



**Family Focus Project
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Family Inclusive Practice Literature Review

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1. Introduction

It is now widely recognised that drug abuse¹ harms not only the user but also family and loved ones (Barnard, 2007; Kroll & Taylor, 2003; Orford, et al. 2005; Tunnard, 2002; Velleman, et al., 1993). Up until relatively recently however, the Alcohol and Drug (AOD) sector has treated the individual drug-user with little positive regard for their broader familial milieu. Historically, for example, the drug user's family (as well as the individual user) has been viewed as 'pathological'. The traditional family theories espousing this perspective blamed the family for the cause, development and continuation of the drug problem and again, later theories focused on the family member's psychopathology as a contributing factor (2000, FSP Vision paper). It was not until the mid 1970s that research was conducted highlighting the positive role that family can play in treatment of AOD issues (e.g., Orford et al, 1975; Orford & Edwards, 1977).

Even so, despite this early research, the AOD sector still focused primarily on the individual substance user (Jacobson, 2006). As a result families did not feature significantly in AOD treatment services. A further consequence of this focus on the individual was that service funding resources and contracts emphasised outcomes aimed at reducing individual drug use, rather than engaging or supporting the family members (Hamilton, Barber & Banwell, 1994). Further, this history also meant that little scientific knowledge existed regarding the impact that problematic drug use had on the family unit meaning Family Inclusive Practice (FIP) was without an empirical basis (Velleman, Templeton & Copello, 1993).

In contrast, more recently the inclusion of family in the treatment of addiction is considered important for a number of reasons. Gruber and Taylor (2006) and others (e.g., Copello & Orford, 2002) argue for example, that substance use is essentially a familial and social problem rather than an individual one. Within this framework drug use is considered in this broader context, including "significant others", because a) "*occurs* in families (and friends), b) it *harms* significant others, c) families and friends both participate in and can *perpetuate active* addiction, and d) the individuals are a potential *treatment and recovery resource*" (p.3).

¹ 'Drug' here is used to describe any substance that is misused and is a focus for treatment. It will be used as such from here on in unless otherwise specified.

This is a significant change in thinking which has a number of consequences for research and service delivery. For instance, as a consequence of this recognition agencies and their funding bodies in Australia and abroad, are increasingly promoting the addition and development of *'family-inclusive'* services and practices. This can be seen in the emergence of formal policy and initiatives directly concerned with increasing the inclusion of families in the treatment of substance users (e.g., Walsh, 2007, Department of Human Services, 2008). Defining family-inclusive practices (FIP) as well as reviewing the research supporting its investment forms the two aims of this review.

It is first important to define FIP because more broadly they serve as models of care and as such, they map expectations for service delivery and development. This has implications for the individual worker and organisational directives and planning. It is therefore important that a clear definition, or model of care, is provided so that these practices can be successfully instituted as service plans. To this end, the aim of this review is to provide a definition of family inclusive practice. Existing views and reflections on our experience as an AOD agency working from a family-inclusive approach - as we have interpreted it- will be highlighted. This will then be followed by a review of research supporting family-approaches within AOD with the aim of developing best-practice recommendations.

2. Definition of Family-Inclusive Practices

There are a number of ways that a definition can be handled depending on the purpose that it serves. Ideally in the social services there is a dynamic interchange between theoretical models and more specific clinical practices and activities. This should be the case because theoretical, research-based knowledge, should inform what we do in practice. As such, the theoretical and the clinical can overlap (as is the case in terms of clinical conceptualisation, for example). Following this line of thought one may break the definition of FIP into two components: theoretical, on the one hand, and clinical (activity) based on the other, with the latter representing more closely what FIP ‘looks like’ in action. These will be addressed in turn to help form a definition of FIP.

2.1 Theoretical Understandings of FIP

Three theoretical perspectives have come to dominate family-based conceptualisations of substance use. These perspectives provide the foundation for the treatment strategies most often used with substance users (for a review, see Fals-Stewart et al., 2003).

Firstly, and the best known of these is the ‘family disease’ approach, which views alcoholism and other drug abuse as an illness of the family, suffered not only by the substance user but also by family members (who are viewed as suffering from co-dependence). Treatment involves the substance-abusing patient and his or her family members addressing their respective disease processes individually; formal family treatment is largely de-emphasised in this model.

The ‘family systems’ approach, on the other hand, applies general systems theory to families, with particular attention paid to ways in which families maintain a dynamic balance between substance use and family functioning; interactional behaviour is viewed as being organized around alcohol or other drug use. As such, family therapy is used to understand the functional role of substance use in the family system, with the goal of modifying family dynamics and interactions to support the substance abusing patient’s recovery goals.

Thirdly and finally, ‘Behavioural’ approaches assume that family members’ interactions serve to reinforce alcohol and other drug-using behaviour. The goal of family therapy from this

perspective is to “eliminate reinforcement for substance use and to promote reinforcement of behaviour conducive to abstinence” (Fals-Stewart, Lam and Kelley, 2009, pp-116-117).

Given the various ways that family are conceptualised into a person’s drug use there are a number of specific interventions that can be used to support changes in drug use. Among these are family and couples therapy, Cognitive-Behavioural Therapies, Motivational Interviewing and educational interventions. Across these therapeutic approaches, change often depends on influencing the way that members interact, support, (this may involve more or less involvement) and feel about one another. Therefore, family-sensitive or inclusive practice means engaging with family members using a number of psychological and behavioural techniques to reform patterns of social interaction that contribute to, and maintain substance use and associated social and psychological problems.

At its core family inclusive practice is about providing support to those experiencing substance use issues. This includes not only the substance user but also others who are involved with the substance user. These might include families, parents, siblings, extended relatives, carers and friends of the substance user(s). The goal and basis of family inclusive practice is to intervene at these multiple levels in the hope of enacting lasting changes.

2.2. Service-Based Understanding

In their submission to the Victorian Government entitled, *A new blueprint for alcohol and other drug treatment services 2009-2013*, the Department of Human Services (2008) detailed their rationale and plan more establishing family-inclusive practices in AOD agencies. Figure 1 details the key points relevant to a definition of family-inclusive practices within AOD services. These statements can be summarised as advocating that services become aware of the drug user’s broader familial and social context and in turn, become skilled at working with these networks by offering ‘family-focused’ (used broadly) interventions directly or alternatively, by having internal or external referral procedures in the allocation of this kind of care.

Figure 1

Key elements to family-inclusive practice in AOD (Department of Human Services)

- All alcohol and other drug treatment services recognise the potential vulnerability of children (including unborn children) with parents who are misusing substances, and respond to their needs.
- Treatment services ensure that their staff always consider and address the potential impact of parental substance misuse on their clients' parenting capacity and the consequent impact on children's' development and wellbeing.
- Better collaboration, stronger links and practice guidelines operate between alcohol and other drug treatment services, family services and other relevant agencies ensuring earlier intervention for vulnerable and at-risk families, children and adolescents.
- Clinicians and other workers in the alcohol and other drug treatment system have the skills and capability to respond to families, supporting and engaging them in addressing substance use issues as part of a core treatment response.
- Treatment services are responsive to the needs of families and work with them to identify the assistance and support they need for strong family functioning and positive engagement in treatment.
- Treatment services operate family-inclusive practices, engaging families in the treatment of young people where appropriate and desired by the young person, and referring families and young people to specialist family therapeutic intervention services when appropriate.
- Treatment services offer information, advice and appropriate referral to family members seeking information about the treatment pathway and services available to their family member and themselves.

Beyond these recommendations for practices of primarily identification, intervention and referral there is little information regarding what this may look like. *How*, for example, do we include family members or, more broadly significant others, in practice and which theoretical frameworks and evidence exist to support this approach? Probably the most comprehensive treatment of the '*How*' of this question is being developed around commission papers in New Zealand (e.g., Mental Health Commission, 2009) and their Mental Health Services (e.g., Lum, 2009). A prime example are service papers developed by Lum (2009) and KINA Families and Addictions Trust (2008) which provide addiction treatment services to families and have developed treatment guidelines for FIP (see also <http://www.kinatrust.org.nz/index.asp>). In *Family Inclusive Practice in the Addiction Field: A Guide for Practitioners Working With Couples, Families and Whanau* KINA (and Lum, 2009) outlined in detail are their family-

inclusive models as well as the specific clinical skills and targets likely to be important in therapy.

The specific of the clinical skills and activities detailed in the models of care developed by these organisations will not be provided in this document. This is in part because they are largely drawn from the theoretical understandings of FIP (above) and their associated treatment approaches. It is, therefore, more informative to address the basis of these practices in scientific research. Inquiry along these lines goes toward answering the latter part of the question above: (*How*, for example, do we include family members or, more broadly significant others, in practice and which theoretical frameworks and evidence exist to support this approach?) At the same time in exploring this question, we also get very close to answering questions of evidence-based family-inclusive practice.

Specifically, it is the study and validation of these theoretical frameworks which supports their utilization within AOD service agencies. This statement can be framed in terms of a second question: Which of these theoretical frameworks and their subsequent interventions have been shown to be efficacious within AOD? These questions will be addressed in turn.

3. The Research Evidence Supporting the Effectiveness of FI Interventions

Copello, Velleman and Templeton (2005) reviewed the evidence of family-focused interventions and broadly categorised them into three types: (1) working with family members with the primary aim of motivating their using relative to seek treatment; (2) working with the family and the user to facilitate the user's treatment; and (3) working with the family as clients in their own right. A number of interventions can be used to achieve these varied therapeutic goals. While utilizing these broad categories, the interventions with the strongest research base will be discussed in turn.

3.1 Engaging the Family to Enhance Client Engagement/Treatment Entry

The first approach, including family members in treatment as a means to motivate a drug-using relative to seek treatment, is relatively straightforward. The primary task of the clinician is usually to shape the behaviour of already motivated family members to facilitate the user's engagement with treatment services. Often the idea is to engage with the family in a way that reduces stress within the family, and between members and the drug user, thereby increasing their coping resources. This is in turn, likely to affect whether the drug user enters treatment (Jacobson, 2006). More specifically, these interventions seek to modify and influence the social and behavioural patterns of individuals to initiate behaviour change; as is the case in traditional, individually-based, contingency management efforts. The difference here is that concerned significant others engage in these modified behaviours in order to influence the identified drug-user. Therefore, one might say that these approaches are grounded in an operant understanding of behaviour change that is socially mediated.

There are a number of programs which have been developed that can act on this basis to enhance client engagement with services (for a more comprehensive review see Copello, Velleman & Templeton, 2005; Stanton, 2004). In order to provide an overview of what these interventions involve in practice, two similar approaches – Pressures to Change and Community Reinforcement and Family Training – will be described below. Then, the evidence supporting these interventions and others of this kind, more broadly, will also be reviewed.

The first example of this approach comes from a program designed by Barber and Crisp (1995) who developed 'Pressures to Change'. In this program a family member of a substance user is

provided with some psycho-education and discussed are their usual responses to drinking situations which, it is argued, can serve to reinforce and/or exacerbate drug using behaviours. The family member is also helped to set up activities incompatible to the substance user's usual patterns in order to interrupt ingrained socially reinforced drug using patterns. Finally, the concerned family member is counselled in confronting the person with the drug problem and they request that they seek help.

A second intervention that engages with family members as a means to foster engagement is Community Reinforcement and Family Training (Meyers & Miller, 2001; Meyers, Miller, Hill & Tonigan, 1999; Smith & Meyers, 2004, CRAFT). CRAFT is a more intensive intervention that incorporates principals in Community Reinforcement Approach (Azrin, 1976; Azrin, Sisson, Meyers & Godley, 1982; Hunt & Azrin, 1972, CRA). CRA has traditionally mobilised concerned significant others as people who can promote abstinent behaviours. Individuals close to the drug user may, for example, monitor relapse and medication and help with resocialisation efforts. A number of the individual components that make up CRA have been found to be highly efficacious in the treatment of serious alcohol misusers (e.g., Miller, Wilbourne & Mesa Grande, 2002).

Some of the specific components in CRAFT are similar to those mentioned in 'Pressures to Change'. This is not surprising given that there is a shared emphasis on motivating treatment entry, through the concerned significant other (CSO), via operant processes (e.g., managing reinforcers, triggers). Beyond raising the CSOs knowledge and empathy, CSOs in CRAFT manipulate environmental contingencies and, perhaps unique to this program, they are provided with social and communication skills to enhance social interactions with their drug using relative (Meyers et al. 1999).

Both of these interventions have been found to be more efficacious than alternative treatments in randomised controlled trials. Targeted individuals at a pre-contemplation stage of change, as defined by Prochaska & Di Clemente (1986), Barber and Crisp (1995, N=8) and Barber and Gilbertson (1996) tested efficacy of 'Pressures to Change' against a group intervention and Al-anon, and wait-list control, respectively. CRAFT, on the other hand, has been compared to Al-

Anon and an intervention where CSOs are prepared for a confrontational family meeting in a randomised controlled study of 130 individuals who were concerned about an unmotivated, drug-using family member (Miller, Meyers & Tonigan 1999).

In all of these studies, significantly more people in the behavioural family-inclusive intervention entered into treatment, when compared to wait-list control or any of the other active intervention strategies. For example, in the study by Miller et al. (1999), following the CRAFT approach 64% of identified drug users entered treatment compared to 13% for Al-Anon and 30% for the intervention preparing CSOs for a confrontational meeting (see also Meyers et al. 1999, for similar findings).

The overall comparative efficacy of these interventions (i.e., compared to alternative treatments) is indicated in a recent meta-analytic study by Stanton (2004). Stanton (2004) was interested in the efficacy of these approaches when they are considered together compared to wait-list control and other interventions. In this vein, Stanton reviewed studies reporting the efficacy of 11 family-orientated programs designed to increase client engagement. He reported that levels of engagement were at upward of 65% for these programs when compared to 6% for wait-list control groups (i.e., groups where user's family members are not receiving this information/support).

Also evident are a number of additional advantages stemming from these engagement-focussed interventions. These advantages extend beyond the interventions intended purpose. First, these programs foster a rather quick response rate, usually by the 4th to 6th session (out of 12). Secondly, they appear to be more acceptable to clients; for instance, the majority (70%) of CSOs did not follow through with the confrontation in the Johnson Intervention. There is also a considerable amount of research illustrating that with people who enter treatment as a result of these techniques, retention is low and relapse rates are high (see O'Farrell & Fals-Stewart, 2003, for a review of controlled research trials).

What is inconsistent is whether these family interventions create additional benefits to the concerned family member. Some studies indicate a reduction in psychological symptomology

(e.g., Barber & Gilbertson, 1996; Meyers et al. 1999), while others do not (e.g., Barber & Crisp, 1995), even when there is an explicit attempt to engage with CSO in this regard (e.g., Miller et al. 1999). Moreover, when a reduction in physical and/or psychological symptomology is reported these do not differ from these alternative interventions. Stanton (2004) in his review on the other hand, states that “it need[s] to be recognised that additional counselling [provided to CSOs]...appears, in and of itself, to be of clear value to CSOs who participate in it” (p. 178).

The research reviewed in this section clearly indicates that family-inclusive interventions that seek to facilitate a user’s engagement with treatment services specifically (e.g., via modifying the social behaviours and environments of concerned others) are highly effective in their own right. In some cases it may even be of benefit to CSOs, when additional counselling is provided. Moreover, in terms of best practice, they are significantly more effective than alternative interventions that do not seek to change the social or familial experience of user and CSO; whether these changes occur through the facilitation of empathy and understanding or more behaviourally-based contingency management (environmentally supportive) strategies.

As Copello et al. (2004) point out these findings “challenge the powerful myth widely held within the substance misuse problems and therapy field: that family members concerned about a relative’s substance misuse cannot influence them to change” (p.373). They further point out that while “it is true that family members cannot make an individual stop drinking or using drugs...they can *change their own behaviour* in ways that will help the misuser recognize that the substance use is problematic and that change is desirable” (p. 373, Italics Added).

3.2 Working with the Family for Better Treatment Outcomes

The research considered above illustrated that including individuals who are significant to and otherwise, can influence the substance-user towards *engagement* with treatment services. This section on the other hand focuses on the positive effects that this type of engagement can have on actual treatment outcomes. That is, the effect that inclusion of significant others has on a users’ drug taking behaviour, levels of consumption and associated problems.

The rationale for linking family members with substance-user outcomes comes from well established findings that the quality of his or her marital and family relationships are unsatisfying and unstable in many cases (e.g., heading to divorce and a lack of emotional and physical intimacy) (e.g. Fals-Stewart, Birchler, & O'Farrell, 1999). Relationship difficulties (e.g., in communication, arguing, financial stress, poor emotion regulation), in turn, impact on and maintain continued substance use and/or precipitate relapse (e.g., (Cummings, Gordon, & Marlatt, 1980; Maisto, McKay, & O'Farrell, 1995). Not surprising then are findings that positive marital and family adjustment are related to positive treatment outcomes (Orford & Edwards, 1977; Orford et al. 1987, Moos & Moos, 1984; Moos, Finney, & Gamble, 1982).

It follows then that many interventions along these lines do not aim solely to reduce substance use. Rather, they focus on improving relationships, decreasing behaviours that facilitate substance misuse, and they focus on increasing marital or family stability and happiness. “In essence, these strategies aim to alter the conditions within the client’s environment in order to support change” [Copello, Orford, Hodgson, Tober, & Barrett, 2002, p. 345].

It is important to note that although user outcomes can be influenced when only the CSO is included in treatment (see Unilateral Family Therapy [Thomas, 1989] for such an example, Stanton, 2004, for review) the emphasis here is on interventions where both the identified drug user and a concerned other engage in treatment together. This decision is made because: 1) interventions where only the CSO enter treatment are similar to those already described – so there is an inherent redundancy in their inclusion – and, 2) by definition, most family interventions do not work by acting with the family member alone. An intervention that has been shown to be highly effective and in which both the user and concerned other are in treatment together is *Behavioural Couples Therapy*.

3.2.1 Behavioural Couples Therapy

There are two broad goals in Behavioural Couples Therapy (BCT): 1) reduced drug use and maintenance and 2) improved relationship functioning (i.e., happiness, communication). As such, BCT can be delineated as having two main components that focus on these complimentary goals. As outlined by Fals-Stewart, Lam and Kelley (2009), regarding efforts to promote

abstinence, the drug using client: 1) signs a recovery contract and they record on a calendar when they have attended self-help meetings; 2) they provide urine screen tests, and; 3) they engage in a 'trust discussion' with their partner, in which they express their intention to stay abstinent that day, while the partner responds in a supportive manner. In their effort to support abstinence the partner in addition 4) learns to minimise behaviours that may trigger or enable their partners substance use, and 5) the couple is supported in reducing the client's exposure to drugs or alcohol within the home and/or during social gatherings.

Relationship focused interventions, on the other hand, aim to: 1) increase partners' positive feelings toward one another, 2) establish a pattern of shared activity and, finally, 3) improve communication. The order and speed in which these components are given can vary depending on client needs and is usually delivered in 15-20 outpatient sessions. Studies supporting the efficacy of BCT for both alcohol and illicit drug problems have been reviewed recently by Fals-Stewart et al. (2009). The research and conclusions of this, and another narrative review by O'Farrell and Fals-Stewart (2003) restricted to alcohol, will be briefly summarised.

First and foremost is the fairly consistent finding that BCT is more efficacious than alternative individual interventions (e.g., cognitive-behavioural therapy, 12-Step) measured on a broad array of outcomes. Specifically, compared to individual treatments, BCT is related to longer and more consistent periods of abstinence and better relationship outcomes, including lower rates of separation (McCrary, Stout, Noel, Abrams, & Nelson, 1991; O'Farrell, Cutter, Choquette, Floyd, & Bayog, 1992). These findings in the context of alcohol have also been replicated in a randomised controlled trial including women as the primary substance using client (Fals-Stewart et al., 2006) and comparing BCT to individualised treatments in illicit drug use (e.g., Fals-Stewart et al., 1996; Fals-Stewart, O'Farrell, & Birchler, 1997; Fals-Stewart, O'Farrell & Birchler, 2001).

Important from a broader social perspective is that BCT has a positive effect on the functioning of couple's children. In the context of male drug using clients, for example, Kelley and Fals-Stewart (2002) reported improved social-psychological adjustment of children even though they

are not an explicit target of intervention. In this study improvements were greater than those in an individual intervention.

A further factor that significantly impacts on the welfare of children and, most often female, spouse, and associated with substance abuse, is domestic violence (Hester, Pearson, Harwin & Abrahams, 2000). BCT has been illustrated to significantly reduce domestic violence in the context of alcohol (O'Farrell and Murphy, 1995) and drug use (Fals-Stewart et al., 1997) and in the latter study, where comparative efficacy was tested against individual treatment, BCT was more effective. Relating to this study reports of domestic violence – experienced by approximately half of the couples – decreased differentially one-year follow-up depending on which treatment they received. Specifically, only 17% of couples receiving BCT reported current domestic violence whereas 42% of couples receiving individual therapy reported such events.

Finally, providing an indication of the magnitude or degree to which BCT is associated with greater gains than individualized interventions is a meta-analytic study by Powers, Vedel and Emmelkamp (2008). Powers et al. (2008) statistical review compared 12 randomized controlled trials ($n=754$) to individual based treatment and individual cognitive-behavioural interventions that do not include relationship enhancing components specifically. There was an overall advantage for BCT over individual treatments that was moderate/medium to high in magnitude, or in 'effect size' ($d=0.54$). When time was considered as moderating influence, at post-treatment BCT was only more effective than the individual-based treatments in terms of relationship satisfaction (with a large effect size, $d=.64$) and not frequency of use or consequences of use, which were equal across interventions. On the other hand, BCT was found to have more of a lasting effect with it being moderately more effective in all areas three areas at 6-12 month follow-up. This, and the above research, demonstrates the broad array and longevity of the benefits afforded by interventions where couples enter treatment together, compared to those where only the identified user enters treatment.

It should be noted that Behavioural Couples Therapy is only one way of working with couples in substance abuse treatment. It is included here in detail because it is the approach that has the most and best designed research behind it (Copello et al. 2005). This status is, in turn, reflected

in the clinical guidelines provided by the National Institute of Clinical Excellence (NICE, the main UK body reviewing treatments that should be provided as part of the National Health Service) wherein BCT is one of only two interventions recommended for treatment of substance use. There are of course alternative ways of working with families in substance abuse. These include working with families on broader issues than what occurs between couples, more or less, on a behavioural level.

3.2.2 Beyond the Dyad

From a family systems perspective, including strategic and structural approaches, for example, it is important to change patterns of social interaction, alter the meanings associated with substance use; and thereby move the client toward behaviour change. These meanings may have aetiology in the past which is transferred inter-generationally and as such, they have a broader socio-cultural foundation than the above approaches. The research dedicated to exploring the effectiveness of these interventions also finds that they are more efficacious than alternative individual treatments at improving drug misuse and family functioning post-treatment and follow-up in both adult and adolescent samples (see Bernal et al., 1987; Crits-Christoph, & Siqueland, 1996; Gacic, Sedmak, Ivanovic, Gardinovacki, & Gacic, 1980; McLellan, Arndt, Metzger, & Woody & O'Brien, 1993; Shoham, Rohrbaugh, Stickle, & Jacob, 1998; Stanton et al., 1982; Szapocznik et al. 1988).

Another broader application of family-inclusive interventions includes times when individuals from the person's broader social system are included (e.g., friends). In this vein there has been recent interest in developing programs that are targeted toward the drug-using person's social networks. Network Therapy (e.g., Galanter, 1999) is multi-modal incorporating cognitive behavioural, network support and community reinforcement strategies in order to effect change. Galanter (1999; 1993) and associates (Galanter, Dermatis, Keller, & Trujillo, 2002) has reported the results of an evaluation of network therapy work with cocaine misuser's and their family and peers, which showed that network sessions were associated with better outcomes over individual sessions.

3.2.3 Interim Summary

To summarise, a number of scholarly reviews, meta-analyses and systematic reviews have shown that the social component of treatments for alcohol (Edwards & Steinglass, 1995; Miller et al. 2002; O'Farrell and Fals-Stewart, 2003) and/or illicit substance use (Copello et al. 2005; Epstein & McCrady, 1998; Fals-Stewart et al. 2009; Stanton & Shadish, 1997; Thomas, Adams, Yoshioka, & Ager, 1990) problems (e.g. community reinforcement, behavioural marital therapy) is highly effective. Moreover, the recent review of family based therapies for adolescent alcohol and drug problems (Liddle, 2004) demonstrated that such family-based interventions had a major positive impact on their engagement, retention and treatment outcomes. As concluded by Miller and Wilbourne (2002) "Attention to the person's social context and support system is prominent among several of the most supported approaches" (p. 276). Moreover, as far as best-practice and first-line treatment approaches are concerned, it appears that agencies should move towards the adoption of family-inclusive intervention as their core business.

3.4 Working with the CSO as a Client Warranting Support in Their Own Right

Increasingly, it is being recognised that the relatives and loved ones of drug users are deserving of treatment in their own right. Orford and colleagues have developed the primary model: the stress strain-coping-support model (Orford, 1988; Orford et al., 2006; Orford, Templeton, Velleman, & Copello, 2005; Velleman & Templeton, 2003), for working with family members in this way. This model assumes that living with a drug user is stressful and that this often leads to physical and psychological strains. The model further suggests that the degree of strain experienced is relative to coping and social supports. Regarding the former, families are seen to do whatever they can to cope with their situations; some of these forms of coping are in turn, more effective than others. Similarly families will differ regarding their level and quality of social support; with quality moderating the degree of stress and strain a family experiences.

From this basic framework there are five steps to be worked through with family members (Copello, Orford, Velleman, Templeton, & Krishnan, 2000). These five steps correspond to the main elements of the stress-strain-coping-support model: (1) Giving the family member the opportunity to talk about the problem; (2) Providing relevant information; (3) Exploring how the

family member copes with/responds to their relative's substance misuse; (4) Exploring and enhancing social support; and (5) Exploring the need for and the possibilities of onward referral for further help and support.

A number of studies have validated the efficacy of this program in Australia ('Stepping Stones, Argyle Research and Training, 2008) the United Kingdom (Copello, Templeton, Krishnan, Orford, & Velleman, 2000; Copello, Templeton, Orford, Velleman, Patel, Moore, MacLeod, & Godfrey, 2009; Templeton, Zohhadi, & Velleman, 2007) and Italy (Velleman, Arcidiacono, Procentese, Copello, & Sarnacchiaro, 2007). Briefly, these studies show that programs based on this model, providing predominately educational and social support, improve physical and psychological health of relatives. In addition they support family members' use of alternative methods of coping and they reduce the negative impact of the problem and enhance social supports.

Overall Summary

Despite a not so distant history of treating only the ‘individual user’ and considering the user’s families as pathological, current research indicates a dramatic change in perspective. Essentially, the research suggests that systemic and family-inclusive approaches to alcohol and other drug treatment are more likely to alleviate the burden of drug abuse and dependence than approaches that do not include others who are significant to the individual.

A broad aim of this paper was to provide a definition of family-inclusive practice in order to provide a basis for a service-based model of care. In line with this, family inclusive practice was defined from a theoretical as well as an operational, or service orientated, perspective. These approaches to definition are however, not mutually exclusive. The theory underpinning family-inclusive practice, for instance, has led to empirically validated treatments which, in turn, inform service provision and vice versa. Therefore, while detailing broad organisational practices (e.g., intake procedures) family-inclusive practice was especially defined with reference to the interventions that have included substance users as well as their significant others and families.

For the most part interventions that include family members draw heavily on systemic and cognitive-behavioural conceptualisations of behaviour and behaviour change. Both theoretical orientations are as such, concerned with understanding the interactions that routinely occur *between* family members and, moreover, there is an explicit agenda to modify the reinforcing or functional qualities of these interactions. It follows then that family inclusive practice can be seen to be operating when the clinician is working with the client and their significant others (whether or not they present directly in therapy) to modify the way in which these individuals interact with one another to promote alcohol and other drug related goals. Importantly, a wealth of empirical research supports such a model of care.

As reviewed, research supports the inclusion of family members of substance users in treatment, as both contributors to the user’s recovery as well as recipients of their own therapeutic intervention. Indeed, this review detailed a number of psychological and behavioural interventions that have been designed to modify the problematic, as well as the more quotidian,

familial interactions that constitute the user's social experience. Importantly, these 'family inclusive' interventions are consistently found to be more effective at reducing or eliminating drug use and/or promoting the psychological health of the family members than alternative individual treatments. This means that even though certain familial and dyadic interactions perpetuate or precipitate another's drug use, the family's capacity to contribute positively to each other's health and recovery cannot be overlooked. To come back the definition of family inclusive practice it follows then, that a practice model that is family inclusive uses these approaches when assessing and treating clients with substance use problems.

At a pragmatic level this means that family-inclusive practice needs to be established through routine inclusion of these programs in practice. Specifically, organisations should adopt the specific, empirically supported treatment protocols, including family members as previously described. Formal policy and fiscal backing in training and employment of workers who are already competent in these modalities of practice is already underway within Australia. This review further point to the ways that family members can be engaged by using specific and well validated means. Organisations which implement such arrangements should be best positioned to maximise outcomes for their drug using clients and their families.

A further review regarding the response to need of children with substance misusing parents in available from EDAS.

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