Family Inclusive Practice

Supporting Evidence

Understanding Family Inclusive Practice

What is it?

Family sensitive policy and practice *'occurs when services and support are based on an understanding of family issues and are sensitive to family needs'* (Gruenert & Tsantefski, 2012). Family Inclusive Practice (FIP) builds on this concept further by working in partnership with families and engaging them in the treatment planning, delivery and on-going support process of a family member experiencing a problem (where appropriate). It also involves raising awareness of the impact of problematic substance use upon the whole family, and addressing the needs of families. FIP works with the family as a whole and sees the family unit, as well as individual members, as the unit of intervention (Battams et al, 2010).

Gruenert & Tsantefski (2012) identified four types of family-focused interventions in the AOD sector:

1. Working with family members with the primary aim of motivating someone with problematic AOD use to seek or engage in treatment.
2. Working with the family *and* with the person experiencing AOD problems to gain greater understanding of their problems and to enhance treatment outcomes.
3. Working independently with family members to support their own needs.
4. Working with some family members *and* with the person experiencing AOD problems, with the aim of identifying and addressing all members' needs and facilitating change to the whole family system.

They also identified two types of family work:

1. Working with the partners and parents of people with an AOD problem.

   It has been recognised that adult family members have two 'related but distinct needs' – receiving support for themselves, as well as supporting the drug-using family member in their treatment. These two needs are not mutually exclusive (Copello & Templeton, 2012).

2. Recognition of AOD users being parents themselves, and working with them to support their parenting skills with a focus on the needs of the children.

Both types of family inclusive practice aim to address issues such as intergenerational AOD problems whilst also being aware of contributing factors including cultural diversity and complex family care arrangements that involve the broader family system and other community members.

Family inclusive practice does not rely on one particular model of treatment or service delivery and can be built into existing practices (Battams et al, 2010). It draws from a systems approach that recognises that people live within networks of relationships, and that the way others in the system view them and react to them has a huge effect on what they do (Winek, 2010).

Family inclusive practice includes working with both the individual and the family, but also goes beyond that and considers work practice, organisational structure, and wider systems in the AOD and public health sectors. Thus, family inclusive practice can encompass a number of interacting levels:

Service delivery	E.g. consideration of families and children within treatment and other services, developing the skills and attitudes of workers.
Organisational	E.g. organisational guidelines for family sensitive policy and practice, culturally appropriate services, processes for interacting with other services, family sensitive physical environments within services.
Systems and Services	E.g. building knowledge and partnerships for family sensitive policy and practice across services and sectors.
Policy	E.g. prioritisation of family sensitive policy and practice within policy, facilitating structures and resources, cross-sectoral policy.

(Battams et al, 2010)

Why is it important?

No individual exists within a vacuum. The term 'family' can mean different things to different people, e.g. single parent, extended, same sex, blood relations only, close friends, carers or support people. Regardless of the definition, family members can be heavily influenced and affected by the actions of each other, both positively and negatively (Few-Demo et al, 2014).

Family members of people with problematic AOD use can suffer stress-related physical and psychological symptoms that can be severe and long lasting (Copello et al, 2009). Structures and functions within the family, such as rituals, roles, routines, finances, communications, social life and relationships are also disrupted by problematic AOD use (Velleman & Templeton, 2016).

Whilst the individual with problematic AOD use affects the family in many ways, it must be remembered that this relationship is bi-directional and that the family also has a profound effect on the individual (Velleman, 2006). Evaluation of ReGen's non-residential rehabilitation program, Catalyst, demonstrates both the impact on affected family members and the improvements in individuals' wellbeing and family functioning that can be achieved through targeted interventions (Caraniche, 2012). It is for this reason that FIP is of vital importance to improving the sustainability of AOD treatment outcomes.

How does the family dynamic help or hinder the individual with problematic AOD use?

It is rare for an individual to experience problematic drug and alcohol use in isolation from any other problems; generally, families in which problematic substance use occurs experience a range of problems (Battams et al, 2010). However, this inter-connectedness can have a positive effect as well as a negative one: if family functioning improves, this can often lead to a decrease in problematic AOD use (Nattala et al, 2010).

Older models of FIP positioned family members as 'enablers' or 'co-dependents', suggesting that they willingly entered into the role of caring for the family member engaged in problematic AOD use

because it somehow met their own needs (Velleman, 2009). This attitude has also been used to discredit the experiences of people with problematic AOD use who are victims of family violence (as well as other victims of family violence), but has been superseded by newer models (see below) that characterise this approach as 'victim blaming', as it places the responsibility on the family member for the abusive behaviour of others, thus pathologising caring behaviour. These new models recognise the crucial importance of listening to and validating the experiences of family members dealing with the violence or problematic behaviour of loved ones:

> *I'd like to hear 'you're not to blame for this' not 'why didn't you leave?' If someone has come from a hateful space then the first thing they need to have reinforced is that they're not to blame, and start lifting the stigma.* (Batty, quoted in State of Victoria, 2016)

One example of these models is the Stress-Strain-Coping-Support model (Orford et al, 1998). It suggests family members are severely stressed by the impact of a relative's problematic AOD use, which can lead to strain, evident in physical and psychological symptoms. The degree of strain the family members experience is mediated by their coping techniques and the levels of support available to them. Unlike older models, this model removes the element of 'victim-blaming', positioning both the substance user and their family members as victims of stress. It also offers two methods of reducing the strain; by either reducing the stress (for example if the individual with problematic AOD use seeks support), or by improving the family member's coping methods or their social support systems (Velleman, 2009).

In terms of seeking support and treatment, family attitudes can have a significant influence on an individual. If the family perceives the level of stigma around admitting to problematic AOD use as high, this can discourage an individual from seeking help. Thus, if the family is supported to identify the benefits of seeking assistance, the individual will be more likely to seek support from AOD services (Battams, 2010, Copello et al, 2005). Evidence also suggests that even if an individual is unwilling to seek treatment, there is a set of therapeutic strategies that can help a family respond positively to the problem, and motivate the individual to change, or to seek treatment (Velleman, 2005).

Involving the whole family in the treatment process can have a significant impact on its effectiveness. When looking at adolescent drug treatments, Liddle et al (2008) found that treatments involving the family with a focus on changing the family environment and parenting practices led to significant improvement of the adolescent's substance use problems. Behavioural couple's therapy and coping skills training for partners and spouses have been shown to improve family understanding and functioning. This leads to improved treatment retention and outcomes for the person in treatment (Raistrick et al. 2006).

ReGen's own experience in program delivery indicates the benefit of integrating family services within AOD treatment services for supporting individual engagement and improved outcomes for all family members (Caraniche, 2012).

As well as influencing entry to treatment and immediate treatment effectiveness, family involvement can also increase the sustainability of outcomes. Copello et al (2005) found that interventions that involve family members showed an increase in the number of days spent abstinent, compared to those where family were involved only minimally or not at all. Other research supports family involvement in the post- treatment recovery phase where support, including anti-craving medication monitoring has been shown to reduce relapse (Beattie 2001; Kampman et al. 2009).

Problematic AOD use and Family Violence

The State of Victoria's Royal Commission into Family Violence (2016) recognised the complex relationship between problematic AOD use and family violence. AOD use is undoubtedly a contributing factor to

family violence, with numerous studies finding links between problematic AOD use and the perpetration of family violence. There is also evidence that alcohol and other drugs are used for a variety of different reasons by both the perpetrators and victims of family violence (Cafferky et al, 2016).

Overwhelmingly, women and children are the victims of family violence (State of Victoria, 2016). Children living in environments where they are exposed to both problematic parental AOD use and family violence are more at risk of adverse outcomes. The presence of family violence is believed to be a particularly significant risk factor (Velleman & Templeton, 2016). Recognising the need for effective interventions for those who use violence (Kildonan UnitingCare, 2015, State of Victoria, 2016), UnitingCare ReGen partnered with Children's Protection Society, University of Toronto and University of Melbourne in 2016 to launch 'Caring Dads' – a targeted early intervention program for fathers who expose their children to neglect, physical and emotional abuse or domestic violence. The program aims to engage fathers who are participating in alcohol and other drug treatment with early interventions to increase their parenting capacity, improve their family relationships and reduce the risks of violence, abuse and neglect to all family members (UnitingCare ReGen, 2016).

Common arguments against Family Inclusive Practice

Bad parents

Whilst there is a common perception that people with problematic AOD use are 'bad parents', the reality is more complex than this.

Parental AOD use has been recognised as a significant risk factor for child abuse and neglect (COAG, 2009, Victorian Government, 2012[a]), and it has been suggested that for every adult seeking AOD treatment, there is generally one child impacted by problematic parental AOD use (White et al, 2012).

However, it is very difficult to separate the impact of problematic parental AOD use from the other socioeconomic factors that may be impacting on the family, such as poverty, housing insecurity, unemployment, public health issues and stigma, discrimination and exclusion (Velleman & Templeton, 2016)

Having children is a powerful motivator for parents to seek help for their problematic AOD use (Fraser et al, 2009, UnitingCare ReGen, 2007). Often, parents with problematic AOD use want to be good parents, and employ a range of strategies to minimise the impact of their problematic AOD use on their children and ensure their basic needs are met, such as keeping their substance use, associates and associated paraphernalia away from the home environment and their children (Velleman & Templeton, 2016). Most parents have a desire for someone to help them with their parenting skills (Gruenert & Tsantefski, 2012).

Protect the children

The AOD & child welfare sectors are increasingly recognising the relationship between alcohol & drug misuse, childhood and adolescent development, and child wellbeing and protection (Battams et al, 2010). However, removing children from parents with problematic AOD use and placing them in out-of-home care does not always lead to better outcomes. A 2014 audit of residential care services for children in Victoria by the Auditor-General found that '*the department had failed to oversee and ensure the safety and development of children in the residential care system'* and identified *'significant shortcomings in the quality of oversight and staffing of residential care services, as well as in achieving outcomes for children'* (Victorian Auditor-General, 2016). Targeted FIP programs in AOD services, such as ReGen's Intensive Playgroup, can simultaneously carry out therapeutic work with the parents with problematic AOD use whilst increasing their parenting skills and confidence in their own abilities, and providing an opportunity for the parent and child to strengthen their bond through play activities

(UnitingCare ReGen, 2007). FIP can enhance the protective or resilience factors known to reduce alcohol and other drugs misuse and its impact by:

- utilising and building upon social capital resources
- enhancing support to parents
- building upon parents' coping strategies
- developing supportive relationships with children
- establishing links with other services such as schools and domestic violence services.

(Battams et al, 2010)

Ultimately, whether or not children should be removed from their family is a matter for the statutory authorities, not for AOD agencies. However, as recognised by the Victorian Government Department of Human Services (2007), best interest principles require agencies to broaden their focus and shift from 'compartmentalised engagement' to a more inclusive practice. Implementation of FIP includes building strong partnerships which will enhance the ability to work with the family as a whole rather than as unconnected individuals.

Inherited behaviour

Whilst parental problematic substance use may in turn be associated with children developing their own substance use problems in later life (Battams et al, 2010), it is important to note that most children of substance-using parents do not have significant problems as adults (Forrester, 2004). There are a range of possible contributing factors to intergenerational patterns of AOD use. Parental use is one, but not the only one (Battams et al, 2010).

Conflict of interest

There is a perception that the needs of a family and the needs of an individual with problematic AOD use differ, and that there will be a conflict of interest in trying to meet both. Certainly, AOD workers utilising FIP will certainly be required to carefully balance any conflicting needs (Battams et al, 2010). Just as the term 'family' means different things to different people, so the impact of the family on the individual and the individual on the family will differ. Like any form of service delivery, there is never going to be a 'one size fits all', and services already utilising FIP in the UK have found that FIP involves assessing what action will suit the particular family best, and may range from actions such as phone calls and other minimal contact through to multiple face-to-face contact with the client and their chosen family members (Orford et al, 2009). It is always up to the individual seeking AOD treatment to decide what 'family' means to them, and how they want to involve (or not) those they define as family.

There is no evidence that involving family members in treatment leads to negative (ie: worse, rather than better) outcomes. In fact, a recent study found multi-dimensional family therapy to be the most effective treatment for adolescents with severely problematic AOD use and/or disruptive behaviour disorder (van der Pol et al, 2017). ReGen has had positive experiences in promoting mutually reinforcing improvements in family functioning and an individual's AOD use through a range of programs including the 'Strengthening Relationships' sessions run as part of Catalyst, ReGen's non-residential, community-based alcohol rehabilitation program (Caraniche, 2012).

How does the AOD sector currently engage in Family Inclusive Practice?

Even though the evidence supporting the benefits of FIP is overwhelming, there is still a prevailing focus on the individual rather than the family unit in the AOD sector, and it has been slow to adopt

therapeutic approaches that include family members (Gruenert & Tsantefski, 2012, Ibanga et al, 2008). A 2010 survey of over 250 workers from Australian AOD treatment agencies including government, non-government, private and community-owned, found that over half of the respondents (57%) saw child and parent-sensitive practice in their work role as 'significant but not central to my role'(Trifonoff, 2010). Nonetheless, 98% of respondents believed it was 'important' or 'very important' to raise the needs of children when working with clients who have parent/caregiver roles, and 90% agreed that assisting a client to manage their parent/caregiver role would contribute to positive treatment outcomes.

Barriers to Family Inclusive Practice in AOD treatment

There have been many barriers identified around the implementation of FIP, for workers as well as for clients. Some are systemic; others are the result of individual perception and fear.

Workers responding to Trifonoff's questionnaire advised some clients were wary or resistant to talking about their children because of their fear of having the children removed, or defensive about their parenting skills (Trifonoff, 2010). There has also been the suggestion that some AOD workers are reluctant to ask about children in case this requires them to make notifications and thus jeopardises their working relationship with the client in treatment (Gruenert & Tsantefski, 2012). Prioritising maintenance of the therapeutic relationship fostered development of a 'don't ask, don't tell' culture.

Over half of the surveyed workers (55%) had mixed experiences when engaging with other services to assist a client with parental/caregiver roles. *'I have had some wonderful experiences of collaboration with child protection, however I have also had some extremely difficult interactions with child protection workers who have failed to believe in the client's ability to change'*. Workers stated that the needs and expectations of other services could often be quite different to theirs, and suggested that the stigma attached to problematic AOD use, in particular injecting drug use, could colour their interactions with other agencies. Lack of linkages between AOD & child/family welfare agencies and limited mutual exchange of information between child/family welfare agencies and AOD agencies were also listed as barriers by the workers responding to the questionnaire (Trifonoff, 2010). A common understanding, conceptual framework and language is needed for cross-sectoral collaboration to be successful (Battams et al, 2010).

Certainly, there seems to be a lack of services with expertise in AOD treatment, parenting and child management. Staff members in AOD treatment services rarely have the knowledge, confidence or skills to provide much in the way of parenting or family support (Battams et al, 2010). Many workers state they have a lack of education or training on child wellbeing and welfare issues relevant to parents with problematic AOD use (Trifonoff, 2010). 40% of questionnaire respondents advised that their organisational intake/client assessment procedures had no provision for an assessment of parenting issues or child well-being/welfare issues, whilst 51% of respondents noted they did not receive regular clinical supervision from someone experienced in child and parent-sensitive practice (Trifonoff, 2010).

It is important for those funding the sector to recognise the importance of supporting the improvement of FIP. In its plan for *Reducing the alcohol and drug toll* (Victorian Government, 2013), the Government has stated they will '*promote more family-inclusive practice across the alcohol and drug sector'*, as well as re-stating its commitment to *'working to strengthen the capacity for adult services to recognise the parenting responsibilities of adult clients in the planning and delivery of treatment'* (a statement initially made in their 2012[a] report on Victoria's Vulnerable Children). The Government's workforce development strategy emphasises the importance of family-focussed practice (Victorian Government, 2012[b]).

Whilst many workers list a lack of access to resources and strategies to assist AOD clients with their parental or caregiver needs (Trifonoff, 2010), Copello et al (2009) found that the treatment does not

have to be of a complex nature, and that a well put together self-help manual delivered by primary healthcare professionals can be just as effective as several face-to-face sessions with a professional.

Changing to a new system of working can be daunting for practitioners, especially if their existing practices have measurable success. Orford et al (2009) found this in their work with two specialist teams in the UK, who reflected how difficult it was to integrate FIP into their existing system:

> It was not just a case of changing ways of thinking, but also ways of advertising the service, recruiting and inducting new staff, carrying out client assessments, thinking about the friendliness of the waiting area, policy about home visiting or seeing clients in other locations such as hospitals or health centres, opening hours and methods of communication with clients.

There is some criticism of the 'invisible barrier' of the competitive tendering environment in both the government and NGO sector, with the outcomes focus and contractual nature of the work leading to short-term contracts, job insecurity and higher workforce turnover (Battams et al, 2010). In Australia, around 40% of AOD workplace questionnaire respondents found heavy workloads and lack of treatment plans/goals that involve parental/caregiver needs either substantial or very significant barriers to FIP (Trifonoff, 2010). The reality of limited resources can also impact on inter-sectoral collaboration and the workforce development necessary to implement FIP (Battams et al, 2010).

There are also barriers to FIP that directly affect the clients. A lack of childcare facilities at most services is an immediate problem for many parents with problematic AOD use seeking treatment (Gruenert & Tsantefski, 2012), and those that do offer child and family inclusive interventions (such as residential services) offer services for mothers and their children, but not for fathers (Gruenert & Tsantefski, 2012). It has also been identified that there is a lack of provision of support for people whose drug-using family member is not in treatment (Copello & Templeton, 2012).

There have been some more recent developments that demonstrate that some change is occurring. Developments at ReGen include the opening of the Mothers and Babies Unit; the Caring Dads program for men who use violence in their relationships, the expansion of supported playgroups and the ongoing Family counselling program.

How do we implement Family Inclusive Practice in the AOD sector?

> 'Services should be person-and family-centred. They should be better integrated, based on the best available evidence, and more responsive to the needs of local communities and particular groups, including Aboriginal Victorians. We need to engage earlier, with more flexible support, recognising that people can, and do, recover' (Victorian Government, 2012[b]).

There has been extensive research into the pathways for implementation of FIP in the AOD sector, and change needs to happen at many different levels. As well as activities such as undertaking an audit of child-friendly practice currently in place in the organisation (Trifonoff, 2010), Trifonoff also suggested developing an organisational checklist in regard to child-friendly practices to ensure child-friendly policies and procedures. Battams and Roche (2010) developed the following checklist for family sensitive practice:

- **Assessment**

  Ensuring the treatment/intake/client assessment procedures currently in use identify whether the client has a parenting/caregiver role (Trifonoff, 2010).

- **Intervention**

  Each intervention needs to be tailored to the particular family and their needs, including cultural and linguistic diversity. There also needs to be recognition that family-inclusive AOD interventions will generally need to be longer-term than the typical 6 -12 week duration of most treatment programs, and funding models should reflect this requirement for longer term aftercare and follow-up support (Gruenert & Tsantefski, 2012). Using a strengths-based approach is thought to be most effective in maintaining engagement with families and achieving sustainable outcomes (Gruenert & Tsantefski, 2012).

- **A partnership and empowerment approach**

  Working with the clients to ensure they are involved in care planning, as well as involved in the planning and design of services and polices.

- **Multi-agency and cross-sectoral working**

  Organisations will need to check that they have appropriate processes in place for cross-sectoral networking. Other relevant sectors will need to support any change in the AOD sector, and the AOD sector will need to build stronger partnerships at a local level (Copello & Templeton, 2012), particularly with the child welfare sector (Gruenert & Tsantefski, 2012). Gruenert & Tsantefski (2012) also suggest a need for AOD competency training for child welfare staff.

- **Workforce development**

  Making sure that staff are aware of FIP, clear about the aims, and confident in the systems that have been set in place to support its delivery. Once the agency has provided education and training aimed at building the capacity of the workforce to undertake FIP, appropriate clinical supervision also needs to be made available (Trifonoff, 2010).

- **Organisational and systems development**

  Ensuring organisational policies and guidelines on FIP are in place. Policy documents should make specific reference to the importance of supporting families of drug users, and recognise the role they can play in supporting their relative (Copello & Templeton, 2012).

- **Building leadership and integrated government policy**

  Gruenert & Tsantefski (2012) assert that a minimum standard of family sensitive practice will be required across all services and programs, and this will require leadership from peak organisations and from government.

- **Accountability and monitoring**

  Assessment and evaluation of practice to not only ensure the best possible implementation of FIP, but also for AOD agencies to routinely and consistently collect data that would give an accurate picture of problematic parental substance use in Australia (Gruenert & Tsantefski, 2012). Developing targets and outcome assessment is also crucial to implementing accountability and monitoring (Copello & Templeton, 2012).

Conclusion

Family inclusive practice is a developing area in practice although the evidence is substantial. AOD services are starting to understand the importance of FIP, and some agencies have embraced it, enabling organisational cultures to change, service users to see the benefits, and workers to be supported and empowered to adopt new ways of working. Support from governments, agencies in

partnership sectors, and other funding bodies will enable organisations to make a sustainable commitment to FIP and through this improve outcomes for clients.

References

Battams, S, Roche, A, Duvnjak, A, Trifonoff, A, Bywood, P. (2010). *For Kids' Sake: A workforce development resource for Family Sensitive Policy and Practice in the Alcohol and other drugs sector*. Adelaide: National Centre for Education and Training on Addiction.

Battams, S & Roche, A. (2010). *Family Sensitive Practice in the Alcohol and Other Drugs Field*, Adelaide: National Centre for Education and Training on Addiction.

Beattie M. (2001). Meta-Analysis of social relationships and posttreatment drinking outcomes: comparison of relationship structure, function and quality. Journal of Studies on Alcohol. 62(4):518-27.

Cafferky, B. M., Mendez, M., Anderson, J. R., & Stith, S. M. (2016). Substance Use and Intimate Partner Violence: A Meta-Analytic Review In: *Psychology of Violence,* Advance online publication. http://dx.doi.org/10.1037/vio0000074

Caraniche. (2012). *Evaluation of UnitingCare ReGen Catalyst Program: Final Evaluation Report July 2009 – June 2012*, Melbourne.

Copello, A & Templeton, L. (2012). *The Forgotten Carers: Support for adult family members affected by a relative's drug use*, UK Drug Policy Commission.

Copello, A, Templeton, L, Orford, J, Velleman, R, Patel, A, Moore, L, MacLeod, J & Godfrey, C. (2009). The relative efficacy of two levels of a primary care intervention for family members affected by the addiction problem of a close relative: a randomized trial In: *Addiction*, 104: 49 – 58.

Copello, A, Velleman, R, & Templeton, L. (2005). Family Interventions in the treatment of alcohol and drug problems In: *Drug & Alcohol Review*, *24*: 369 - 385Council of Australian Governments (2009) *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009 – 2020*, Commonwealth of Australia.

Few-Demo, AL, Lloyd, SA & Allen, KR (2014). It's All About Power: Integrating Feminist Family Studies and Family Communication In: *Journal of Family Communication*, 14(2): 85-94

Forrester, D. (2004.) Social work assessments with parents who misuse drugs or alcohol In: *Children exposed to parental substance misuse: Implications for family placement*. British Association for Adoption and Fostering, London.

Fraser, C, McIntyre, A & Manby, M. (2009). Exploring the impact of parental drug/alcohol problems on children and parents in a Midlands county in 2005/06 In: *British Journal of Social Work,* 39: 846 – 866.

Gruenert, S & Tsantefski, M. (2012). Responding to the needs of children and parents in families experiencing alcohol and other drug problems In: *Research Prevention Quarterly*, Drug Info, 17.

Ibanga, A, Copello, A, Templeton, L, Orford, J & Velleman, R. (2008). *Early experience with a web-based intervention with family members of alcohol or drug misusing relatives* http://www.crisanet.org/docs/conference_08/Papers/INTERVENTIONS/Ibanga_EarlyExperience.pdf Accessed 04/01/13.

Kampman K, Pettinati H, Lynch K, Xie H, Dackis C, Oslin D, et al. (2009). Initiating acamprosate within-detoxification versus post-detoxification in the treatment of alcohol dependence. Addictive Behaviors, 34(6-7):581-6.

Kildonan UnitingCare (2015) *Royal Commission into Family Violence: submission prepared by Kildonan Uniting Care*, Melbourne, Victoria

Liddle, H A, Dakof, G A, Turner, R M, Henderson, C E, & Greenbaum, P E. (2008). Treating adolescent drug abuse: a randomized trial comparing multidimensional family therapy and cognitive behaviour therapy In: *Addiction* 103: 1660 – 1670.

Nattala, P, Sang Leung, K, Nagarajaiah, Murthy, P. (2010). Family Member Involvement in Relapse Prevention Improves Alcohol Dependence Outcomes: A Prospective Study at an Addiction Treatment Facility in India In: *Journal of Studies on Alcohol and Drugs* 71: 581-58

Orford J., Natera G., Davies J., Nava A., Mora J., Rigby K., Bradbury C., Copello A., & Velleman, R. (1998). Stresses and strains for family members living with drinking or drug problems in England and Mexico In: *Salud Mental* (Mexico), 21: 1-13.

Orford, J, Templeton, L, Copello, A, Velleman, R, Ibanga, A & Binnie, C. (2009). Increasing the involvement of family members in alcohol and drug treatment services: The results of an action research project in two specialist agencies In: *Drugs: education, prevention and policy* 16(5): 379 – 408.

Raistrick D, Heather, N. & Godfrey, C. (2006). Review of the effectiveness of treatment for alcohol problems. National Treatment Agency for Substance Misuse. London.

State of Victoria (2016) *Royal Commission into Family Violence: Summary and Recommendations*, Melbourne, Victoria

Trifonoff, A, Duraisingam, V, Roche, A M, & Pidd, K. (2010). *Taking First Steps. What Family Sensitive Practice Means for Alcohol and Other Drug Workers: A Survey Report.* Adelaide: National Centre for Education and Training on Addiction, Flinders University, Adelaide.

UnitingCare ReGen. (2007). *Intensive Playgroup Evaluation*, Coburg, Australia.

UnitingCare ReGen. (2016). *ReGen welcomes funding for 'Caring Dads' family violence program*, media release on website: http://www.regen.org.au/news-advocacy/regen-in-the-media/media-releases/746-regen-welcomes-funding-for-caring-dads-family-violence-program-23-05-16

van der Pol, TM, Hoeve, M, Noom MJ, Stams, GJJM, Doreleijres, TAH, van Domburg, L, Vermeiran, RRJM (2017). Research Review: The effectiveness of multidimensional family therapy in treating adolescents with multiple behaviour problems – a meta-analysis, In: *The Journal of Child Psychology and Psychiatry,* 58(5): 532-545

Velleman, R. (2009). The 5-Step Intervention as a way of Working with the Adult Family Members of those with AOD Problems, In: *A Family Sensitive Policy and Practice Toolkit*, NCETA, South Australia.

Velleman, R. (2006). The importance of family members in helping problem drinkers achieve their chosen goal In: *Addiction Research and Theory*, 14(1): 73 – 85.

Velleman, R & Templeton, L J. (2016). Impact of parents' substance misuse on children: an update In: *BJPsych Advances 22: 108-117*

Victorian Auditor-General. (2016). *Follow up of Residential Care Services for Children*, Melbourne, Australia

Victorian Government. (2013). *Reducing the alcohol and drug toll: Victoria's plan 2013-2017*, Melbourne, Australia.

Victorian Government (2012)[a] *Victoria's Vulnerable Children: Our Shared Responsibility*, Melbourne, Australia

Victorian Government. (2012)[b] *Victoria's alcohol and drug workforce framework: Strategic directions 2012-22*, Melbourne, Australia.

Victorian Government Department of Human Services (2007) *Best Interest Principles: a conceptual overview*, Melbourne, Australia.

White, M., Nicholas, R., Roche, A M., Long, C, Gruenert, S & Battams, S. (2012). *How to break the silence: An AOD Clinician's Guide to asking about family and domestic violence.* Adelaide: National Centre for Education and Training on Addiction (Draft).

Winek, J.L. (2010). *Systemic family therapy: From theory to practice.* London: SAGE Publications, Inc. Retrieved from http://www.sagepub.com/sites/default/files/upm-binaries/29841_Chapter5.pdf

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About ReGen

Our purpose is to promote health and reduce alcohol and other drug related harm.

ReGen is the lead Alcohol and Other Drugs (AOD) treatment and education agency of UnitingCare Victoria and Tasmania. ReGen is a not-for-profit agency, which has over 45 years' experience delivering a comprehensive range of AOD treatment and education services to the community.

These services include Counselling and Support, Assessment and Intake, Community Outpatient, Home-based and Residential Withdrawal for adults and youth, Supported Accommodation, Drug Diversion programs, Youth and Family Services, an Intensive Playgroup, Alcohol Community Rehabilitation Program and AOD services at Port Phillip Prison. ReGen also delivers Education and Training programs nationally.

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ReGen INSPIRING ALCOHOL & OTHER DRUGS TREATMENT & EDUCATION

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