



Family Inclusive Practice in the Addiction Field

A Guide for Practitioners Working with Couples,
Families and Whanau.



Acknowledgements

This document grew out of initial discussions amongst a number of practitioners within the addiction treatment field. The trustees particularly acknowledge the contribution of Pam Armstrong in this process. Also, thanks go to Joel Porter for his work in scoping this project.

Simone Oortman created the initial framework and drafts - special thanks to her for her time and energy. Similarly, Fran Lowe has made a significant contribution to this document, her attention to detail being most useful. Acknowledgement goes to all those who contributed to the reviews and drafting process, particularly the staff at Springhill and Nga Punawai Aroha for their contribution.

Thanks to photographer James Lawson, Town and Country Imaging and the whanau of Kahungunu who feature in the photos.

James Dale of Horizon Advertising has voluntarily provided valuable advice and assistance.

Financial support was received from the:

- Alcohol Advisory Council
- Auckland District Health Board
- Eastern and Central Community Trust
- J.R. McKenzie Trust
- Lakes District Health Board
- Matua Raki (National Addiction Treatment Workforce Development Programme)
- Northland District Health Board
- Odyssey House Trust (Auckland)
- Waikato Health
- Waitemata District Health Board

A significant grant from the Mental Health Commission covered the production costs.

Finally, an acknowledgement to those directly and indirectly affected by addiction. Their courage in entering into recovery remains an inspiration.

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Kina Families and Addictions Trust

July 2005

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Preamble

How to use this guide

This resource is intended for addiction practitioners who have an understanding of drug and alcohol assessments and interventions and who want to acquire skills to work in a more inclusive and contextual fashion.

Families, whanau and other social networks can be complex and at times challenging to work with. This resource is not intended to make people experts in the field, nor is it about specialist family therapies. This resource does not cover working with families where the impact of family violence, severe addiction or mental health issues mean that more specialist intervention is required. It will be of value where a practitioner wishes to work with a client and their immediate social network, be it partner, family or whanau, in a manner that acknowledges the role of family members in the process of recovery.

The guide is divided into sections that can be accessed separately depending on the needs of the practitioner.

- Section One - provides a background to the issues of Family Inclusive Practice.
- Section Two - addresses some specific practice issues including environment and initial contact.
- Section Three - provides some specific examples that the practitioner can directly apply in the clinical environment.

In developing this resource the authors have been eclectic in their approach. The interventions described draw on evidence-based work. The guide includes other resources that the practitioner may wish to access and will form the basis for further training in the field.

SECTION ONE

Principles of Family Inclusive Practice

A predominant model within the addiction field is the all-encompassing biopsychosocial model that locates the causes of addictive behaviour in the physiology, psychology and environment of the individual.

The current focus on genetics, neurotransmitters and cognitive behavioural patterns has led to therapeutic interventions that tend to focus on the client as an individual. Family Inclusive Practice takes a contextual view of addiction. This allows for the above interventions to be used whilst ensuring therapy includes significant members of the social environment in which the individual is located.

This approach recognises that interventions are more effective when they include family members.

This model supports the view that individuals influence other members in their environment, especially family, and that family members in turn have an impact on these individuals. Services can address these factors alongside medication and individual counselling. Unlike family therapy models, the focus is not exclusively on the systemic issues.

Underpinning Principles

- **Family and whanau members have a right to participate in and receive services.**
- **Services are more effective and sustaining when they involve family and whanau.**
- **Interventions with clients include broader social issues and services need to respond to these through interagency work.**
- **Harms associated with addiction (such as marital problems) extend beyond the individual, and these can be addressed effectively.**

Family Inclusive Practice is linked to ecological models, resilience models, systems theory, multicultural and bicultural models of practice.

Recognising the Benefits of Family Inclusive Practice

Why Treat Families?

Most alcohol and drug counsellors are well aware of the pain and disruption that is caused when a family or whanau struggles with addiction. Sometimes it is referred to as a family disease because of the serious effects of alcohol and drug use on those living with and surrounding the client. Relationships with family and whanau are often troubled because the relationship with alcohol and other drugs becomes more important than intimate relationships. Over time, family patterns may unknowingly reinforce the client's addiction. Interactions amongst family members may become unhelpful, habitual and repetitive.

Historically, alcohol and drug problems were often viewed as individual problems and treated on an individual basis. In the last three decades, the role of family members in the initiation and maintenance of alcohol and drug behaviours has gained recognition. Research has shown that alcohol and drug treatments that involve family have resulted in higher levels of abstinence for clients (Fals-Stewart, O'Farrell and Bircher, 2004).

Policy Context

The Ministry of Health published a guide to involving family in client mental health treatment (Ministry of Health, 2000). The National Mental Health Standards, Standard 10, requires providers to work effectively with family members and significant others in their services (Standards New Zealand, 1999).

Whanau Ora, the wellbeing of the network of supports (whanau) of Maori in treatment, is core policy for Maori (Ministry of Health, 2002). Despite these recommendations Family Inclusive Practice is still not a standard practice (Mental Health Commission, 2000, cited in Whiteside & Steinberg, 2003).

'It is likely that, if the family is willing to participate in treatment, the client is more likely to pursue seeking help' (Diamond, 2002).

Benefits for Maori

In Kaupapa Maori Services, inclusion of whanau is considered to be standard practice. Practising the principle of Whanaungatanga means embracing whanau and incorporating them in treatment. It is about acknowledging the inter-connectedness and interdependence of an individual and all members of the whanau, hapu and iwi.

Benefits for Pacific Peoples

Pacific Island cultures see the person as an integrated part of a bigger picture. Family and culture play an essential role in the health and wellbeing of a person. Working towards good health means that everybody is included and affected by interventions and outcomes of the treatment.

Benefits for Families

Family Inclusive Practice acknowledges that alcohol and drug use is often an indicator of other problems in the family and provides an opportunity for everyone to receive the support they need. The benefits include the following:

- Families, whanau and significant others can provide more comprehensive information and insight about stressors, problematic situations, and coping strategies.
- Families may start addressing issues relating to their own substance use.
- Open communication may increase within the family.
- Everyone involved gains insight and learning, receives support and experiences opportunities to make change.
- Children can be referred to appropriate programmes or receive input from specialist services.
- Support systems are more able to provide support beyond the sessions.

'A whanau will provide reassurance, aroha, confidence, warmth, empowerment and mana to the client which will sustain the client' (ALAC, 1996).

Benefits for Clinicians

Working in this field can be challenging and if Family Inclusive Practice is not standard practice, it may seem a daunting task. However, the process of recovering from addiction demands great courage on the part of the client and considerable support from those surrounding him or her. The benefit for the clinician of focusing on support networks is that the client is more likely to succeed in treatment. Family Inclusive Practice requires certain skills but most of all it is about believing that it provides better outcomes for the client and those affected by their alcohol and drug use.

Barriers to Using Family Inclusive Practice

Some of the reasons for not using Family Inclusive Practice may be:

- Lack of time and high caseloads.
- Too challenging to work with more than one client
- Unsuitable physical environment
- Lack of client consent to involve family
- Low client motivation and unwillingness to change
- Difficulties with cultural issues
- Concerns about family safety
- Standard agency practice is not family inclusive
- Insufficient support for practitioners in Family Inclusive Practice

Key Service Conditions that Encourage Family Inclusive Practice:

- Recognition by counsellors of the benefits of engaging and working with families and integrating Family Inclusive Practice models in to their practice.
- Promotion of Family Inclusive Practice from a management level, with service policies that promote family and whanau inclusion and ensure a family friendly environment is available.
- Availability of training, support, supervision and guidelines on how to develop Family Inclusive Practices.



SECTION TWO

Practice Models

Family Inclusive Practice is not based on one particular practice model. Instead, there are various models that are family inclusive. Maori practice models include whanau, as whanau is intrinsically interconnected with the wellness of people (whanau ora).

The following four theoretical models underpin family based alcohol and drug treatments:

1. The Family Disease, or 12-Step model, views addiction as an illness of the family, primarily located with the identified client, but also directly affecting the family members who are seen as co-dependent. Interventions primarily involve the use of the 12-Step process of change, often self-help group based, with a view to change occurring in individuals independent of one another. AlAnon is a 12-step group for family members.

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

Example

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

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

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

Examples

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

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

The CRAFT Model focuses on behavioural analysis of the drinking or drug using behaviour and training the family to ensure there is reinforcement for abstinence (Meyers & Smith, 1995).

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

Family Inclusive Practice can be incorporated into most theories and models.

'Addiction does not happen in a vacuum;

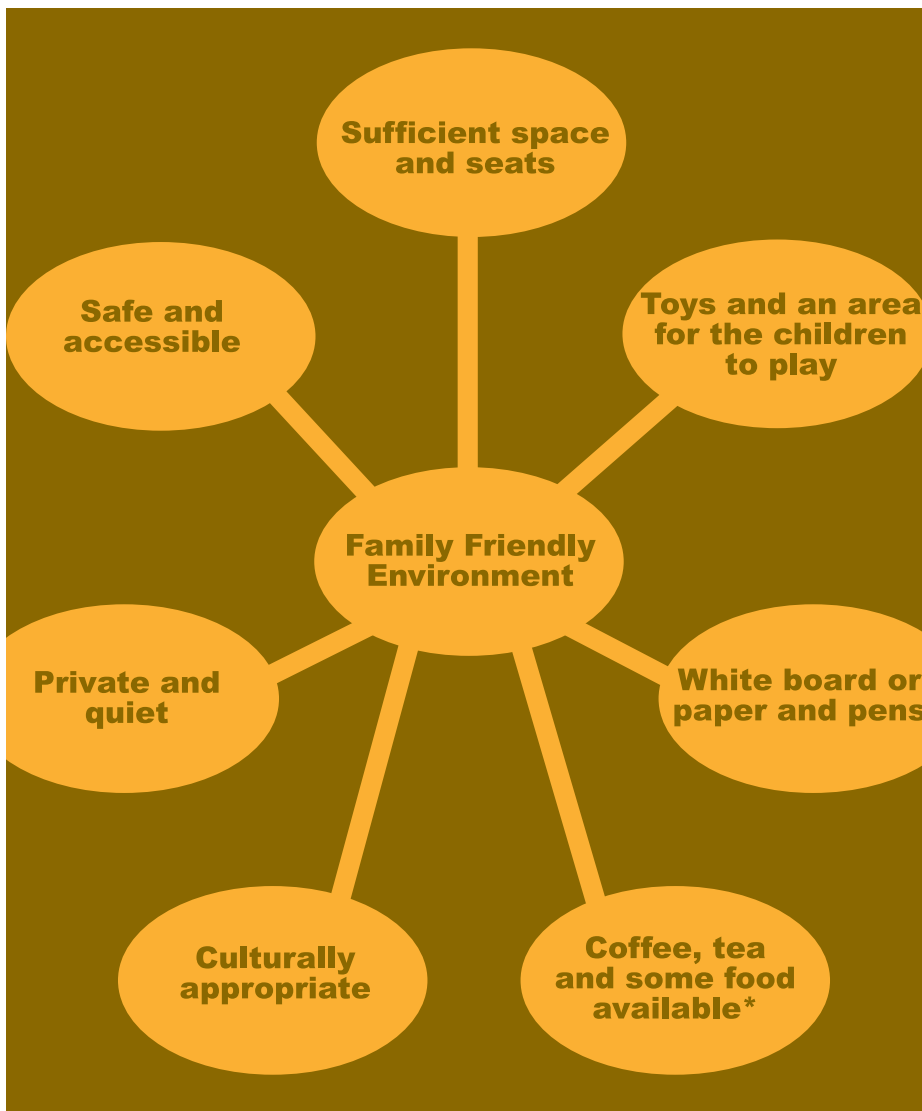
it exists within an environment that includes family, peers, neighbourhood, and the cultures that define the rules, values and behaviours' (NIDA, 2005).

Family & Whanau Friendly Environments

Working with families, whanau and significant others requires environments that are child friendly, comfortable, have a friendly atmosphere, and allow for a 'cuppa' and something to eat.* The atmosphere conveys welcome, a valuing of the family's attendance, an expectation of positive outcome and acknowledgment of different family needs, particularly those of children.

Ideally the service has a room available suitable for the family to use. Where this might not be available, other options are to use a family and whanau friendly space within another service or visit the family at home. Safety and confidentiality, counsellor experience and service expectations will influence these decisions.

*It may not always be appropriate to eat and drink in the same area that counselling takes place. Make sure an appropriate area is available.



Family Inclusive Attitudes

Working with family and whanau becomes primary to the way in which practitioners work with clients. The need to embrace working with family or whanau becomes an essential, as well as a stimulating and rewarding way to effect change. Peer support, mentoring and supervision must be available, and ongoing training in working with groups will need to be encouraged.

Find out about the policies and procedures of the workplace that cover working with family and whanau. Some services expect that two practitioners are present in sessions, particularly where there is a large family or whanau or sessions occur in the home. Some services expect a gender balance of practitioners.

Where there is a large family or whanau also consider working with other services and having inter-service relationships or co-working cases with other agencies.

If the workplace does not have any policies and procedures for working with families, or provide adequate support, take the time to work with managers and staff members to remedy this.

'It has become clear that the more support an addict or abuser can muster, the greater the likelihood of achieving and maintaining abstinence, as well as the possibility of achieving deeper characterological changes' (Galanter & Brook, 2001).

Family Inclusive Practice Skills Overview

The following pages describe some of the general issues to be considered when working with families. More details concerning the skills needed to successfully conduct sessions are found in Section 3.

Safety

In some situations the maintenance of safety becomes the primary issue and may preclude the involvement of significant others and family or require careful management to protect people. Examples of careful management could include involving a co-therapist of opposite gender, clearly stated rules, along with close liaison with other agencies, especially those providing care and protection, mental health services and services addressing family violence. If the situation is impeding the client's ability to change, residential alcohol and drug treatment needs to be considered.

Attendance of Kaumatua or Kuia at whanau hui will help maintain cultural safety.

Safety reasons for not working with family or whanau may be:

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

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

Initial Contact

At the point of receiving a referral, and before making contact, consider those people involved with the client and possibly affected by their drug and alcohol use. Whilst you may wish to make a first contact with the referred person, there are many circumstances where involving the partner, family or whanau from the outset would be highly effective. If pursuing initial contact and assessment with the client only, continue to review the involvement of others as treatment progresses.

In engaging with the referred person consent can be constructively obtained through invitation as in the following example.

Counsellor: *“Kia ora, thank you for contacting our service. We can give you an appointment on Friday at 2 pm, is that OK?”*

Client: *That's fine*

Counsellor: *Who would you like to bring to the appointment? There may be family or whanau members or a support person that can be of help to you.*

Client: *Why do I need to bring someone?*

Counsellor: *In the time we will spend together we will be talking about what's been happening in your life recently and if your support person is available they can have a part in what we call an assessment.”*

As you work together, the client will identify other people important to them in their community who will be a part of their recovery and may or may not be directly involved in the counselling.

Work with client support networks can be initiated at any stage of the client's treatment.

Allow the client to determine who it is important to involve. Younger people, in the first instance, may identify peers as their most available support system. Many European adults may identify their intimate partner as important to involve, whilst people from different cultural backgrounds may identify members of their extended family or whanau as crucial.

Beginning the Session

The skills used in greeting clients readily transfer into Family Inclusive Practice. Where appropriate make eye contact, shake hands, greet people by name and introduce yourself. Be sensitive to family structure, consider greeting more senior family members first, use appropriate language to include children and acknowledge their developing relationship with the client.

Once seated, acknowledge people's willingness to participate and their commitment to address change. Invite the family to determine how they wish to start this session. For example, a karakia, a poem or acknowledgment of those not present. Ensure people are comfortable, aware of facilities and establish how each person in the room wishes to be addressed.

Take time to make certain that children know and understand what is happening and that they will have opportunities to participate if they wish. Convey that people can relax; that children can play, that the family remain responsible for their children, and any other expectations specific to your setting.

Assessment

The assessment process can be focused on the presenting client with the family contributing or on the family processes as a whole. This will depend on the counsellor's perspective, the presenting issues at the time and the family's expectations. It is essential to commence a session with clarification of expectations.

Including family in assessment provides an opportunity to view the client as part of the family system as well as obtaining relevant clinical information from family members.

This approach acknowledges the various roles and activities of those present that could lead to ensuring effective recovery processes for all involved. Specific needs of family members could include, for example, referral for additional support for children, attendance at AIAnon, or specialist physical or mental health input.

When assessing the client, use your agency's documentation if required, or your own process and allow the family or whanau to contribute. For more information on assessments access the resource "Guidelines for Alcohol and Drug Assessment" (ALAC, 1996). The National Addiction Centre's comprehensive alcohol and drug assessment tool should also be considered.

McCrary (2005) recommends a number of screening tools specifically for family. Similarly the Family Support Scale (Hanley, Tasse, Aman & Pace, 1998) is a useful tool for detailing a client's social networks (see Appendix 1).

A widely used tool that has both assessment and therapeutic value is the genogram. This is a visual representation of family relationships, roles and patterns of addiction. It is usefully constructed on a white board in conjunction with the client. The example opposite illustrates a common method of constructing a genogram.

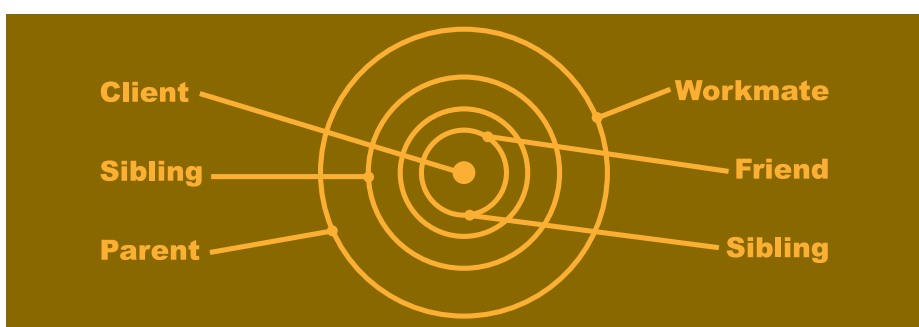
A genogram begins with the client and their immediate family and then the construction of a family tree back for at least three generations using the symbols shown in the example. A discussion is held about patterns of addictive behaviour, mental health issues, and other intergenerational issues. These are then added to the diagram. The effect of this is to emphasise the pervasive impact of addiction and can stimulate a desire to halt the family cycle of addiction.

This process is also used to identify key family members who can be included in recovery plans, particularly those who are seen to be supportive. Also, family members who have displayed resilience in the face of addiction can be identified and acknowledged.

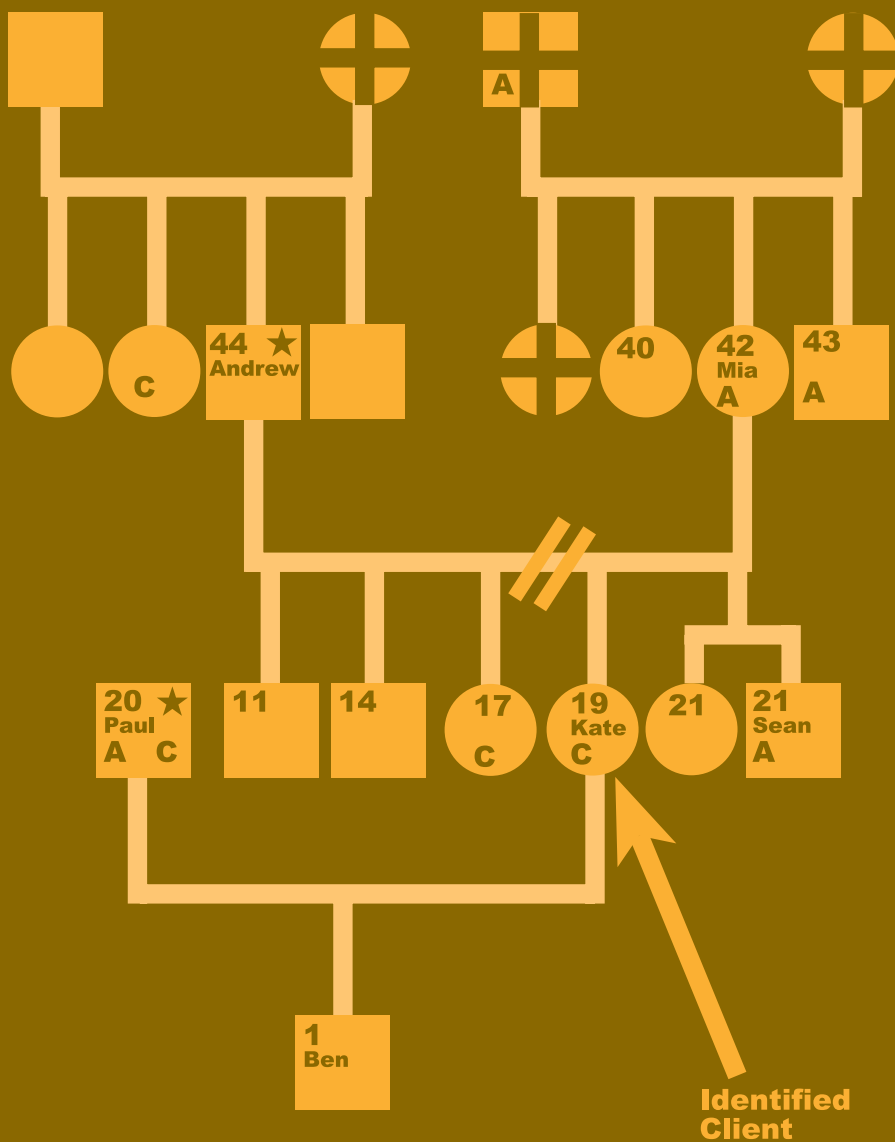
As demonstrated in the table below, use a whiteboard to help the client identify who is affected by the alcohol or drug use, who could be included in recovery planning, and who can provide additional support for the client throughout treatment.

People affected by my A&D use:	Support People:
*Jo, Partner	Jo
*Lu (14), Adam (12) and Tess (9) (Children)	Lu
Work Colleagues	Rangi
*Rangi Mum	
*People I need in my recovery plan.	

Other visual forms such as concentric circles can be used to illustrate important support people and their relative proximity to the client.



A Genogram



	= male		= twins
	= female	A	= uses alcohol
44	= age	C	= uses cannabis
	= married = children		= deceased
	= divorced	★	= include in intervention

In counselling, Kate constructed a genogram showing her family. Kate is married to Paul and has a 1 year old son, Ben. She identified the people who use alcohol and cannabis. Kate would like to give up cannabis and wants her husband and father to be involved.

The initial assessment will clarify what changes the client needs to make, their motivation, goals and who the client will work with in their recovery.

It is also useful to allow time in the assessment to identify the factors currently working well in the family that are valuable to maintain and build upon in recovery. These may include:

- Established family routines and rituals
- Effective communication processes
- Positive parenting practices
- Flexible roles and structures

It is important not to disrupt, through intervention, family routines such as childcare arrangements or family time together that provide a sense of continuity and predictability. Other inherent family qualities such as helpfulness, caring and respect for members or extended whanau support can be acknowledged and enhanced in the recovery process.

Ask questions about:

- **Family routines.**
- **How the family spends time together.**
- **What they enjoy doing.**
- **What is important to the family as a unit.**
- **The skills and attributes of different members.**
- **How the family manages stress.**
- **What else supports the family during challenging times.**

Validate the family and educate about the value of these processes through positive comment. Enjoy these stories with the family.

Assessment should also determine the level of commitment of those present, the capacity of people to support recovery and how family members are able and prepared to support each other.

'Do include significant others, family/whanau, close friends wherever possible. Not only do these people provide more information and a different perspective but they are also crucial allies in the development and maintenance of change strategies' (ALAC, 1996).

Working with Specific Family Members

Spouse or Partner: Relationship problems are usually present and high levels of dissatisfaction are not uncommon. Over time, couples unconsciously develop patterns that enable the client to continue their addiction without negative consequence. A destructive cycle develops, involving relationship stressors (particularly poor communication and limited problem solving skills), and alcohol and drug use.

The practitioner commences the process of identifying the existing issues and sets up a treatment plan with the client and their partner that addresses the alcohol and drug use and the associated problems (see example of Couples Sessions, Section 3).

There is usually an expectation that "things will get better" now that counselling has started. New communication patterns, redeveloping intimacy (including sexual intimacy) and new goals, can prove unexpectedly challenging and require input from the practitioner. Explaining why the challenges are occurring, and allowing couples to express their views and experiences will facilitate both decision-making and growth.

Regularly review the involvement of other services, such as Relationship Services or Family Violence Intervention Services to address wider relationship issues.

Children: The practitioner may not feel confident including children in family work. Ethical considerations or service policies may preclude such work, as might the perception that children are doing well.

Family Inclusive Practice supports the view that children have specific needs and also have the right to be protected, to be provided with services and to participate where appropriate.

Children are often not included in treatment, or they receive treatment that occurs in isolation through other agencies or specialised services, where the problem can remain located with the child (Gledhill, 2002).

Children that live in families with problematic alcohol and drug use are more likely to have increased emotional, psychosocial and behavioural problems. Alcohol and drug use in the family can have major effects on children and the increased risks on children are various (Fals-Stewart et al. 2004; Gledhill 1999; Lindstein 1996; Odyssey Institute of Studies, 2004). These risks include:

- Low self-esteem
- Pre-disposition to substance abuse
- Mental and physical health problems
- Experience of neglect and abuse
- Impaired academic performance
- Relationship problems

- Behavioural difficulties
- Criminal behaviour

Odyssey Institute of Studies (2004) found that many drug or alcohol affected parents were:

- More irritable and intolerant towards their children.
- Lacking quality interaction with their children.
- Inconsistent or lacking in parenting routines during periods of active drug use or withdrawal.
- Preoccupied and unable to be present for their children.

Assessment of the family may uncover concerns about the child's safety. Should this occur, care and protection issues are paramount.

Where care and protection concerns arise, referral to Child, Youth and Family Services (CYFS) is essential. Depending on the circumstances, this may or may not involve the consent of the parents.

Children may appear to be, or are reported to be doing well at home and school, but this may mask the fact that children are experiencing stress and developing patterns of behaviour that may be adversely affecting their optimum development. Claudia Black (1982) developed useful metaphors in describing some of these patterns of behaviour such as:

- An overdeveloped sense of responsibility
- Use of humour to mask feelings
- Withdrawal as a coping mechanism
- Perfectionism

An effective means of addressing these issues lies in group-based programmes for children e.g. 21 Fun Street, (Gledhill, 1999), or Alateen. If these programmes are not able to be provided locally, meet with the children and:

- Educate them about the features of addiction and treatment processes.
- Create opportunities for them to access other activities where they may develop further skills and support.
- Without disregarding any risk to children, focus and build on any resilient factors that are reported. For example, a child doing well at school, strong connections with an extended family member, sporting achievements, talents and interests.

Working With the Diversity of New Zealand Families

When working with couples, families, whanau or significant others, be open minded about family arrangements, and welcome and respect diversity. Treatment sessions will be more flexible and appropriate expectations will promote more effective outcomes.

Families reflect culture. Typically a Pakeha family is nuclear, whereas a whanau could include up to four generations. New immigrant families may well be maintaining traditional gender roles, with the man as the head of the family. Increasingly, blended families are presenting to services.

Families of Young People

'Where the client is a young person, the family is critical in both prevention and successful treatment' (Miller & Rollnick 2002, Howard 1997).

Involvement of family in treatment does need to take into account critical factors such as the stage of development of the adolescent (for instance, are they moving away from family?) and any safety concerns.

Young people often use alcohol and drugs as part of a coping strategy, when dealing with stressors such as:

- Environmental stressors, especially school, work demands
- Internal processes, including depression and anxiety
- Early exposure to alcohol and drug use
- A means of gaining attention from the people surrounding them
- Difficulties when engaging with peers
- Family tension and conflict
- Sexual identity issues

If the client is an adolescent, family or support people are included:

- To increase the support system for the client
- To rebuild the relationship
- To improve communication patterns
- To change patterns of interaction between the client and their parents and siblings

Family problems have been linked to the initiation and maintenance of adolescent drug use (NIDA, 2005). Improving the conditions in the young person's most enduring and influential environment, the family or whanau, is the key to successful outcome.

Maori Families and Whanau

There are various resources published on working with Maori families. Where possible treatment should be 'for Maori by Maori'. See Section 3 for information on working with whanau.

Pacific Peoples

Although generalisations can be made, Pacific Island cultures are diverse. The Practitioner Competencies for Pacific Island Workers published by ALAC (2002) is a useful resource. Working with Pacific Peoples requires the acknowledgement of the 'whole' person.

Immigrants

Using family as a support system may not always be possible when the client is an immigrant, as most immigrants leave their family in the country of origin. Depending on the time they have been in New Zealand, they may have built up a support system of people that they want to invite to the sessions. The use of interpreters may be necessary where English is not fluent.

'The Pacific world does not separate aspects of life, but sees life as an integrated whole. Definition of a holistic approach and how it applies will differ between different Pacific groups' (ALAC, 2000).

Asian peoples

People born into an Asian culture tend to seek professional help as a last resort due to strong family values and to avoid family shame. Having limited knowledge about the services available to them is another issue that stops them from accessing help (ALAC, 2004). This poses particular issues in engaging the client and their family. The availability of Asian counsellors will improve the attendance of this group.

Gay and Lesbian clients

'It is important to acknowledge sexual orientation when changing problematic alcohol and drug using behaviours' (MacEwan & Kinder 1991, MacEwan 1994).

The following issues will influence treatment approaches:

- 80% of gay and lesbian clients report severe social isolation
- Typically gay and lesbian clients hear anti-gay slurs 12 times a day
- One in five will attempt suicide
- 67-72% will withhold information about their orientation until satisfied they won't meet homophobic or uninformed attitudes
- 42% of homeless youth identify as lesbian/gay

Treatment needs to recognise and utilise different support structures because many gay and lesbian people identify close friends as family (MacEwan, 2005). These clients often lack the guidance of manuals, social culture, and inter-generation expectations around relationships: their conduct, their pathways or their ending. Some clients will be in multi-gendered relationships and life patterns (hetero-, homo-, bi-, trans-gendered). Successful treatment outcomes will be dependent on how well these multi-layered experiences are integrated into the intervention. Some lesbian and gay social settings have a heavy drug using culture.

Lesbian and gay clients should be encouraged to bring their partner, or close friends who are likely to be supportive of any treatment plan. The client, partner, and friends will assist the empathic practitioner with setting the context for any intervention and the practitioner should not be shy in asking for this help. Possible issues of low self-esteem, shame, family rupture, trauma, current communication problems and role expectations all need to be assessed. Some clients will have hidden their sexuality, others will, for varied reasons, be socially isolated, and a good treatment outcome will rely upon improvement in these areas of functioning.

Working in Different Addiction Contexts

Residential

Residential treatment centres all include families, whanau, or significant others in the treatment programme to varying degrees. If the centre is distant from family, this may be more difficult.

Clients that go to residential treatment for their alcohol and drug use can work more intensively on their alcohol and drug behaviours and family issues.

Methadone Clients

Methadone clients are engaged with alcohol and drug services over the medium to long term. This provides excellent opportunities for essential family work, as the stress of long-term drug use often causes troubled relationships between clients and their families. Methadone clinics work with clients and their families on:

- Family relationships
- Providing education about Methadone
- Problem solving
- Developing communication skills
- Providing support
- Advocacy, liaison and education with agencies such as Child, Youth and Family Services
- Pregnancy and maternal health needs

Compulsory Treatment

Occasionally, family members will enquire about the Alcohol and Drug Act 1969 that allows a family to commit a family member (under Section 9) or the client to commit themselves (under Section 8) to treatment for a period of up to two years.

The counsellor's role under this Act is to ensure the family have considered the implications of committal, particularly any damage to the longer-term family relationship, guide the family with the committal process and ensure there is a residential treatment bed available to receive the client.

Committal under this Act is relatively rare, good practice requires that all other avenues and interventions have been explored before it is utilised.

The Act is currently under review.

SECTION THREE

Introduction

The following set of four examples provides a specific set of guidelines for the practitioner working with couples, families, whanau, and significant others when the potential client is Pre-Contemplative.

The first three examples assume that an assessment has already been done with the identified client and that involvement of others is part of an ongoing recovery plan. For some practitioners the assessment would begin with family involvement in which case the routine assessment questions would be incorporated into the family session with responses sought from everyone present.

The following are suggested guidelines only. Practitioners will need to modify them appropriately according to the circumstances of the case.

Regardless of the family members involved, the Kawa or guidelines of the session need to be agreed before beginning work.

We all agree that:

- **Everyone is treated with respect and fairness**
- **One person speaks at a time**
- **Everyone will get a turn**
- **Anger and tears are OK**
- **Intimidation, abuse and aggression are not OK**
- **Confidentiality of all present is respected.**

Please note that each example does not stand in isolation from the others and the techniques can be interchangeable. As well as the more detailed examples below, see Appendix II for a quick check list to assist in the preparation and execution of a basic family session.

Couple Sessions

The following sessions are largely based on the work by Barbara McCrady (2005) and Fals-Stewart et al. (2004).

First Session

Introduction and welcome - ensure that people are introduced and feel comfortable and are clear about your role.

- 1.** Set the Kawa as above and an agenda for the session, planning to spend about one hour per session.
- 2.** Use a whiteboard to identify the problems experienced and identify issues that both partners are concerned about.
- 3.** Identify behaviours that trigger and reinforce alcohol and drug use, work on dysfunctional thoughts and feelings that relate to the triggers and generate discussion regarding how the couple can work on these together.

4. Identify positive and negative consequences of alcohol and drug use for both the client and their partner.

5. Identify behaviours that enable the client to continue to use alcohol and drugs, again expecting both the client and partner to work at this.

6. Set goals for alcohol and drug behaviours.

7. Ask the couple to keep a record of such behaviours, and other issues that need to be addressed, as they arise over the week.

8. Set a time for the next week for both to attend.

Second Session

1. Welcome the couple and ask for feedback on the past week.

2. Identify any behaviours that have arisen over the week that have been a problem for one or both parties. Record on a white board.

3. Review the work from last week, reinforce positive changes, treat missed goals as areas for further discussion and learning.

4. Where new problems have arisen, address these as described in the first session. Assist the couple to develop an understanding of how their interactions might contribute to problem behaviours. Help them learn to modify their patterns of behaviour so that they can take responsibility for their part in any situation.

5. If required, describe the Wheel of Change to provide an understanding of how motivation develops. This can be completed for both client and partner. Encourage the partner to respond with support where the client is in an Action phase. Reinforce the need for the client to be exposed to (negative) consequences if in Contemplation stage.

6. Identify coping behaviours and assist the couple to understand their coping style by describing three distinct ways of coping: engaged, tolerant and withdrawn coping. Work with the couple on 'engaged coping' skills. Copello et al (2000) provide the following meanings for these behaviours (these are explained in more detail in the significant other example below):

- Engaged coping means active interaction between the partner and the alcohol/drug user, attempting to deal with the problem.
- Tolerant coping involves interactions, or lack of actions, that remove negative consequences for the user.
- Withdrawn coping is an attempt to put distance between the partner and user, often by a need to look after self.

7. Ask each person to write down a list of needs of the other, and to share these. Encourage functional communication.

8. Homework can be given around engaged coping behaviours and caring for each other. For example, ask the couple to tell each other every day one good thing about the other person, or surprise each other once in the week.

9. Set date and time for the next session.

Third Session

1. Review work to date. Reinforce adaptive behaviours reported, and use a white board to record areas for further work including those goals that were not achieved.

2. Spend time talking about the surprises and treats that occurred over the week.

3. Use the process from session one that allowed analysis of problem behaviour, particularly how behaviours were maintained in the relationship. Work through any issues on the white board and review the drug and alcohol using behaviours.

4. Again, set goals for behaviours over the week, particularly those regarding drug and alcohol use and redeveloping the skills of caring for each other.

5. Subsequent sessions continue to focus on the pattern established. As drug and alcohol issues become less prominent, focus on the development of shared activities and goals.

'Alcohol travels through families like water over a landscape, sometimes in torrents, sometimes in trickles, always shaping the ground it covers in inexorable ways' (Caroline Knap in Diamond, 2002).

Family Sessions

Preparation

1. Organising a family session can seem a difficult task. Talk with the client as to a possible time and date for a meeting and how to best communicate with family members. Spend some time discussing any anxiety the client has concerning the process and content of a family session.
2. Consider an appointment letter to the family members to ensure that all are fully aware of appointment details and possible content of the session.
3. Book a family friendly room or create a family friendly atmosphere in a room available (see diagram on page 14).

The First Session

1. As an important starting point introduce yourself, your service and allow the family members to introduce themselves. When working with other cultures allow for the cultural processes to occur. If you are not sure what the correct cultural process is, check with colleagues and cultural advisor. It can be helpful to ask an appropriate family member to open the session.
2. Establish the guidelines of the session (make sure there is a copy on the wall). You may also need to agree on times for breaks. Emphasise that everyone will have a chance to participate. Spend time on this as it can assist where there is a need for structure to maintain progress, and avoid 'derailing' when there is considerable family stress.
3. The main focus of the session is getting to know the family and the problem. Use active listening skills, empathic listening skills, allow for emotions to be expressed and set achievable goals that will empower the client, family or significant others.
4. Allow for each family member to identify the problems and strengths that exist and the stressors that they experience. Using a white board allows for common issues to be identified and clearly prioritised. Assist the family to identify a problem to start working on, make sure that everyone is heard and has some level of agreement. Problem solving and negotiation are key skills to be modelled and reinforced in the session.
5. Consistently reinforce clear communication.
6. The client sets achievable goals around their alcohol and drug use and is asked to report this back in the next session. Talk with the client and the family about the risks of monitoring and establish with the client explicit means of monitoring their use. Sometimes it is helpful to limit discussion about past alcohol and drug use, to individual sessions between the client and the practitioner.
7. Sometimes it is not appropriate for children to be present, for instance, if parenting roles are being discussed. If children are present, ensure there is time allowed to address the children and explain in developmentally appropriate language, the processes that are underway. Encourage children to ask questions to determine their level of understanding, remembering that children may only wish to hear limited information.
8. Explore some of the following options for additional intervention:
 - Attending meetings e.g. AlAnon, AA/NA, GA, ACOA
 - Other Health Services including Mental Health Services
 - Residential treatment
 - Relapse prevention courses
 - Other types of specialised therapy, e.g. Family therapy
 - Strengthening Families (CYFS)
 - Education/courses
 - Children's programmes
 - Parenting programmes, employment services
 - WINZ
9. Set another appointment in a week's time and identify who will attend this session. Determine if young children need to attend further sessions and investigate other agencies that may provide additional support. eg subsidised childcare.
10. At the end of the session, where at all possible, provide information on topics and a written summary of homework.
11. Record details of the session, identifying key process details, identified strengths and goals to be worked on.

Second Session

- 1.** Preparation as is outlined above. Have the Kawa or guidelines visible in the room.
- 2.** Allow time for feedback about the last session and the last week before moving on to setting the agenda for this session.
- 3.** Working on family relationships is a key aspect of treatment. This can be done by increasing communication skills, problem-solving skills, increasing quality time as a family and developing caring behaviours (Fals-Stewart et al. 2004).
- 4.** Affirm people when they do something positive or when you notice positive change, for example “Good listening” or “That was a really good way of saying how you felt without blaming John”.
- 5.** Some of the areas that you can work on with the client and family could be:
 - Understanding the overall effect of addiction on those present to provide insight and facilitate discussion.
 - Using a genogram to deepen understanding of familial patterns (see page 21).
 - How do family members feel and react when the client uses drugs or alcohol?
 - How does it affect each one of them?
 - What are the reasons for drug and alcohol use?
 - What are current coping skills, what are the advantages and disadvantages of these and what are alternative ways of coping?
 - What changes would each one like to see?
 - Learning to communicate and work together.
 - Monitoring change, following individual steps.
 - Cultural appropriateness, continuing family traditions and culture.
 - Discussing how those present maintain resilience by effectively managing family process and developing additional skills and resources. Reinforcing any useful and healthy strategies.

You will not be able to address all of the above. Plan your session but be flexible. When working with a group of people a session may change direction. Monitor process and acknowledge shift from the original plan. Determine any changes in the session direction with the family.

- 6.** Consider homework aimed at, for example, noting communication patterns in specific contexts and practising different skills covered in the session. Alternatively, homework could be about monitoring any feedback of drug and alcohol use. Only introduce homework if the family is likely to complete it.
- 7.** Set another time to meet, let the family know that the next session will involve an evaluation of sessions to date to determine what the next steps will be.

Third Session

- 1.** Welcome the client and their family.
- 2.** Discuss and review time since the last session - have changes been made?
- 3.** Review the identified problems and goals set in the first session. Check whether they are still relevant or whether they need modifying. Steps towards family goals may be illustrated using different visual methods.
- 4.** Evaluate the work the family has completed in these three sessions and make sure that each individual feels confident to achieve the steps towards their goals. Key components are a good support system and ideas on how to care for themselves in stressful times.
- 5.** Finishing the session, poroporoaki and farewell the members that will not continue treatment in your service. Follow the process that is suitable to the client and their family.

Treatment need not stop after the three sessions. By this time there will be a clearer picture of the treatment that is needed to instill and maintain changes.

'Clients and their family/whanau are not usually at their best when we meet them. Their circumstances may cause them to be agitated, frustrated, or vulnerable and they may demonstrate erratic or emotional behaviour'
(Whiteside & Steinberg, 2003).

Whanau Sessions

He aha te mea nui?

He tangata

He tangata

He tangata

What is the greatest thing?

It is people

It is people

It is people

With consent, an effective counsellor involves whanau and social networks to assist in achieving the tangata whaiora's (client's) treatment and recovery goals. The counsellor encourages and promotes the involvement of whanau members and significant others in all aspects of assessment and intervention to find solutions to alcohol and drug related problems and other addictions.

Whanau for some tangata whaiora may not necessarily mean whakapapa (genealogy) but those that they consider whanau members.

Alcohol and drug misuse, and related problems, can often mean that tangata whaiora have disassociated or disconnected from their immediate whanau. In the initial stages of treatment and recovery, this disconnection can be acknowledged and reconnection planned. Identifying whom the tangata whaiora would like to include will help to create clarity and identify who needs to attend future whanau hui.

A long history of oppression of Maori society has contributed to the loss of mental, emotional, physical, cultural and spiritual balance. This has led to dysfunctional whanau, fragmentation of cultural traditions and loss of cultural insight, identity, structures and social networks.

A successful outcome of counselling, which is achievable over time, will be when the tangata whaiora addresses their misuse of drug and alcohol and other addictions, acknowledges their cultural identity and reunites with his or her whakapapa.

As an overall goal, the invisible patterns of thinking, behaviour and non-communication that make whanau dysfunctional need to be uncovered and transformed into healthy and positive patterns.

Implicit in these statements is the notion that cultural considerations in intervention, treatment and recovery, when working with Maori whanau, are essential and will link to successful outcomes.

It needs to be said that Maori people come in many shapes and colours and it is not too difficult to make errors in cultural identification. Within Maoridom, views about alcohol and drug use are also likely to vary greatly, so no single view can be regarded as the viewpoint of all Maori.

When working with whanau, one must not make assumptions about the extent to which a person identifies as Maori.

There is a need to be informed and sensitive to Maori cultural values and norms. A great deal is written about Maori cultural values and practices and how they relate to health. Take every opportunity to learn more about these by reading, or talking to Kaumatua and Maori colleagues.

Above all, observe the old fashioned virtues of mutual respect and courtesy.

Approaches when working with whanau.

When organising to meet your tangata whaiora whanau for the first time, check out the following with tangata whaiora, colleagues and Kaumatua :

- Do members of the whanau speak Maori?
- Is there a Kaumatua or older person from the same Hapu or Iwi as the tangata whaiora in the service or community who can assist you?
- Is the environment for the hui appropriate e.g. large enough to accommodate whanau, adequate seating and safe environment?
- Organise something to drink and eat at the completion of the welcome process.

If not already determined, ask the tangata whaiora whom they would like to attend. Prior to the meeting, get to know a little about each whanau member and their relationship to the tangata whaiora.

Te Powhiri – (Welcome)

A Powhiri is not invariably “performed” for every whanau or Manuhiri (visitor) who comes into a programme, with each service determining when it will perform a Powhiri. A Powhiri requires a lot of organising.

Those taking part must include a Kai Karanga and Kaumatua.

The Kai Karanga calls the Manuhiri (visitors) into the service.

The Manuhiri will then return the call, with women entering the hui ahead of the men. The group then sits. Speakers and senior members, usually men folk, occupy the front seats, older women and those who will support the Kai Korero (speakers) with waiata (song) sit close behind the speakers.

It is then open for hosts and visitors to exchange speeches of welcome. It is here too that the kaupapa (topic) of the meeting is discussed. On nearly all occasions the tangata whenua (host) usually speak both first and last. However, there are variations across Iwi. At the conclusion of the Powhiri process, a spokesperson for the tangata whenua will invite the visitors to cross the paepae (courtyard) to hariru (shake hands) and hongiri (touch noses). Sometimes this will be the person who delivered the final mihi (welcome), sometimes it will be the person who picks up the koha (gift). Depending upon your feelings at the time, you can hariru, hongiri or kiss, or do all three.

The hariru and hongiri – the physical contact between tangata whenua and manuhiri - remove the tapu (sacredness) that existed as the result of entering and meeting on the marae-atea or designated marae-atea. The people and the marae-atea have now become noa (free from tapu).

Whakatau – Mihi Mihi

This process is most commonly used when the meeting occurs outside of the Marae-Atea (Marae courtyard).

Both host and visitors gather together in a room, designated for the whanau hui.

Normally a Kaumatua, or elder, from the host side will open the hui. A waiata can be sung and karakia provided. If an elder is not available a Maori colleague could assist.

Participants from both sides introduce themselves and share a little about themselves.

All participants should then share light refreshments. This will be followed by the whanau hui. The process and the hui should not be more than one and half hours unless agreed to by the participants.

Welcome

Welcoming whanau in English need only occur if there are no Maori available to assist.

The counsellor takes the lead role by welcoming the visitors and inviting them to share who they are and their connections to the tangata whaiora.

Getting it right at the first hui enables the connection and purpose to be explored by both parties and lays the foundation for further hui. Trust, honesty, respect and acknowledgement are key guiding principles to establishing a working relationship and achieving the desired outcomes.

Once one of the options for the first whanau hui has been completed a whakatau or welcome is appropriate for any following meeting that might take place. A whakatau consists of a brief greeting followed by Karakia.

Session 1

Following Powhiri, Whakatau or Welcome, work with whanau can proceed. Depending on need, the following priorities could be established:

- Provide information and education to whanau about alcohol and drugs, detoxification and recovery from addiction. Future sessions can identify sources of awhi and manaaki (support) for the tangata whaiora.
- Allow whanau to discuss their fears and concerns over relapse or continuing drug or alcohol use. Develop a whanau plan to identify triggers and a plan to prevent relapse, with whanau members occupying useful, positive roles identified by the tangata whaiora.
- Encourage whanau to discuss their own whanau processes, particularly how decisions are made, communication patterns and responsibilities. Sessions detailed below can facilitate this process. Support and reinforce effective communication, including active listening by whanau and tangata whaiora.
- Determine what broader priorities exist for whanau, especially regarding finances, housing or employment. Work with whanau to address these and enlist the assistance of other agencies.

Make arrangements for next session, and close the session with a karakia.

The following sessions can be used to address priorities outlined above. Also, the family sessions (page 36) can be utilised with whanau.



Session 2

Crawford (1991) identified that a connection, a sense of belonging, can start a learning and spiritual journey that addresses feelings of loss, despair and alienation.

The Powhiri process starts this journey. Introduce the following diagram, drawn on a whiteboard, to provide a framework for further recovery.

This shows how an individual is part of a bigger system: family, relatives, their living environment, hapu and iwi. The foundation is Whakawhanaungatanga (practising the principles of Whanaungatanga), then Whanaungatanga (acknowledging the inter-connectedness and interdependence of an individual and all members of the whanau, immediate and extended family, community and bigger society), whanaunga (relatives), whanau (immediate and extended family) and then au (me).

Encourage whanau and tangata whaiora to talk through the issues raised.

- What is the reaction of each person to the diagram?
- How does the whanau experience each level? How is the foundation strengthened?
- What stories do the whanau know that convey Whakawhanaungatanga?
- Identify with whanau, what they are doing, and what they could do to strengthen the foundation.
- The tangata whaiora's role, both past and in the future, in the whanau can be discussed and strengthened.

Have whanau agree on strengthening activities that they will use before next session. Make the next appointment and end with karakia.

Session 3

Open as described earlier. Review the week, reactions to the last discussion and share how the week has been. Introduce the Te Whare Tapa Wha model (Durie, 1994). Identify the 4 cornerstones on a white board:

- **Taha Wairua (spirituality)**
- **Taha Tinana (physical body)**
- **Taha Hinengaro (the mind)**
- **Taha Whanau (family)**

Develop discussion on where the whanau is now and what needs to be done to achieve balance. Get each person to contribute in turn, following from their experience. Encourage the tangata whaiora to describe how their addiction impacts on these dimensions of health.

Write whanau comments on the white board. Gaps and imbalance will be evident. Seek solutions to this.

- Activities that whanau can engage in to strengthen weaknesses.
- Specific issues for tangata whaiora to deal with, with whanau support, to achieve balance.

Agree on the main points raised, arrange for next session and end with karakia.

Session 4

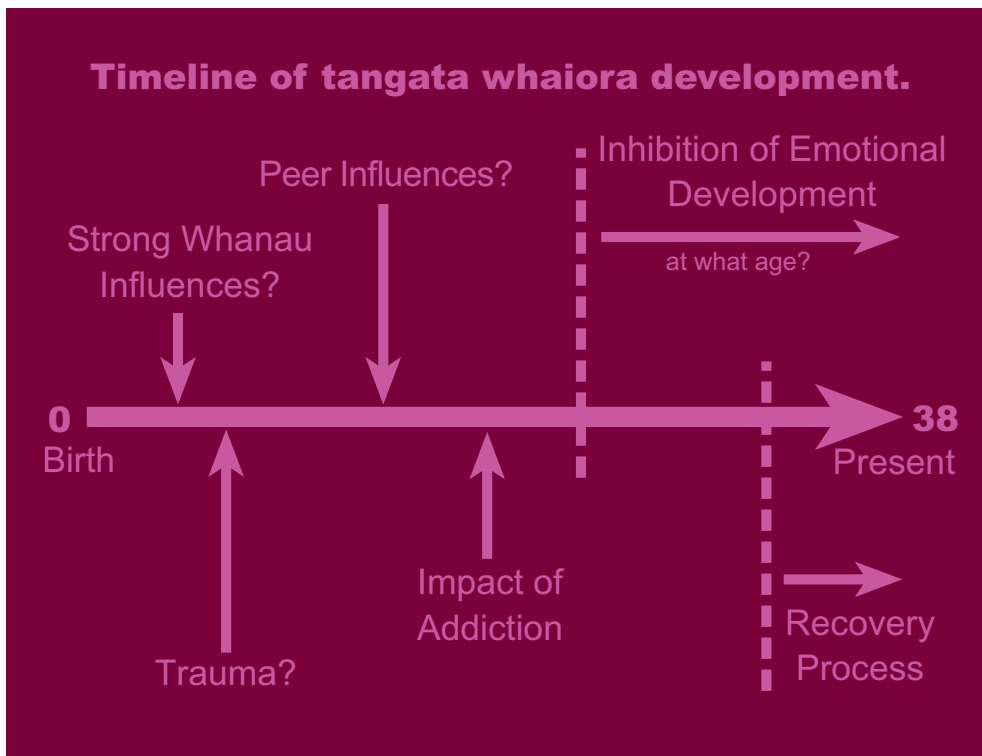
Begin as described. Allow for discussion on the preceding exercises and activities.

This session can focus on developing a greater understanding of whanau support for tangata whaiora. Whanau structure, and historical assumptions, can lead to limited support for tangata whaiora. Fear of hurting others, of causing offence, of damaging mana, can lead to tangata whaiora not asking for support. Questioning can help.

- What support does the tangata whaiora need? Explore this using the Te Whare Tapa Wha model.
- Who in the whanau has a role, and where? Encourage all to participate.
- Encourage discussion of the assumptions made e.g. that mum always provides emotional support.
- Ensure that senior whanau do not lose mana during this discussion. Do they carry a sense of responsibility for all the whanau? Is this stressful? Can it be shared?

The protection of mana of all present is crucial. As the tangata whaiora looks to other whanau members for support, reinforce and acknowledge the role of those who have occupied a traditional support role.

A developmental perspective for the tangata whaiora, and the impact of addiction, can be helpful. The following diagram illustrates this.



This diagram allows whanau to discuss:

- Early influences on childhood (usually whanau).
- Events of significance in the tangata whaiora's early development.
- Where did alcohol and drug influences occur?
- The impact of addiction, locking the tangata whaiora into a pattern of limited development.
- That the tangata whaiora, now at a certain chronological age, is not at that age psychologically. What does this mean for them, and whanau, as they enter recovery?
- A developmental perspective allows a sharing of history, an opportunity to acknowledge fears and guilt and movement of whanau from blaming.

Again, close with karakia if planning more sessions or move to the poroporoaki.

Poroporoaki

The poroporoaki, or speech of conclusion and farewell, is as important as the speeches of welcome.

It is the acknowledgement, thanks and endorsement that is delivered in a face-to-face situation between the hosts and the visitors. A poroporoaki is begun by the visitors and finished by the host. It concludes with karakia and farewell gestures.

Significant Other Sessions When Identified Client Is Pre-contemplative

This example is based on the Stress Coping Health Model (Copello et al. 2000). The focus is on the interactions between relatives and their alcohol and drug using family member or partner. A primary care provider or an alcohol and drug counsellor can deliver this intervention.

The model provides a way of helping family, whanau and significant others who are struggling with an addicted loved one who is unwilling to change.

There are six steps to this brief intervention, which are presented here in three sessions. However the steps can be undertaken in one to six sessions depending on the client and the circumstances:

Session 1

1. Getting to know the significant other and the problem – identify the stresses and strains.

- Use open questions and reflective statements to allow the person to express the problem safely.
- Encourage the expression of emotions.
- Acknowledge the person's feelings and remain interested and respectful.
- Convey hopefulness of change for the significant other, if not for the user.
- Identify the needs of the significant other and any information needed.

2. Provide relevant information about alcohol and drugs, the effects and issues of dependence.

- Discuss the substances being used and provide leaflets for the significant other to take home. Discuss their concerns about the user's health and behaviour.
- Discuss the nature of dependence, and some common dependent behaviours.
- Discuss treatment options for the user if that is relevant.

Session 2

3. Describe the following three ways of coping with excessive drug or alcohol use in the family.

- Be careful not to convey to the significant other the impression that he/she is not coping.
- Discuss engaged coping, tolerant coping, and withdrawn coping styles as shown below. Ensure that the significant other understands that each coping style has positive and negative aspects to it. Tolerant coping, especially if it is self-sacrificing, is associated with worse physical and psychological problems.

Engaged Coping - involves active interaction between the relative and the alcohol and drug user, which is focused on attempting to deal with the problem. Gives the significant other a sense of doing something positive but assumes responsibility for user's behaviour change, and angry/hurt when change does not happen. Can cause stress and a sense of resentment in the user.

Tolerant Coping - can involve 'enabling' behaviour or lack of action. The user does not suffer negative consequences. The significant other makes excuses for the user and can feel powerless, guilty and taken advantage of. Conflict is avoided.

Withdrawn Coping - avoiding interaction with user, resulting in distancing from the user usually for self-preservation reasons. Pursues own interests. The significant other can feel self-reliant or hurt, but avoids becoming over-involved. May also feel guilty about rejecting/excluding the user, and the user may play on this.

4. Exploring how the significant other is coping.

- Get the significant other to identify what coping style he/she is currently using, and other styles that have been tried.
- Discuss how he/she feels about the styles of coping used.
- Discuss the feelings associated with the other styles of coping.
- Discuss the advantages and disadvantages of changing styles of coping, with the option of maintaining a withdrawn coping style while the client remains precontemplative.

Session 3

5. Exploring and enhancing social support.

- People who experience the effects of a dependency problem of a loved one are often not supported by their relatives and friends. Poor communication and disagreements about coping strategies can lead to potential support people distancing themselves.
- Unsupportive people tend to:
 - encourage user's behaviours
 - condemn the user
 - be uninvolved in, uninformed about and/or condemning of the situation
 - give unhelpful advice.
- Discuss and review available support with the significant other.
- Aim to recruit or enhance positive sources of support.
- Aim to neutralise or reduce sources of unhelpful influence.
- Enlist the help of one or two other key family members.
- Encourage more communication in the family.

6. Ending and discussion of the need for further help (self and user).

- The counsellor will expect to continue to provide support for the significant other while it is needed, and whether the user seeks help or not. Couple, family or whanau counselling may then be possible.
- There may be reasons to refer the client on for his or her mental or physical health.
- The client's family, children, or the user may also need specialist assistance.
- The clinician needs to maintain a high level of knowledge of available and appropriate local services for referral and to be able to suggest the referral sensitively.
- Once the client's ability to cope or circumstances have changed sufficiently to improve presenting issues, a final session would cover strategies to: cope with future problems, maintain supports, and enhance self-care.

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Appendices

Appendix I

FAMILY SUPPORT SCALE (adapted from Hanley, Tasse, Aman & Pace, 1998)

INTERVIEWER:

READ THE FOLLOWING: *I'm going to read you a list of people and groups that often are helpful to members of a family raising a young child. Please choose one of the numbers on the card to describe how helpful sources have been to your family during the past 3 to 6 months. If a source of help has not been available to your family during this period of time, tick the "not available" response.*

For example, if your parents were not helpful to your family during the past 3 to 6 months, choose (1) – "Not at All Helpful". If they were sometimes helpful choose (2) – "Sometimes helpful". Choose (3) if they were generally helpful, (4) if very helpful and (5) if extremely helpful. If your parents are no longer living, choose (0) which tells me they were not available during this time period.

NAME	DATE

	0 Not Available	1 Not at all Helpful	2 Sometimes Helpful	3 Generally Helpful	4 Very Helpful	5 Extremely Helpful
1 Your parents						
2 Your spouse or partner's parents						
3 Your relatives/ whanau (other than parents)						
4 Your spouse or partner's relatives						
5 Spouse or Partner						
6 Your friends						
7 Your spouse or partner's friends						
8 Your own children						
9 Other parents						
10 Co-workers						
11 Parent groups						
12 Social groups/ clubs						
13 Church members/ minister						
14 Your family GP						
15 Early childhood programmes						
16 School/ day care centre						
17 Professional helpers (social workers, therapists, teacher, etc)						
18 Professional agencies (public health, social services, mental health, etc)						

Appendix II

Family Friendly Environment Checklist

- Sufficient space and seats
- Toys and an area for the children to play
- White board or paper
- Coffee, tea and some food available
- Culturally friendly environment
- Private and quiet
- Safe and accessible

Family Inclusive Practice Skills Checklist

- Identify who has been affected by the alcohol and drug use
- Recognise the role of the family or whanau or significant other
- Identify support people
- Clarify who will be involved in the sessions
- Seek consent from the client
- Be responsive to cultural and other specific needs
- Inform the client and family of the client rights, processes, timeframes etc; be transparent
- Introductions
- Set Kawa or guidelines
- Set agenda
- Get to know the family or whanau or significant other
- Identify the problems
- Set goals for the client around their alcohol and drug use
- Set goals for the family or whanau or significant other
- Steps to achieve goals
- Make another appointment
- Identify if referrals need to be made
- Explain referral processes

Appendix III

Helpful websites and contact details to access assessment tools and treatment manuals.

- Brief Behavioural Couples Therapy for Alcohol and Drug Abuse Manual and other manuals available on www.addictionandfam.org
- Coping Questionnaire: Alex Copello, University of Birmingham, School of Psychology, Birmingham, UK
- Family environment scale: www.mindgarden.com
- Communication Patterns Questionnaire by Christensen A, & Shenk J.L. (1991) *Communication, conflict and psychological distance in non distressed clinic and divorcing couples*. *Journal of Consulting and Clinical Psychological* 59, 458 - 463
- www.genogram.com
- Mental Health Commission
www.mhc.govt.nz
- Ministry of Health, DHB Toolkits, Guidelines for Practitioners
www.moh.govt.nz
- Resiliency Links
www.resiliency.com
- Substance Abuse Mental Health Services Administration. USA
www.samhsa.gov/about/content
- Kina Families and Addictions Trust
info@kinatrust.org.nz

Kina Families and Addictions Trust

Kina Trust (Kith and Kin Whaanau Whaanui, Families, Children and Addictions Trust) is a Charitable Trust that promotes the development of services and programmes that are inclusive of the needs of families and children affected by alcohol and drug addictions.

Kina Trust was established in 2002 by professionals who were concerned with the lack of services provided for families and children in the addictions field.

For a range of reasons most alcohol and drug services are delivered in settings and with practices that exclude meaningful involvement of family or significant others.

The Trust aims to support research in current practice and advocates for family inclusive practices for alcohol and drug counsellors.

When a person has an alcohol, drug or other addiction problem it is also a family and community issue. Involving family in the process means more chance of successful recovery

(Kina Trust, 2004).

For more information contact

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