two hours, and the Sunday Night Group is ongoing.
Rationale for the Program
The experience of workers in the residential detoxification program determined that families needed to be prepared for the return home of the young person after the treatment and this led to the creation of the Family Support Groups.

Theoretical Framework
The Parent Support Group is based on the Tough Love model. Integrated cognitive/behavioural techniques are used in both the treatment program and with the two groups. The focus is on changing behaviour first and attitudes later. Solution focused therapy helps look at reality first.

Prerequisites
The credibility of the agency conducting the program is crucial to its success. Staff skills in communication, knowledge of how to use the techniques and the latest information, combined with experience is essential.

Outline of the Program
The program contains the following components:

- Confidentiality and ground rules of the group established
- Discussion about current issues for families
- Sharing solutions
- Establishing boundaries
- Dealing with consequences.

Evaluation
Parents are asked to write about their experience of the Support Group in the client follow-up and this feedback has been positive.

Expected Outcomes of the Program
The expected outcome of the program is an increased awareness among families about how drugs affect their adolescent and how to support them.

Further Information
Susan Jackson, Unit Manager, Dunsmore House (Western Sydney Area Health Service), 38 Dunsmore St, Rooty Hill NSW 2766, Ph: 02 9881 1756.
6. Dunlea Alcohol and Other Drugs Adolescent and Family Work Project (NSW)

**Brief Description**
Families are invited to look around the residential detoxification centre and at the initial interview the extent of family involvement in the treatment is ascertained. Both the young people and the parents to date have predominantly chosen counselling, but a Parent Support Group has recently been established which is facilitated by a psychologist and an Drug and Alcohol worker. Parents attend for two or three sessions.

**Target Group**
Parents of young people in the treatment program at Dunlea are the target group.

**Timeframe**
The program is held fortnightly for two hours.

**Rationale for the Program**
The main rationale for the program is to offer parents greater understanding of their situation and to share experiences with other parents that have dealt with similar issues.

**Theoretical Framework**
The program is based on cognitive behavioural therapy, solution-focused and narrative therapy.

**Prerequisites**
The staff must be very skilled in dealing with the methods used in the program.

**Outline of the Program**
The involvement of the family varies according to their wishes and to date the family counselling has been most successful. As the Parent Support Group develops it is expected that more parents will attend.

**Evaluation**
An evaluation of the Alcohol and Other Drugs Adolescent and Family Work Project has been undertaken by the Juvenile Justice Department.
Expected Outcomes of the Program
The expected outcomes of the program include the following:

- Better support for the young person when they return home after the detoxification program
- A reconnection between family and the young person
- A reduction in crime rates.

Further Information
Anthony Foster, Alcohol and Other Drugs Adolescent and Family Work Project, Dunlea, PO Box 8, Marylands NSW 2160, Ph: 02 9681 6578.

7. Elura Outpatient Counselling Clinic (SA): Parent Support Program

Brief Description
The Parent Support Program is a structured program for parents whose adolescent children are not in treatment. Parents are referred through Departmental counsellors whom they have contacted about ways to support their drug-using child. It focuses entirely on parents increasing their understanding of drugs and alcohol, their feelings about their situation and on developing parenting skills. Programs conducted in the past have usually resulted in ongoing self-help groups and now the agency is introducing co-facilitation by long-term attending parents to replace staff in assisting these groups.

Target Group
The program targets parents of young people who are drug dependant and not receiving treatment.

Timeframe
The program is held weekly for two to three hours for a six-week period.

Rationale for the Program
The previous program was developed on a needs basis, but the one proposed for 1999 is based more on empirical evidence relating to involvement of relatives, mental health and adult learning, for example, Orford 1994, Brown 1991 and Willis 1993.

Theoretical Framework
No specific family-related theoretical framework is involved in the program for 1999. It is shaped by the principles of Adult Learning and is based on behavioural change techniques and skills development.
**Prerequisites**
The main prerequisites to facilitate a program such as this include:

- Social workers experienced in group work
- Suitable venues for example, local youth and health centres
- Follow-up counselling available for those with need.

**Outline of the Program**
The components of the program are as follows:

<table>
<thead>
<tr>
<th>Session</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Drugs and their use by Adolescents</td>
</tr>
<tr>
<td>2</td>
<td>Communication</td>
</tr>
<tr>
<td>3</td>
<td>Conflict Resolution</td>
</tr>
<tr>
<td>4</td>
<td>Negotiation and Assertiveness</td>
</tr>
<tr>
<td>5</td>
<td>Loss and Grief</td>
</tr>
<tr>
<td>6</td>
<td>Stress Management</td>
</tr>
</tbody>
</table>

**Evaluation**
Participants have been asked to provide feedback on the main benefits of the course and to suggest improvements. Most courses have evolved into an ongoing support group attended by one staff member. The recruitment of parent-facilitators for these support groups will free staff time.

The program for 1999 will have clear aims so that process and outcome evaluation can be undertaken. Pre- and post-group evaluation after six months and 12 months is proposed.

**Expected Outcomes of the Program**
The expected outcomes are:

- Reduced sense of isolation felt by parents of adolescents with problematic drug use
- Increased parental understanding of their feelings and how to deal with them
- Increased understanding of young people
- Development of parenting skills.

**Further Information**
Sandy Dunn, Manager, Elura Outpatient Counselling Clinic, Drug and Alcohol Services Commission, South Australia, Ph: 08 8267 3588.
8. Grove Street Service (TAS) Making a Difference: A Drug Awareness Program for Parents

**Brief Description**
Making a Difference is an educational program for parents which is the result of a coordinated approach between four key agencies in the north-west of Tasmania. This coordinated approach provides the opportunity to meet geographical needs as well as establish a base level of parental knowledge throughout the region over several years. A Presenter’s Manual has been developed to enable similar presentations of the three-hour session to be conducted at other services.

**Target Group**
The program targets parents/grandparents in general—not only those of young people with problematic drug use. Families do not attend as a group as the sessions are pitched at the adult level.

**Timeframe**
The timeframe of the program is a single, three-hour session, held day or evening, according to need. If the group wants to pursue an issue raised at the session for example, sexual health, follow-up meetings can be arranged utilising co-facilitators experienced in the topic.

**Rationale for the Program**
The need to offer information/education sessions for parents in the area of drug and alcohol use was identified as a priority by the National Drug Strategy North West service providers. It was agreed to develop such a program in the north-west as a key area of cooperative activity, as each service had previously received requests for educational sessions. The latter was often a consequence of sensational media attention focused on parents and the debate about harm minimisation.

**Theoretical Framework**
The educational session is based on adult learning techniques.

**Prerequisites**
The main prerequisites to facilitate a session, such as this include:

- Group skills of presenters
- A successful marketing strategy to promote the sessions
- Flexibility, so that changes may be incorporated over a period of time.
**Outline of the Program**

The components of the session include:

- An overview of drug use in society
- Opportunities for parents to identify and reflect on their own beliefs about, and attitudes to, drug use
- Opportunities for parents to consider the importance of effective communication and to learn some new skills and strategies in this area
- The opportunity for parents to meet local service providers in a ‘safe’ context.

**Evaluation**

This program was based on similar previously evaluated programs and as there was nothing new being trialled, process evaluation monitors the quality of the program.

An evaluation sheet is completed by participants at the end of each session and the presenter completes a feedback sheet after each session. These combine to provide a picture of participant satisfaction with the content and presentation and allow presenters to reflect on their performance and make recommendations about alteration to program marketing, course content, presenter’s manual and/or resources. Statistics are also recorded on numbers attending and geographical spread of sessions.

The evaluation will seek to ensure that the program’s strategies are effective, with particular regard to target population coverage, quality of program and participant satisfaction with structure and content.

**Expected Outcomes of the Program**

The expected outcomes include:

- Improved knowledge about the use of drugs and drug related issues in Australia
- An understanding of the importance of the home as a place of learning about drug use for children and their role as teacher/role model
- Greater confidence in communicating about and addressing drug related issues with their children.

**Further Information**

Janice Trezise, Education and Information Coordinator, Drug and Alcohol Service, 11 Grove St, Ulverstone Tasmania 7315, Ph: 03 6425 5511.
9. Hothouse Youth Community Team—Parent Education and Support Group

**Brief Description**
This program is a five-week evening course for parents, who are concerned about the drug use of a young person in their family and want some help. Parents are then encouraged to attend either facilitated monthly follow-up groups for support and to share problem-solving ideas and/or individual family therapy. The aim is to let parents know how influential they are in helping their young person to change and to explore options.

**Target Group**
The target group is parents of young people with problematic drug use under the age of 25 years.

**Timeframe**
The course is conducted one night a week from 6.30 pm to 8.30 pm, over a five-week period.

**Rationale for the Program**
The program was developed in response to the high number of enquiries from parents with three main themes:

- Lack of knowledge about drugs.
- What should I do?
- Need for support.

**Theoretical Framework**
A systems approach of family therapy and developmental model are the main theoretical frameworks underpinning the course.

**Prerequisites**
The main prerequisites to facilitate this course includes:

- Two staff members to co-facilitate the course—one to focus on the content and the other to focus on process and answering questions
- A good working knowledge of the drug and alcohol field
- An understanding of family dynamics
- Members of other teams (psychologists, nurses, social workers) to sit in on sessions.
Outline of the Program
The outline of the program is as follows:

<table>
<thead>
<tr>
<th>Session 1</th>
<th>What is a Drug: types and categories. How they are used and how they influence a person. Reasons young people use drugs. Effects: immediate, dangerous and long-term.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 3</td>
<td>Changing role of parents. Responsibility and consequences.</td>
</tr>
<tr>
<td>Session 4</td>
<td>Communication skills: listening, assertiveness and conflict resolution.</td>
</tr>
<tr>
<td>Session 5</td>
<td>What blocks effective communication? Building relationships. Personal blocks for parents.</td>
</tr>
</tbody>
</table>

10. Queensland Community Drug Awareness Council: Stepping Stones

Brief Description
Support, education and information are provided to families so that they see the stepping stones to recovery. The support group meeting provides a safe environment for parents who often feel isolated, to talk with and learn from each other. This program is conducted by a parent who has been in the same situation.

Target Group
The target group includes anyone involved with the young person using drugs, including parents, siblings, significant others, friends, but not the young person themselves. The young person generally receives support separately in the detoxification program.

Timeframe
The program is held on a weekly basis with sessions generally lasting of 1.5 hours. The Program is ongoing, so that people may come in and out at any stage.

Rationale for Program
Stepping Stones was developed in recognition of the need for somewhere for parents to go, by a parent whose own adolescent had been drug dependant.

Theoretical Framework
The principle underpinning this program is empowerment of people so that attitudes and behaviour in the whole family may change.
Prerequisites
Facilitator’s compassion and passion to support families so that they do not feel alone and uninformed.

Outline of the Program
Planned sessions include boundary setting, enabling behaviours, empowerment and communication skills. These are encompassed in discussion of issues raised by participants.

Evaluation
No evaluation has been carried out to date, but questionnaires requesting feedback will be given to future participants.

Expected Outcomes of the Program
The expected outcomes of stepping stones includes:

- Increased understanding and knowledge for parents
- Reuniting of young person with family
- Provision of supportive re-entry environment for young person;
- Availability of ongoing support for young person:
  - If the family is not suitable linking them into local ‘grey power’ at the retirement centre where they can write up the history of older people.
  - Referral out to counsellors.

Further Information
Sue Coningen, Queensland Community Drug Awareness Council, c/- Mirikai Drug Rehabilitation Centre, Burleigh Heads Queensland 4220, Ph: 07 5535 4302.

11. Rehabilitation and Family Therapy Inc (RAFT)

Brief Description
RAFT provides a counselling service for individuals, couples and families, through qualified and experienced counsellors with expertise in dealing with problems associated with addictions. The aim is to address the addiction and the reasons why the addiction developed. People self-refer or come via referring agencies.

Target Group
Any combination of the individual with the addiction, family members, partners or friends. The choice is made by the client(s).

Timeframe
As long as the family and the therapist want to continue. This means it could be a year or one session. Commitment to attend four sessions is sought and moving at the pace of the client's choice is crucial.
Rationale for the Program
RAFT was established in recognition that other agencies working in the addiction area are not applying the systemic approach which posits addiction within a wide framework in our society.

Theoretical Framework
This program is based on a systemic approach which acknowledges the impact of the family we are born into, the influences of peers, the times we live in, the political scene and other circumstances and systems which operate in our society.

Prerequisites
A number of prerequisites were identified in order to be able to deliver a program, such as this, including:

- Recognition that the family is very important to the recovery of the addicted person.
- Acknowledgment that damage to the family has occurred, that they have been alienated in the treatment of the addict and their level of distress not addressed.
- Understanding of the ‘iceberg’ model—the tip presents, but underpinning it are many other issues relating to boundaries, discipline, neglect and abuse.
- Adequate training in family systems approach for the workers involved.
- Provision of supervision for workers to deal with transference and counter-transference.
- Working as a team with families.
Outline of the Program
The program components include:

- Establishment of a trusting relationship between the family and the therapist, which takes time.
- Outline by therapist of what could be done over a series of sessions and clients provide feedback on this to determine a path.
- Relevant articles and written information are handed out depending on the issues raised in sessions.

Evaluation
RAFT has not been formally evaluated, however statistics on those attending and for how long as well as geographical areas are recorded and supervision provides reflective time for the therapist.

Expected Outcomes of the Program
The main expected outcomes are to bring insight and change into the patterns of families and helping families to ‘grow up’.

Further Information
Maria Podbury, Chief Executive Officer, RAFT, 295A Bell St, Coburg VIC 3058, Ph: 03 9350 5241.

12. Ted Noffs Foundation

Brief Description
The Ted Noffs Foundation was established in 1971 to provide specialised support to young people with problematic drug use. Family involvement is seen as an essential component and is incorporated into the treatment process in both residential and non-residential programs. The Family Program offers support and involvement of families through family and adolescent counsellors. The family is involved in the young person’s recovery, from assessment to discharge and even in after-care. In a three-month residential program, some of the program components include recreational activities, education involving group work, anger management, assertiveness and individual therapy.

Target Group
The Family Support Project targets family members or people the young person is residing with.

Timeframe
There is no specified timeframe to family involvement, as support is offered according to need.
**Rationale for the Program**
A decision from Juvenile Justice to work towards stabilising the family unit when a young person was returning to the home environment influenced this program. At Ted Noffs Foundation it is considered important not to isolate young people from their family and that workers should deal with the whole system, because drug-taking disrupts homeostasis in the home.

**Theoretical Framework**
An eclectic approach is used depending on the needs of the family and the problems being demonstrated, but it is based on structural family work and narrative therapy.

**Prerequisites**
- Workers must be trained in family work. Their backgrounds can range from psychology, social work, psychiatry or counselling.
- Supporting families takes time and this must be addressed in the worker’s role.
- Market the service to young people, particularly at the assessment stage and they usually come around to seeing the benefits.
- Ability to conduct groups.
- Undertake needs assessment in the community.

**Outline of the Program**
- Engage families through activities, such as barbeques, where they can meet other families and the workers.
- Accommodation in a family flat is available on the premises so that people can come from anywhere.
- Families are seen however they wish—parents, individually or together.

**Evaluation Process**
The program is currently being evaluated by Juvenile Justice.

**Expected Outcomes of the Program**
- Family members are far better equipped to deal with the situation at home.
- Homeostasis is restored to the home environment.
- Help and support is offered to the recovering young person.
- Better ongoing communication among family members.
- Relapse prevention because the family is there for them and the family knows how to deal with the situation.
- Reintegration into the home is easier.

**Further Information**
Lee Cohen, Family and Adolescent Counsellor, Family Program, Ted Noffs Foundation, 150 Avoca Street, Randwich NSW 2031.
13. Western Australia Drug Strategy Office—Working in Partnerships with Parents

Brief Description
This cannot be described as a discrete program, rather as an integrated approach utilising cross-government policies, service provision and community involvement of parents, who are seen as peers in reducing the drug problems of their adolescents.

Components of the approach include:

- 24-hour Parent Drug Information Service which accesses other parents
- Support to police for provision of Intervention Packages to parents
- Practice Development projects which enhance mainstream services to families
- School Drug Education Program involving parents
- Provision of training for chaplains, nurses, school psychologists, etc
- Local Drug Action Groups.

Target Group
A broad range of organisations are targeted in this approach, such as:

- Mainstream services relating to families and children—Schools, Drug and Alcohol
- Community groups formed around drug action—Local Drug Action Groups (55 around the State of WA).

Timeframe
Funding is available to implement this model over a three-year period.

Rationale for the Program
Through the formation of the Local Drug Action Groups and individual contacts made by parents looking for help from the Drug Strategy Office, it became clear that parents of young drug users were struggling to have their voices heard at the many agencies they already had contacted.

A Parents’ Reference Group of 8 people with a variety of experiences as parents of young people with problematic substance use was established. To ensure an even wider range of views was canvassed, a consultation with parents of young drug dependant people was set up through an advertisement in papers asking parents of teenagers if they had problems with drugs. As a result, over 100 families were interviewed in their homes by the same researcher, very few of whom had received help from an agency.
The main finding from the consultations are summarised below.

- Research, policy and treatment workers had not understood that regular drug use is beginning at a younger age and that this has a major impact on families.

- Parents had often begun expressing concerns about their child’s drug use at an early stage.

- As drug use is embedded in other issues these concerns were minimised by professionals encountered in the range of agencies consulted resulting in families not seeking drug treatment until a very late stage, by which time the problems were significant and a number of hurdles then had to be overcome.

- Counselors and staff exhibited an inability to advocate for the family if the young person was the client.

- Parents felt agencies had often subtly supported their child leaving home.

- Because of confidentiality issues, parents often found it very difficult to obtain information about their child’s whereabouts.

- Parents felt rejected and were seeking to talk about their situation and get help.

- Even agencies contributed to the degree of shame and blame felt by parents. If they were asked to confront their own drug use, or their attitudes, they often left, because they were not receiving support for where they were.

- Parents expressed a preference for more experienced workers, that is, people who were parents themselves.

**Theoretical Framework**

- The belief that the best place for a child/young adolescent drug user is with their parent(s). Coupled with the information revealed by the consultation with parents, this led to the conviction that the development of policy, professional approach and services had to involve parents of under-18 year olds.

- The family is seen as the focus. Parents need to be included in strategies for decision making in relation to their adolescent. A 13 or 14 year old is not viewed as the best person to make decisions about their life.

**Organisational Prerequisites**

- Willingness to view parents as peers in addressing drug problems

- Willingness to involve parents where they are at and not try to change them or teach them to be ‘better’

**Outline of the Program**

Eleven Community Drug Service Teams work with local communities and agencies in providing facilitated support groups for parents which:

- Encourage them to stay together as a family

- Promote finding common ground with their adolescents
Encourage doing more of what seems to be working and less of what is not working.

Promote finding ways to use problems positively, that is, getting the family to talk about how they feel.

Evaluation
Evaluation is built into all programs at the local level.

Expected Outcomes of the Program
A State-integrated strategy to involve families in dealing with drugs use by adolescents. This means early intervention, support, information and education through community groups, professional and policy makers.

Further Information
Melanie Hands, Principal Policy Officer, WA Drug Abuse Strategy Office, First Floor 6 Thelma St, West Perth WA 6005, Ph: 08 9483 8244.

Overseas Case Studies

1. Odyssey House Auckland Youth Services: Day, Residential and Evening program

Brief Description
Odyssey House New Zealand provides both structured day and residential services for young people based on a therapeutic community approach. This approach incorporates school, family therapy, recreation, group and individual therapy, medical and legal advice in the one setting. Odyssey House also provides an eighteen-week evening program for young people and their families consisting of three phases.

Target Group
While both the day and residential program target adolescents aged between 13 and 17 years who have problematic substance use and other associated problems, each program targets specific young people in this age group.

In the day program young people targeted include those with:

- A history of substance abuse difficulties
- A deterioration in school or vocational options
- Family willing to support treatment
- West Auckland catchment area and
- Adolescent at risk of criminal offending.
The residential program targets young people with:

- No stable home environment
- Difficulty functioning with peers or adults
- Persistent offender or requiring supervision with residence
- Dangerous to self or others
- No educational or vocational placement
- Community-based placement unsuitable or exhausted
- Drug use escalating and being maintained.

The evening program is designed for young people with problematic substance who are still able to function in the community, school or work, in a stable home environment and having minimal criminal offending.

Rationale for the Program
A therapeutic community model as an approach for adolescent drug treatment in the day and residential program enables a young person and their family to change negative behavioural patterns to self-enhancing behaviour through the integration of a range of social, educational, vocational and family and medical services.

Theoretical Framework
The therapeutic community is an holistic approach to rehabilitation, consisting of four views:

- The drug abuse problem
- The client themselves
- The recovery process and
- The importance of right living.

Outline of the Program
The treatment process in both the day and residential programs have a number of service components, including:

- Drug, alcohol and smoke free environment
- Group therapy
- One-to-one counselling
- Family therapy
- Individual treatment plans
- Schooling
- Cultural program
Specifically, family involvement is incorporated into the program in the following ways:

- Family assessment via a family interview
- Individual family therapy at a time identified in the young person's treatment
- Attendance by all families to multiple family groups, which are offered Thursday evenings and the first Saturday of each month.

In the evening program the treatment process involves four main phases, including:

<table>
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<tr>
<th>Phase</th>
<th>Description</th>
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<tr>
<td>Phase 1</td>
<td>Assessment and introduction.</td>
</tr>
<tr>
<td>Phase 2</td>
<td>(Six weeks): Involves weekly attendance to One-to-one counselling and group and fortnightly attendance to family group.</td>
</tr>
<tr>
<td>Phase 3</td>
<td>(12 Weeks): Fortnightly attendance to six group sessions, six multiple family groups and six one-to-one meetings.</td>
</tr>
<tr>
<td>Phase 4</td>
<td>Once monthly attendance to group for those who have completed any Youth Services program.</td>
</tr>
</tbody>
</table>

Source: Taken and adapted from Odyssey House Auckland Youth Services Information Booklets.

A review meeting is organised at the end of each phase.

2. Thunder Road Drug Rehabilitation Program

Brief Description

Located in Oakland, Thunder Road drug rehabilitation program is owned and operated by Adolescent Treatment Centres, Inc., a non-profit subsidiary of Summit Medical Center.

The program adopts both a medical model and social approach (or Therapeutic Community) to addressing problematic substance use amongst adolescents. The model is primarily abstinence based and follows the 12 Steps recovery advocated by Alcohol Anonymous and Narcotics Anonymous. Family involvement is a significant component of the program model and is considered essential to the young person's long-term recovery. Family is defined broadly to include significant adults in the young person's life, including parents, guardians, other relations or close friends. As a part of the rehabilitation process, family members are required to attend meetings...
and group sessions at least twice per week throughout the year of treatment. The
program also has a Continuing Care component requiring the young person and
their family to attend the Centre twice weekly once the young person has returned
home following in-patient treatment.

Target Group
The program targets both male and female young people in middle and high school
with a history of drug and alcohol abuse or dependency. A proportion of the beds in
the program are occupied by clients whose fees are paid by referring governmental
agencies under Federal Aid to Families with Dependent Children—Foster Care
Programme.

Timeframe
Length of stay in the residential program varies from 45 days for the ‘Short-Term
Track’ to three to six months for ‘Fast Track’ and up to twelve months for young
people in the ‘Long-Term Track’.

On successful completion of in-patient treatment, the client is transferred to the
Continuing Care aftercare phase, extending for one full year.

Rationale for the Program
The purpose of an extended period of in-patient treatment is to change behavioural
patterns of both the young person and the their family or significant other and
provide time which the young person and the family can be assisted to form new
patterns of constructive behaviour.

Theoretical Framework
The framework for the program draws from several models including, medical and
social models, 12 Step abstinence model utilised by Alcohol Anonymous and
Narcotics Anonymous and family based models of treatment. Also incorporated is a
nicotine cessation program model.

Throughout the program the principles that are constantly reinforced include:

- Personal pride and self-esteem
- The creation and pursuit of educational and vocational goals
- The creation of a structured living environment
- The implementation of clear and reasonable rules and the imposition of logical
  consequences when they are violated
- Honesty and confrontation when a client acts dishonestly or irrationally and
- Physical health.

Prerequisites
Thunder Road has 70 full-time equivalent positions, 50 of which are engaged in the
 provision of clinical services. Clinical staff are from a range of backgrounds,
including three psychiatrists, a paediatrician, marriage, family and child counsellors,
registered nurses, numerous counsellors with advanced degrees in behavioural sciences and many who are certified drug and alcohol counsellors. Thunder Road’s main facility is a free standing hospital building accommodating 50 clients in residence.

Outline of the Program

On commencing in-patient treatment the young person undergoes an assessment of medical condition, psychiatric, social aptitude and adjustment, educational level and vocational aptitude. Following assessment the young person passes into a regular treatment program, including the following components:

- Individual counselling
- Group therapy
- Family groups
- Chemical dependency education
- Schooling
- Recreation
- Exercise
- Random drug screen testing.

Evaluation and Outcomes

Thunder Road was accredited in 1996 under the 1995 Standards Manual and Interpretive Guidelines for Behavioural Health for a period of three years (the maximum) for Alcohol and Other Drug Programs/ Residential Treatment Programs.

Thunder Road utilises both formal and informal sources of information to measure program effectiveness and outcomes. Specific resources and standards utilised during the year included:

- Quarterly utilisation review and quality assurance committee review meetings
- Exit surveys of clients, family members and staff
- Returning alumni
- Client satisfaction survey to obtain information on clients six months after leaving thunder road (data from the survey will be compiled during the coming year)
- Dr Chris Vourakis of Samuel Merritt College furthered development of long-term Clinical Outcome Study (LTCOS) during the year. The service is in the Second phase of a three-phase project in pursuing the goal to develop a valuable outcome measure.
Resources for Family Inclusive Practice

A Three-Part Resource For Services

Success Works 1999

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Section One: Your Organisation

Family Inclusive Practice is not just a new approach for workers in their work with young people. It involves the whole organisation—its philosophy, organisational structure, financing, staffing, promotion, as well as other policies and procedures.

The following checklist is a self-examination tool for organisations interested in assessing their compatibility with a family inclusive framework. It will help determine:

- Which aspects of your agency/program are already family inclusive
- Which could be more so
- Where barriers exist to working with families
- What needs to be radically changed.

When using this checklist, bear in mind that different facets of your organisation may be at different points on the compliance continuum.
Philosophy and Attitudes

Ask some of these questions to elicit how the philosophy of your organisation expresses the involvement of families in the treatment of young people who are problematic substance users:

- In general, how are parents and other family members viewed in relation to the young person’s problems?
  - As victims of the young person’s problem or as contributors to it?
  - As a resource to help the young person or as a hindrance to them?
  - As a resource to the program staff or as a hindrance?
  - As consultants/partners in treatment?
  - As having their own treatment needs?

- How is this philosophy expressed? What is written about the family’s participation in any program descriptions or advertising?
  - What is told to the young person and family at intake?
  - What is told to referral sources or expressed in any community outreach programs?
  - What is told to new employees?

Overarching Questions and Issues

How is the current philosophy about the family’s role carried out in the program operations? Is it explicit or implicit? Consistent or inconsistent? What needs to be done, if anything, to reflect a more family inclusive philosophy? If the stated philosophy is family inclusive how well does the program carry out this philosophy in its operations?

Adapted from Ooms and Snyder (1996)
Profile of the Family Backgrounds of the Young Person

To provide adequate and appropriate family inclusive services to the young people currently being served by your organisation, it is necessary to review what is known about family characteristics, circumstances and living environments. This may be found in your statistical data bank or you may have to rely on knowledgeable ‘guestimates’ based on clinical experience.

- What is the current family structure breakdown of your client population—percentage separated, divorced, remarried, never married?
- What percentage of young people live with their parents? Other relatives? In foster care or other non-familial care?
- What is the ethnic composition of the families?
- If there are significant numbers of people from different cultural and linguistic backgrounds, what does the staff know about adolescence in these cultures and the attitudes of parents towards treatment for problematic drug and alcohol use?
- What is the socioeconomic background of the families? What barriers do they face in gaining access to and paying for treatment services?
- What are the age and life-stage profiles of parents?
- What social stresses are families likely to be dealing with in the way of unemployment, crime and violence or rural isolation?
- Has there been recent change in the types of families receiving services?
- Are there families with any other specific characteristics—for example, highly mobile families, military families, etc?

**Overarching Questions and Issues**

When you have collected this information ask yourselves if the program you currently deliver, or intend to deliver, reflects both the profiles and needs of families in your area. If not, why not? What additional information is needed? What could the program do better?

Adapted from Ooms and Snyder (1996)
WORKSHEET THREE

**Staffing and Organisational Practice**

Staff and organisational practice in terms of training and supervision are perhaps the key to positive Family Inclusive Practice. A skills audit and a training needs analysis are the first step to ensuring that the organisation has the base required to embrace Family Inclusive Practice.

**Staffing**

- What time is allocated for workers’ involvement with the family?
- What kinds of professional background or experience do the program staff have in working directly with families?
- To what extent does the ethnic background of staff mirror that of the client population?
- Do those staff members who have the most contact with parents also have contact with the young person?
- When staff account for their time, what ‘credits’ can they claim for working with the family? Are there ‘incentives’ or ‘disincentives’ for working with the family? For time spent on home or school visits?
- Is transport available for staff to make home/school/agency visits?
- How is the work done with families evaluated in the organisation? What weight is allocated to work with family members in staff performance appraisals?

**Supervision and Training**

- What kind of supervision is available for those working with families? How is burnout prevented?
- What regular opportunities are made available to staff for in-service training? How are the topics chosen? Have any ever focused on working with families?
- If staff development in working with families has been provided, what was the nature of these sessions? Did you use clinical case material through videotapes or live supervision? Were the sessions helpful or not? What could have been improved?
- How could more in-service training be financed?
- What regular opportunities, if any, are provided for specialist consultation, especially with difficult family situations? Does the program ever employ family therapy consultants to work with the staff?
- How much responsibility (permission) do supervisors have to identify relevant professional development for staff.
If the program serves particular ethnic groups have consultants from their communities ever been used? In what way?

Has the service developed good contacts with other agencies or programs in the community that staff can use to refer families to for help with family problems not directly related to their young person?

**Overarching Questions and Issues**

In what ways are the staff skills and expertise relevant to Family Inclusive Practice? What training and supervision needs to be developed to ensure that the whole organisation is able to understand the new ways of working?

Adapted from Ooms and Snyder (1996)
Confidentiality, Consent and Recording

Family inclusive practice may raise troublesome issues concerning professional confidentiality and consent to treatment. Some of the questions to ask about this issue are:

- What are the laws regarding parent consent for a minor’s treatment (and for related issues that may arise, such as reproductive health care, treatment for sexually transmitted infection, HIV testing, etc.). Are the laws known to all relevant staff?

- What is agency policy about parental consent for a minor’s outpatient or inpatient treatment? What is agency policy about a young person’s right to consent to treatment? What is said about these policies in service literature?

- How are conflicts between parents and young people about consent/ confidentiality handled?

- What are the young people and parents told about protecting their confidentiality and about when and if information about each other will be divulged by the worker?

- What are the policies about the confidentiality of records? What access does the young person have to these records? What about the parent? Who signs for release of information to other agencies or professionals?

- Does the service practice differ on these issues between young clients who are minors and those who are adults?

- If audiotaping, videotaping, or a one-way mirror is used, when and how are families informed and asked for permission to use these procedures? How is their confidentiality protected with respect to their use? What kinds of forms are used?

- What kinds of service and management data are collected?

- Does the format of client records and the filing system allow for the participation of family members to be recorded and followed?

Overarching Questions and Issues

Are the program’s policies on these issues known and understood by staff? How are they carried out in practice? Are they consistent with a family inclusive approach, or do they make it difficult to implement such an approach?

Adapted from Ooms and Snyder (1996)
WORKSHEET FIVE

Client Feedback
As Family Inclusive Practice will be a new and even challenging, approach for some services it will be critical to engage families and young people in its development, implementation and ongoing monitoring. Many services have a range of ways to engage consumers/clients in service development.

- How does the service invite feedback from family members about their involvement in the treatment of their young person?
- How, if at all, does the program tap into the experience, knowledge and expertise of its clients as consumers to monitor and improve operations?
- Does the service ever invite parents/family members who have been clients to join special committees, boards, or other structures set up to provide advice on service design, management and policy?
- Are young people who are ex-clients ever used in these or other ways?
- Are parent/consumers ever asked to participate in public education, media and outreach programs? Are they ever asked to participate in government hearings or other events, such as conferences?

Overarching Questions and Issues
Are clients seen as legitimate contributors to service development? Are they seen as ‘experts’ in their own treatment?

Adapted from Ooms and Snyder (1996)
Family-Friendly Facilities
A family inclusive service will give that message even before clients enter the facilities. The waiting room, reception area and receptionist are the front line interface to a service. This interface can support, enhance or undermine any interventions taken by the workers.

- Is the waiting room convenient, friendly and attractive for family members, especially those with other young children?
- Are there any toys or a separate playroom available for the younger children while the family waits for appointments?
- Are the interview rooms and staff offices large enough to interview several members of a family at once? Do they offer privacy?
- If the cost of transportation to the service is a major barrier in a family’s participation are funds available to assist it with transportation?
- For residential programs, is inexpensive accommodation available in the community for families who live in outlying districts?
- Is there clearly defined space in which family members can be seen?

Overarching Questions and Issues
Which areas of administrative policy and procedures presently provide the strongest support for family inclusive treatment for young people? Which areas most need to be changed? What are the expected rewards and benefits of working more with families? What are the anticipated problems and resistances?

Adapted from Ooms and Snyder (1996)
**Worksheet Seven**

**Change Analysis**

After working through the questions, it might be useful to prepare a ‘change analysis’ to assist with future planning.

**Diagram 1**

![Diagram 1: Beliefs and practices that increase family inclusiveness](image)

This helps in identifying the beliefs and activities above the line that you can build on and those below the line that will need addressing.

**Diagram 2: Beliefs and Practices that Increase Family Inclusiveness**

- **Strong belief that family members are the best resource to adolescents.**
  - See whole family at intake.
  - Have a list of family inclusive principles on office walls.
  - Planning process that makes sure family resources are known before agency resources are allocated.

- **Believe family problematic behaviour gets in the way of recovery.**
  - Confident in working with adolescents but not families.
  - No time to chase up family members.
  - Adolescents reluctant to allow worker to contact family members.

Adapted from Ooms and Snyder (1996)
**Change Analysis** *

This exercise invites you to carry out an analysis of a particular problem which is facing you at present.

**Step 1: What is the current situation with the involvement of families. Choose a problem and write it down.**

- It must be a real one which concerns you right now.

**Step 2: Define the problem in specific terms.**

- Who is involved?
- What is the magnitude of the problem?
- What other factors bear on the situation?

**Step 3: How would you like to change the situation?**

- Try to make this as measurable as possible, so that you can set a clear target and know when you are reaching it. Sometimes this may not be possible, but try.

**Step 4: What currently exists that supports the goal?**

- What are the barriers?

**Step 5: When all forces are listed, rank them as being of high, medium or low power. Do this for both supports and barriers.**

WORKSHEET SEVEN (CONTINUED)

Step 6: Draw a diagram showing the driving and restraining forces. The length of the arrows should indicate the magnitude of the force.

(In the example, the manager’s desire to engage children is a HIGH power driving force, while the attitude of older employees is a MEDIUM power restraining force).

```
HIGH  Manager's desire
to engage families

SUPPORTS  MEDIUM

PRESENT SITUATION (EQUILIBRIUM)
LOW

BARRIERS  MEDIUM  Attitude of some employees

HIGH
```

Step 7: Prepare a strategy for changing the situation.

Your strategy should include the stages to occur in sequence, with rough timings and the resources you will need at each stage, particularly people who can help.
Driving and Restraining Forces

SUPPORTS     MEDIUM

PRESENT SITUATION (EQUILIBRIUM)  LOW

BARRIERS     MEDIUM

HIGH
Section Two: You, The Worker

This section considers some ways that workers can prepare themselves for operating in a family inclusive framework. As a worker adopting this approach you will need to clarify some issues for yourself. The following questions and strategies are designed to assist you in this process.

How will my personal beliefs and values fit with working with families?

It is important to understand clearly your values about the family. No clinical, outreach, educational or counselling situation is free of values and it is helpful if you have thought about your own position/stance beforehand. This awareness is imperative to lessen the chance of working from your own particular bias and imposing your values on others. You will most certainly be working with families whose views are counter to your own and you must be willing to acknowledge that others’ values, beliefs and life experience may be different from yours.
Families Are…
This worksheet is designed to help you to think about your own values about families and young people. It is a series of sentence starters for you to finish.

1. For me a family includes—

2. I think that families are—

3. If I was a young person seeking treatment for problematic substance use I would want my family to—

4. In my family there were always—

5. When the crunch came my family could—

6. I think that my experience with my family—

7. The way my family experience influences my work includes—

8. When I am in difficulties, I hope my family would—

Please reflect on your responses.
**Worksheet Nine**

**Family Inclusive Practice Values**

Consider the following statements and mark on the continuum where you personally position yourself.

1. **The family is the most important resource that a young person can have**

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

2. **Young people carry their family with them regardless of the level of current contact**

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

3. **Family members can grow and adapt if given support**

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

4. **Family members have needs and rights which need to be protected**

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

5. **All interventions should be aimed at building and strengthening family relationships**

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>
6. Young people have a right to Family Inclusive Practice

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

7. By resourcing the family the young person has an ongoing place of support

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

8. While families are part of the problem they are also an essential part of the solution

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

9. The family is a victim of the young person's problem

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

10. The young person is a victim of the family's problem

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

11. Having family members involved in the treatment process is a hindrance and interference

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

12. Family members need their own support and treatment

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>
13. Working with family members will create a conflict of interest for the organisation.

Strongly agree  Agree  Not sure  Disagree  Strongly disagree

Please reflect on your responses.
Personal Support System

This worksheet is designed to have you consider the current supports that you receive in relation to your work with young people and the ways in which you engage their families in the treatment process.

1. List the current members of your professional support group. These may include other staff, management, friends, other service providers:

2. Now tick those who support you in Family Inclusive Practice.

3. What training have you had that would support you in working with families?

4. What do you see as the gaps in your knowledge, experience and skills as they relate to working with families?

5. What training would support you in your work with young people and their families?

6. What gets in the way of you adopting Family Inclusive Practice?
   - Personally:
   - Organisationally:

7. What supervision do you currently receive and how does this support your practice?
Network Map

INSTRUCTIONS FOR COMPLETION

What supports do I need?
Working within a team at your workplace is one valuable support for you. It is important to have people around who can support you, challenge you, offer ideas and motivate you. You might also find it helpful to establish a small group from outside to provide you with more of this support.

Access to relevant resources and references for yourself and for families you are working with is also an important support.

1. Label each segment of the map with the type of services you are going to place in that segment.

2. Brainstorm the services to which you relate and write these in each segment, for example, for information exchange, receipt of referrals, giving of referrals, joint projects/initiatives, etc.

   If the relationship you have with the service is a close one, place it closer into your organisation in the centre. If it is a looser or infrequent and a not strong connection place it further out in the segment.

3. When you have finished step two please write next to each entry on the network map a letter to match the following:

   L = local service
   R = regional service
   S = statewide service
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service Type</th>
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<td></td>
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<tr>
<td>Service Type</td>
<td></td>
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<tr>
<td>Name of Service</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Service Type</td>
<td>Service Type</td>
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</table>
Section Three: Phases of Intervention
This section identifies some family inclusive elements under the following phases of an intervention:

- Intake
- Assessment
- Goal setting
- Treatment
- Closure
- Evaluation

The description of each phase offers some examples of ways to talk to family members, ways to engage or involve families, case studies.
Intake
Intake is a critical time to establish a family inclusive context. Clear messages that the service values families should be given from the outset.

Service Description
Written service descriptions should contain clear family valuing statements that invite family input, such as:

While recognising the young person’s right to use our service, we value the caring and supportive role of other family members.

Explanatory notes should include details about family members. They should make clear what the service will both expect from and offer to the family. If a young person is under age, explanatory notes should clearly clarify where parental consent is required.

Information from other family members will assist in deciding what we can offer. The young person will be asked to nominate who should be approached. Rules about confidentiality will be explained.

Ways of Talking
At times the young person will present by themselves, but it is important to remember that a young person’s perspective is only one dimension of the situation. The service should assume that they have family and significant other relationships in their life. ‘Family’ should be introduced in intake conversations.

Who in your family knew you were coming here?

What does your family know about you choosing to come here?

Which member(s) of your family would say it was a good idea?

Which member(s) of your family would want to support you here?

Adapted from Ooms and Snyder (1996)


ASSessment

The purpose of assessment is for the client and the service to develop an insight into the concerns and an understanding of the desired outcomes. If the family is viewed as ‘the problem’ then they can also be seen as assisting with the solution. If this approach is not adopted then the family will only ever be ‘the problem’.

It is critical at this phase that all stakeholders are developing a sense of hope that things can be different. Family members can provide significant insight into the concerns and just being heard will often allow them to offer help constructively. Each family member will carry their own truth about the situation, as will each worker. Having input from several sources deepens the understanding of the concerns and the solutions. Seeking information about who is doing what when things are working well, the exceptions to the dangerous behaviour, raises self-esteem and provides an insight into solutions.

Ways of Talking

To a family member:

- When do you feel most hopeful that things will be different?

To the young person:

- Which member of your family will want to believe that you can make good choices about drugs and their use?

It is usually not difficult to get a family to come in when it is concerned about a young person, but if the young person has already been involved with professionals without family involvement, it may be more difficult. Initial efforts to involve the family are part of the process of joining.

Joining is about listening to the family’s story, encouraging family members to describe their efforts to solve problems in the past and confirming their caring and competence.

Failure to solve the problem is not blamed on them, but on the difficulty of the problem.

Support their efforts as well intended.

In assessment each individual needs to be asked such things as:

- Is there a time or incident when you believe ‘things changed’?

Workers have to be comfortable with their skills and authority because during assessments difficult questions need to be and have to be, asked. Workers need to be able to explore the dynamics of the family.
Is the eldest daughter a favourite, while the middle child has been seen as difficult since conception?

Workers must have eyes and ears.

Does the least favoured son look exactly like the ex-partner who was abusive?

Does this son mirror his father in his mother’s eyes?

How did partners discipline, how do they now?

Assessment is the time to seek out the inconsistencies and strengths within the family. It is also the sessions that will decide initial goals.
Genogram

A genogram uses graphic representations to identify the family relationships in a young person’s life and as defined by the young person. It is usual to include immediate family and extended family members such as grandparents.

The following symbols are used to identify various people and relationships:

- Female symbol
- Male symbol
- Unknown
- Death of a male
- Death of a female
- De facto relationship
- Separation (add year if desired)
- Divorce (add year if desired)
- Married
- Young person lives with those enclosed in the circle

Example 1

[Diagram of a genogram showing family relationships with specific years and symbols indicated]
WORKSHEET FIFTEEN

Ways of Engaging the Family—A Family Map

Worksheet 15 can be used to engage families as a group.

- Explain to the family that you would like them, as a group, to map the breadth of influences and supports in their world.
- Ask them to write the names of people, organisations, places and services in the ovals of the worksheet.
- When they have finished this task, discuss what they learnt from doing this map.
- Explain that their young person is nested within and interacting with many external systems and that each system interacts with all the others with differing degrees of impact.

A Family Map—For Workers

Use this map to help yourself explain to the family the types of supports they could write in each oval.

Adapted from Snyder (1996)
A Family Map
Use this diagram to map the influences and supports which exist in your world. Write the names of people, places, services, organisations, etc in all the ovals.
WORKSHEET SIXTEEN

Problem Maintenance
What does each member of the family see as the main problem that they as a family member need to deal with? List these:

No matter what the problem, everyone in the family plays a part. What part do each of you play in...? 

1. 

2. 

3. 

4. 

5.
**Desired Solutions**

Ask the members of the family to each identify their desired solution to the current situation/problem. When you overcome the problem, what will be different about you/your family?

**Difference 1:** __________________________________________________________

How will this be accomplished? _____________________________________________

Target date: __________________________________________________________________

**Difference 2:** ____________________________________________________________

How will this be accomplished? _____________________________________________

Target date: __________________________________________________________________

**Difference 3:** ____________________________________________________________

How will this be accomplished? _____________________________________________

Target date: __________________________________________________________________

**Difference 4:** ____________________________________________________________

How will this be accomplished? _____________________________________________

Target date: __________________________________________________________________

**Agreed and Signed**

Name ________________________________________________________________

Date _________________________________________________________________

Name ________________________________________________________________

Date _________________________________________________________________

Name ________________________________________________________________

Date _________________________________________________________________

Name ________________________________________________________________

Date _________________________________________________________________
**Goal Setting**

Engaging family members in treatment requires that they have a clear understanding of their goals. They may or may not have been involved in the young person’s goal setting but without an insight into the desired outcomes their contributions will be less targeted. The process of involving family in goal setting or in assisting the young person to explain their goals to their family, should model a communication process that facilitates healthy interdependence.

Through a goal setting process that is shared, each person can determine useful strategies to apply, which will facilitate reaching the desired outcomes. A shared process leads to a coordinated response. In a least marginalising model, the young person would determine what they wanted to try, the family members would determine how they could support that effort and then the service would decide what they could offer to assist and complement the process.

**Ways of Working**

A plan developed through shared goal setting could include:

<table>
<thead>
<tr>
<th>Desired Outcome</th>
<th>Goals</th>
<th>Client’s Tasks</th>
<th>Family Tasks</th>
<th>Service Tasks</th>
<th>Indicators of Achievement</th>
</tr>
</thead>
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Where family members or significant others are not present physically, it might be appropriate to include a goal about making contact with them.

(This plan could be adapted from the current treatment plan.)
**Name ____________________________**

<table>
<thead>
<tr>
<th>Desired Outcome</th>
<th>Indicators of Achievement</th>
<th>Service Tasks</th>
<th>Family Tasks</th>
<th>Client Tasks</th>
<th>Goals</th>
</tr>
</thead>
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**Worksheet Eighteen (continued)**
Treatment

Treatment of the young person in isolation does not take into consideration the impact of other factors in their environment that will influence both recovery and relapse. The family is a critical factor. Family Inclusive Practice recognises this and invites family members to play a constructive role in treatment. The level of resources in a service will influence what that service can provide. Networks with other services can provide coordinated family services.

Case Study

A young mother from a rural region was admitted to a metropolitan residential treatment service. Her mother cared for her child. A service from the same town supported the grandmother to develop an adult to adult relationship with her daughter so that she could feel safe about returning the child on the mother's discharge.

Sharing the pain and the joys during treatment can be a bonding process. A service can assist in the development of trust by providing a framework that helps interpret what is happening in treatment. Staff working in partnership with parents can also strengthen parenting capacity.
Family Action Plan
Complete the following:

1. We want to achieve the following goals:

2. The things that might stop us from reaching our goals
   - We lack the necessary skills
   - We fear failure
   - We don’t feel supported
   - We lack motivation
   - The goal is too difficult
   - Other

3. The following actions and people might help us to overcome these obstacles:

<table>
<thead>
<tr>
<th>Actions</th>
<th>People</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
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</tbody>
</table>

4. Some of the negative things that might happen if we achieve these goals:

5. Some of the good things that would result:
   — for us
   — or others

6. The first steps we will take towards achieving this goal:
Closure
Closure should be built in from the beginning. Services intervene for specific reasons at specific stages in the young person’s life cycle. Evidence suggests that young people continue to be a part of their family forever. It is more difficult to facilitate a healthy family response if this is not initiated until the young person is due to leave the service. Families will have experienced degrees of trauma during the young person’s substance misuse and for many, at other times in their life. They need to feel resourced to try again. Information about other support services and a chance to take stock of their own resourcefulness should be offered.

Ways of Talking
This is the time where it is reinforced to the family that it is ‘them’ that have adjusted, made change, helped each other achieve an outcome; that while the future may not always be smooth they are not on their own—other families and individuals also experience difficult periods and issues—services that will not judge them are available.

It is also a time of congratulations and further motivation, but also a time to make them aware it may not be all over yet.
Evaluation
Service users provide the most useful feedback on the services offered. Often family members are in the best position to offer comment on changes that have occurred during an intervention. Asking families’ advice is an indication of how the service values their role. That valuing can help build self-esteem and confidence and young people will often interpret that worth and respect as a valuing of their origins.

Ways of Working
At some stage during a family involvement visit, a manager should take the opportunity to introduce themselves to the family and ask evaluation questions, such as:

I’m interested to know if you feel this services is meeting your requirements?
Do you feel the workers are being honest with you?
Is there anything else we can do for you?

Perhaps the most relevant evaluation question is:
Would you be happy to be involved with this service again?

We all perform difficult work and, in some evaluations, families may never like us, but they should always respect us for the way in which we have involved them.