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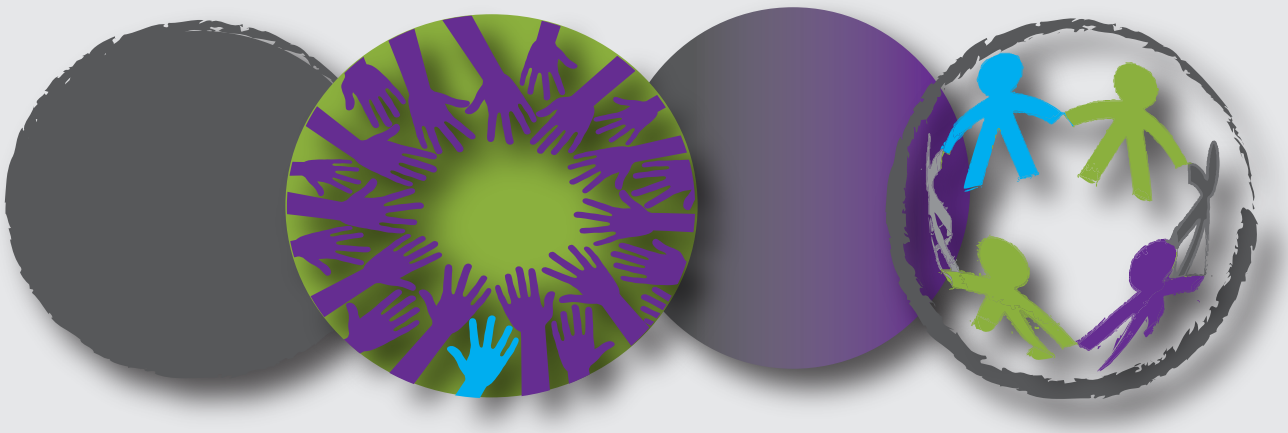
THE family eclipse PROGRAM

# Summary Evaluation Report

## APRIL 2014

An Odyssey House Victoria Program for young people affected by co-occurring mental health and substance use issues - and their families



# Acknowledgements

We would like to sincerely thank the staff of the Family Eclipse Program for their work in data collection and participation in the focus groups. In particular we would like to thank the Program Manager and Developer, Miranda Manning for her commitment to and total backing of this evaluation. We would also like to thank Neos Zavrou and Stefan Gruenert at Odyssey House Victoria for their support and helpful comments. Thank you also to Professor Sharon Dawe for her assistance with this project and writing the foreword. We would also like to thank the many families who took the time to participate in the evaluation of this program; their input has been invaluable. Thank you to all the agencies that supported the project through referrals and case consultations. Thank you in particular to Kristen Tulloch for her dedication in interviewing the families. Thanks also to Elodie O'Connor, Ann-Marie Polemeni, Eloise Leeson-Leahy and Evelyn Tan for their assistance with data entry, analysis and review of the literature. Thank you to Anita Fraser for her wonderful graphic design work. Finally, many organisations have assisted this program by providing accommodation for program staff and referrals, especially:

- Taskforce Community Agency Inc (project partner)
- Interact Australia (project partner)
- Western Headspace
- SEADS (South Eastern Alcohol and Drug Service)
- WYCH (Windana Youth Community House )
- YSAS (Youth Support and Advocacy Service)
- Banyule Community Health Service
- ARAFEMI
- SHARC (Self Help Addiction Resource Centre)
- Orygen Youth Health

**Program developed by:**
The Family Eclipse Program was developed and operated by Odyssey House Victoria.

**Program funded by:**
It was funded by the Australian Government Department of Social Services. Deakin University was commissioned to evaluate and document the Family Eclipse Program by Odyssey House Victoria.

**Evaluation/Report conducted by:**
This evaluation was developed and conducted by Associate Professor Petra Staiger, Mr James Williams, Ms Caroline Long, Dr Hayley Matic, Dr Linda Byrne.
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# Foreword

Managing the transition from adolescence to young adulthood is far from straightforward in contemporary Australian society. Challenges are thrown at young people from all directions: the competitiveness of the educational system with a growing emphasis on academic achievement, negotiating the complexities of early intimate relationships, the added pressure associated with social media, the growing rate of unemployment for those transitioning from school to the work place. Add to this the complexities of trying to manage a serious emotional and psychological problem in a society where alcohol and other substances are readily available, relatively inexpensive and, on the face of it, a quick solution to the complex problem of great emotional pain. This is the experience of the majority of the young people who took part in this evaluation. They are young, actually very young, with an age range from 16 to 24 years. Their rates of serious mental health problems are high and these are co-morbid with substance abuse problems. Notably substance use has been a longstanding problem, an average of 7 years equates to approximately one third of your life, if you are 21!

Sadly, all of this is very familiar territory for those of us who have been working in the field for many years. Our longitudinal studies from both Australia and internationally, have provided us with a clear picture of the rates of co-occurring mental health and substance use problems in young people. What is new in this study, is the focus on families. Somewhere in amongst our efforts to help young people and develop services that provide an accessible and integrative approach to managing both mental health and substance misuse, we have neglected to ask, what is in my view, some of the most critical questions: "Who is your family?" "How is your family?" "When did you last feel connected to your family?" and in this process: Involve family members in the treatment of young people. Support family members and help repair some of the rupture in relationships that often results from engagement in substance abuse. Help reconnect young people to those who often care most about them, who flounder in understanding how to help and who often unwittingly place even greater pressure on a vulnerable young person.

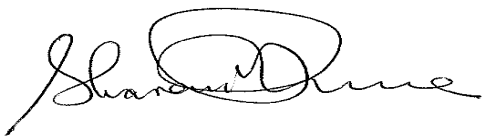
Family Eclipse is an Australian first. The program developers have taken the research evidence as their starting point and developed an integrative service that addresses the many complex issues I have described above. The current evaluation provides considerable encouragement that such an approach offers an innovative and effective approach that results in a stronger, more supportive family environment. Young people reported that the quality of communication and emotional support had improved. Their family members similarly reported that life was better: there was clearer family communication and carers were feeling less anxious and more hopeful about the potential for ongoing improvement.

Family connections can be one of the most important protective factors in a young person's life. These are vital in the presence of highly impactful risk factors. Changing the balance by supporting the family environment makes complete sense. Let us hope this evaluation will lead to even greater service development for this ultra-high risk group of young people.

Professor Sharon Dawe

School of Applied Psychology

Griffith University, Australia



7th May 2014

# Brief Summary

## The Family Eclipse Program

- The Family Eclipse Program (Eclipse) is a family intervention for young people aged 16-24 years who have been diagnosed with one or more co-occurring mental health and substance use issues, together with those people they identify as their family.
- The program was developed by Odyssey House Victoria drawing upon best practice family intervention approaches for this target group.
- Eclipse staff have experience in mental health, AOD & family therapy. They provide assessment, intervention, referral to young people and their families, as well as secondary consultation to youth services that are faced with the distressed and vulnerable families of a young person. Eclipse clinicians are often co-located within youth services.
- Funded by the Australian Government Department of Social Services; formerly the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA).

## The Evaluation

- An independent evaluation led by Associate Professor Petra Staiger, School of Psychology, Deakin University was commenced within 6 months of the Eclipse program's establishment.
- The evaluation utilised a mixed method design which included staff and client consultations and a longitudinal outcome study of the intervention only, with family interviews occurring 3 months post treatment completion.
- The evaluation involved 236 clients (75 families) who reported high levels of stress, family tension, mental health disorders, significant substance misuse, trauma and intergenerational distress upon entry into treatment.

## Key Findings

- The majority of **young people presented with multiple mental health problems.**
- Their family members reported significant stress and burden as carers.
- **Treatment outcomes were very positive:** Young people and their family members reported **statistically significant** and in most cases **clinically relevant** improvements in family functioning, mental health and quality of life after attending the Eclipse program.
- **88% of families reported high levels of satisfaction** with the program upon completion.
- Young people reported **significant decreases in cannabis use** during the treatment program, however these gains were not maintained.
- Evidence of improvement in social relationships and decreases in stress in family members.
- Evidence of prevention/early intervention of family problems, **reducing likelihood of demand for tertiary services by family members.**
- Clients were positive about the Eclipse program's unique service and family members reported greater understanding of the young person's mental health problems as well as the service system.
- Eclipse staff reported an **increased understanding of Family Inclusive practice** amongst staff in co-located services.

## Recommendations

- Given the promising findings and the program's unique mandate, it is recommended that Eclipse funding continues. Further consolidation and continued support will enable its full potential to be realised.

- It is recommended that state and national policy and reforms consider Family Inclusive Intervention programs such as Family Eclipse being delivered within youth mental health and alcohol and drug services.
- It is recommended that the current findings be disseminated to the wider service community to inform and enhance practice change for this complex client group, who often fall through the gaps due to multiple interacting impairments, poor compliance and service limitations.
- We recommend skills sets for clinicians in both AOD and MH sectors that should have as a base (minimum) Family Inclusive practices but should increase to more systemic family based interventions.
- It is recommended that ongoing evaluation, professional development and review be considered a fundamental part of the program. It is preferable if a replication of the evaluation could occur to ensure that best practice is supported by rigorous empirical support.
- It is recommended that families are linked into local community supports in order to maintain the gains achieved during the Eclipse intervention.
- It is recommended that the young person is aware that they may require longer term alcohol and drug treatment in order to reduce use.
- It is recommended that following program completion, the young person is linked with longer term alcohol and drug treatment (if required) in order to reduce use.

## Summary of Previous Research

- Reviews have found evidence that family therapies are effective in treating substance use problems (e.g., Cynthia L. Rowe, 2012; Williams & Chang, 2000), specific psychological disorders (e.g., externalizing disorders; see Slesnick, Guo, & Feng, 2013) and have been found to be improve family functioning (Yuen & Toumbourou, 2011).
- Few studies have examined the impact of family interventions in the treatment of clients with dual substance use and mental health diagnoses.
- While evidence for the effectiveness of family therapy programs in assessing behaviour problems and family functioning is good, evidence for the efficacy of family therapy in addressing substance use is mixed. In addition, in studies which do report improvements in substance use, unfortunately there is only limited evidence to suggest that treatment gains are maintained (Thompson, Pomeroy, & Gober, 2005).

# Summary Report

## Introduction

The Family Eclipse Program (Eclipse) is a family intervention for young people aged 16-24 years who have been diagnosed with one or more co-occurring mental health and substance use issues, together with those people they identify as their family. The program is co-located in selected youth services across metropolitan Melbourne. The Odyssey House Victoria program uniquely combines: (a) strengthening the capacity and resilience of families (who are most often the primary support for young people with chronic mental health disorders), with (b) responding to the specific mental health and substance misuse issues of the young person.

Working with the young person in the context of their family has a strong evidence base (Diamond & Josephson, 2005; Rowe, 2010, 2012; Sprenkle, 2012) and yet is often not part of therapeutic practice in mental health and substance use settings. This program addresses this gap by providing a family inclusive service as well as working collaboratively with youth, mental health (MH) and alcohol and other drug (AOD) services.

This report draws together the results of an independent formal evaluation conducted by a research team led by Associate Professor Petra Staiger within the School of Psychology at Deakin University. The purpose of the evaluation was to examine the efficacy of the Eclipse Program between July 2009 and April 2012 and provide key recommendations based on these outcomes. To our knowledge this is the only formal evaluation of a family therapy program of this type in Australia i.e., a program **embedded** within the service sector working with young people with a dual diagnosis and their families.

## Context

The Eclipse Program is funded by the Australian Government Department of Social Services, formerly the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). It began in 2008 in response to increased awareness of the profound impact on family functioning and well-being when a family member has mental health and/or substance use issues. A key aim is to enhance supports for affected young people. The service provides intervention to the family system and its individuals, and ensures active linkage to appropriate services that can provide ongoing care beyond involvement with Eclipse. In addition to intervening therapeutically, the Eclipse clinicians negotiate collaborative relationships with professionals from other systems, particularly those systems within the mental health and alcohol and other drugs sector, within which program participants are involved or require referral.

The Eclipse program is unique in the Australian context and as such can be seen as experimental. Its activities have complemented other parallel initiatives that promote inclusion of family within these sectors. Since the inception of the Eclipse program, there have been policy changes to have a more integrated system for individuals with co-occurring mental health and substance use and a greater awareness of the benefits of involving families. Despite this, anecdotally, it seems the two sectors still remain dominated by an individual-based approach where family members are not included, and in some cases families are actively excluded. At the time of writing this report, both service sectors are undergoing a reform process and family involvement in treatment has been recognised in this. Victoria's *Mental Health Bill 2014* (the Bill) was passed in parliament on 26 March 2014, scheduled to commence on 1 July 2014. The Bill is a key element to the government's mental health reform agenda. It recognises the important role of families and carers in supporting the recovery of people living with mental illness and places individuals and families at the centre of mental health treatment and care. Proposed changes for the AOD service sector indicate continued support to families in their own right. Although minimal, they have included brief family involvement as an aspect of service delivery in an individual's treatment experience.

These changes however fall short of a truly integrated system that growing evidence demonstrates improved client outcomes are achieved when families are part of the interventions. Families and young

people traditionally approach services because they are in crisis. Families are often the principal enduring support of young people and are often polarised and consequently fragmented as a consequence of coping with a young person struggling with their symptoms**. In essence a stressed and fragmented family environment is coupled with an equally fragmented service system.** Family Inclusive practice across AOD Services and MH services is variable. At one end of the continuum, the focus is on the individual. At the other end, including families equates to the provision of support, psycho-education, assessment and treatment planning as a means to support the young person's participation in treatment, rather than to benefit the family system as a whole. The distinctive feature of the Eclipse program is that it views the family system as the focus of treatment rather than just the young person. The program considers the developmental context of the family life cycle and identifies dysfunctional family dynamics and communication patterns. Interventions aim to promote new family characteristics that increase family resilience and functional interaction to sustain longer term positive outcomes.

The Eclipse program endeavours to reduce the family fragmentation that can escalate in a service system that is individually focused. Its focus is to integrate treatment (MH and AOD) pathways where the MH and AOD sector continue to struggle with integrated pathways or shared care arrangements for clients.

Current interactions between many AOD & MH services function in the following ways:

- Services engage independently with the young person, and consider the family as a separate entity from the young person
- Involvement between services is often fragmented or irregular
- Involvement and contact with the family is generally initiated by the family. As services are not geared towards involving the family, interactions are often strained

Eclipse acts as a link between the services, the young person and their family. It leads to improvements in service pathways in the following proposed ways:

- Youth services value and engage in Family Inclusive practice when appropriate
- Families have a greater understanding and feel connected to both the AOD and MH services involved in the young person's treatment
- The young person feels a greater connection and understanding about how services can strengthen families to support them

## The Family Eclipse Program

One of the primary aims of the Eclipse program is to improve the relationship between the affected person and their family. That is, the program aims to increase the family's understanding of the interactions between mental illness, substance use and family dynamics. Also to build awareness and skills in communication, managing stress and coping. Session content may also include anger management, problem solving, conflict resolution, parenting boundaries, emotional regulation, communication skills, stress vulnerability, self-care and sleep education.

The program is informed by a family behavioural therapy framework (see Carroll & Onken, 2005; Godley & Godley, 2013). It incorporates psycho-educational components with other therapeutic approaches such as Motivational Interviewing (Carroll et al., 2006; Korcha, Polcin, Evans, Bond, & Galloway, 2014; Martino, 2013) and strength-based family interventions (Walsh, 2003). It includes case management and crisis support. Given families present in many different forms, a 'family' is considered to be a young person (with a co-occurring disorder) and one or more other family members, consisting of any identified carer(s), such as (but not limited to) the parent, step-parent, grandparent, partner, sibling or cousin. It uses an integrated approach that combines family interventions (i.e., systems thinking and behavioural family therapy) with interventions suitable for co-occurring mental health and substance abuse. The program incorporates case management with active referral to relevant services for longer term management. The program is co-located in sites across Melbourne to facilitate access and accepts referrals across metropolitan Melbourne. The length of time families attend is flexible, according to the needs of individual families. The young person and the family also meet independently to build rapport

and support individual goal achievement. Sessions occur weekly or fortnightly and reduce over time with improvement. Afterhours and individual sessions are provided to support the process.

## Primary Goals of the Program

- Reduce the young person's problematic use of substances and associated problem behaviours
- Reduce anxiety and stress in young people and their family members
- Increase the families' understanding and response to the young person's co-occurring mental health and substance use problem
- Improve family functioning
- Reduce experience of carer burden in relevant family members
- Enhance quality of life and social relationships in all family members
- Increase the confidence of family members to seek assistance to meet their needs
- Actively link and support engagement to appropriate services

The program has four stages: Engagement, Assessment, Treatment and Conclusion

## Engagement Stage

The clinician works on engaging relevant family members whilst building rapport and engaging with other services involved at this stage. The primary goal of this phase is to engender willingness among family members to work collaboratively with the clinician. The Eclipse clinician works with the person that first presents. The program is explained and that person is mobilised and supported to bring other family members to an orientation session, at which point the family agree to participate and assessment is commenced.

## Assessment

The young person has an individual assessment to ensure an accurate portrayal of their circumstances is disclosed and the family are involved in a family assessment. This is followed by a family session to share assessment outcomes and develop a treatment plan that includes personal goals that may be the focus of family goals. Assessment and goals are monitored and modified throughout the family's involvement with the program. Assessment involves understanding the substance use, mental health conditions, legal concerns, family functioning, living situation, social connections and school and vocational circumstances.

## Treatment/Service Linkage

This phase includes addressing the mental health and substance use issues of the young person and often involves referral to relevant services not already in place. Family treatment (including the young person) includes psycho-education, where participants learn relevant information about the mental illness, medications, substance use, and the treatment of dual disorders. This information is essential to help participants understand the role of substance abuse in worsening the course of the mental illness, along with the importance of medication or other therapies for the management of the mental illness. The information is often repeated throughout the treatment experience, as family members grapple with its significance and implications for family life.

Skills training in family communication and problem solving are also components of this stage. Specific coping strategies are introduced to reduce stress and deal constructively with the problems created by both conditions. Family are encouraged to engage in activities that bring back fun and family connection. Homework to encourage these activities is vital, as is the use of solution focused strategies. The use of Structural and Strategic Family Therapy approaches are beneficial in addressing unhelpful family patterns of interaction and role definitions, particularly where interactions support problem behaviour, exacerbate symptoms and family dysfunction.

## Conclusion

In this phase, the clinician reviews the family's accomplishments, clarifies continued involvement with other services, potential problems are discussed and plans for responding to relapses in psychiatric symptoms or substance abuse are reviewed.

# Program Evaluation

## Design

The design was a mixed method evaluation of the Family Eclipse Program. Due to ethical considerations it was not possible to include a 'no treatment' group as a comparison. In this respect the evaluation needs to be considered as preliminary, although its mixed method approach adds weight to the strength of the methodology. The evaluation consisted of three parts: (1) client outcome evaluation, (2) client feedback and (3) staff consultation. Clients were interviewed face-to-face or over the telephone at three time intervals, the beginning of the program, at program completion (T2) and three months post completion (T3 - Follow up). Staff participated in focus groups at two time points to review their experience of the work.

## Procedure

Between July 2009 and April 2012, families attending the Eclipse were invited to participate in a formal evaluation of the program. Relevant ethics approval was granted. Once informed consent was obtained, families underwent an interview and completed a questionnaire. Treatment was commenced and upon completion an interview and a questionnaire was re-administered. An independent researcher completed the final interview over the phone three months post treatment completion. At this stage, as part of the interview, open ended questions were asked regarding client experiences and satisfaction with the program. Staff focus groups were conducted in order to gain an understanding of their experiences with this type of work. The first was held at the initial implementation phase of the program and again when the program was established.

## Evaluation Outcome Measures

The table below outlines the outcome measures utilised in the evaluation. All measures were psychometrically valid instruments and were directly linked to the proposed goals of the program.

| Domains assessed | Measures |
|---|---|
| **Family Functioning** | The Family Assessment Device (FAD; Epstein, et al., 1983) includes subscales for Communication (clarity and directness), Affective Responsiveness (ability to experience and respond emotionally) and Affective Involvement (involvement of family members with each other) |
| **Mental Health** | Behaviour and Symptoms Identification Scale-32 (BASIS-32; Eisen, et al., 1986) assessed impulsive behaviours, physical health, mental health and social relationships |
| **Alcohol and Drug Use** | Average alcohol and drug use over the last 30 days - Addiction Severity Index (ASI: McLellan, et al., 1996) |
| **Quality of life** | Quality of Life - World Health Organisation Quality of Life - BREF (WHOQOL-BREF, 1996) |
| **Impact of Caregiving** | Experience of Caregiving Inventory (ECI; Szmukler, et al., 1996) |
| **Client Satisfaction** | Qualitative questions |

## Participants

During the period between July 2009 and April 2012, all families were invited to participate in the evaluation. Seventy-five families (236 participants – 75 young people) out of a potential 91 eligible families (81% or more than four in every five families) provided informed consent to participate in the Eclipse evaluation.

Two thirds of the young people reported involvement in a past traumatic event (59%) and the same proportion reported legal issues at some time in the past. Alcohol (80%; to intoxication 60%) and cannabis (72%) were their most frequently reported drugs used, with heroin use being reported in about half of participants (over half were on pharmacotherapy - Methadone/Buprenorphine; 56%). Table 1 and 2 provide the demographic characteristics of the families and young people.

Table 1. Demographic characteristics of young people (N=75)*

| **Demographics** | | | |
|---|---|---|---|
| **Age** | **Average** | **Range** | |
| **Young people** | 19.1 | 16-24 | |
| **Gender** | **Number** | **Percentage** | |
| **Female** | 27 | 39% | |
| **Male** | 42 | 61% | |
| **Relationship status** | | | |
| **Single** | 58 | 77% | |
| **In a relationship/Defacto** | 8 | 11% | |
| **Psychiatric diagnoses AXIS 1** | **Number** | **Percentage** | |
| **Mood disorder(includes bipolar)** | 51 | 69% | |
| **Anxiety disorder** | 34 | 46% | |
| **Schizophrenia/Psychosis** | 10 | 14% | |
| **Autism Spectrum Disorder** | 3 | 4% | |
| **ADHD** | 7 | 9% | |
| **Conduct disorder** | 1 | 1% | |
| **Substance use** | **Average age at first use (years)** | **Average no. of years used** | **Number (%)** |
| **Alcohol** | 14.8 | 7.1 | 60 (80%) |
| **Alcohol to intoxication** | 14.5 | 7.4 | 45 (60%) |
| **Heroin** | 15.7 | 5 | 23 (31%) |
| **Sedative/Hypnotics** | 12.8 | 4.7 | 24 (32%) |
| **Cocaine** | 10.2 | 4.9 | 21 (28%) |
| **Cannabis** | 15.7 | 7 | 54 (72%) |
| **Hallucinogens** | 14.6 | 4.6 | 25 (33%) |
| **Methadone/Buprenorphine** | 15.9 | 4 | 42 (56%) |
| **Amphetamines** | 14.8 | 5.1 | 28 (37%) |
| **Referral source** | **Number** | **Percentage** | |
| **ARAFEMI** | 3 | 4% | |
| **Child Protection** | 8 | 11% | |
| **Schools** | 2 | 3% | |
| **Mental Health** | 26 | 36% | |
| **Odyssey Services** | 12 | 16% | |
| **Pamphlet** | 1 | 1% | |
| **AOD Services** | 20 | 27% | |
| **Youth Community Houses** | 1 | 1% | |

*Missing data means not all percentages add up to 100

Table 2. Demographic characteristics of family members (N=161)

The incidence of family members receiving treatment in the past for psychological disorders was also relatively high (41%). Significant others (161 participants) were most commonly parents or guardians.

| Gender | Number | Percentage | |
|---|---|---|---|
| Female | 92 | 56.8% | |
| Male | 58 | 42.6% | |
| **Relationship to young person** | **Number** | **Average age (years)** | **Age range** |
| Parent/Guardian/Aunt | 119 | 48.6 | 37-59 |
| Siblings | 31 | 19.1 | 13-25 |
| Grandparents | 5 | 76 | 75-77 |
| Young Person's Partner | 5 | 21.4 | 18-25 |
| Cousin | 1 | * | |
| **Relationship status** | **Number** | **Percentage** | |
| Single | 33 | 21% | |
| Relationship/Married/Defacto | 86 | 54% | |
| Divorced/Widowed | 13 | 8% | |

*Missing data

# Treatment Outcomes

The table below demonstrates statistically significant increases in positive family functioning and quality of life in addition to significant reductions in mental health in a relatively short time frame (average number of sessions = eight) for clients.

Table 3. Treatment Outcomes associated with participation in the Family Eclipse program.

| | | *= Statistically Significant positive outcome | |
|---|---|---|---|
| | **Measure** | **Results** | |
| | | **Completion** | **Follow up** |
| **Young People** | **Family Functioning** | | |
| | **Quality of communication among family members** | | ✓* |
| | **Quality of emotional expressiveness within the family** | | ✓* |
| | **Quality of emotional involvement with family members** | | |
| | **Mental health** | | |
| | **Difficulties relating to other people** | ✓* | ✓* |
| | **Symptoms of Depression & Anxiety** | ✓* | ✓* |
| | **Difficulty experienced in daily life** | ✓* | ✓* |
| | **Impulsive and addictive behaviours** | ✓* | ✓* |
| | **Psychosis** | ✓* | ✓* |
| | **Quality of Life** | | |
| | **Overall perception of quality of life** | ✓* | ✓* |
| | **Substance use** | | |
| | **Alcohol use (number of drinking days)** | | |
| | **Cannabis use (number of days cannabis was used)** | ✓* | |
| **Other Family Members** | **Family Functioning#** | | |
| | **Quality of communication among family members** | | ✓* |
| | **Quality of emotional expressiveness within the family** | | ✓* |
| | **Mental Health** | | |
| | **Difficulties relating to other people** | ✓* | ✓* |
| | **Symptoms of Depression & Anxiety** | ✓* | ✓* |
| | **Difficulty experienced in daily life** | ✓* | ✓* |
| | **Quality of Life** | | |
| | **Overall perception of quality of life** | ✓* | ✓* |
| | **Experience of caring for the young person** | | |
| | **Negative experiences of caregiving** | ✓* | ✓* |

Note. * = statistically significant at p<.05. # = The family functioning emotional involvement variable is excluded for significant others because they scored above the clinical cut-off at all three time points indicating no problems in this area.

## Outcomes for Young People

Young people reported statistically significant improvements in mental health symptoms (measured by BASIS 32) and fewer difficulties with daily living at the end of treatment and this was maintained three months later. Given the BASIS 32 does not have normative data, it is not possible to determine whether these improvements indicate that young people are now symptom-free. Given the long term nature of some of the mental health disorders (i.e. bipolar, autism, ADHD, schizophrenia) it would not be expected that the young person would be symptom-free following family therapy treatment. However, the statistically significant improvements in Quality of Life across a number of psychological, health and social domains is extremely positive. Indeed, three months after completing the program, the young people

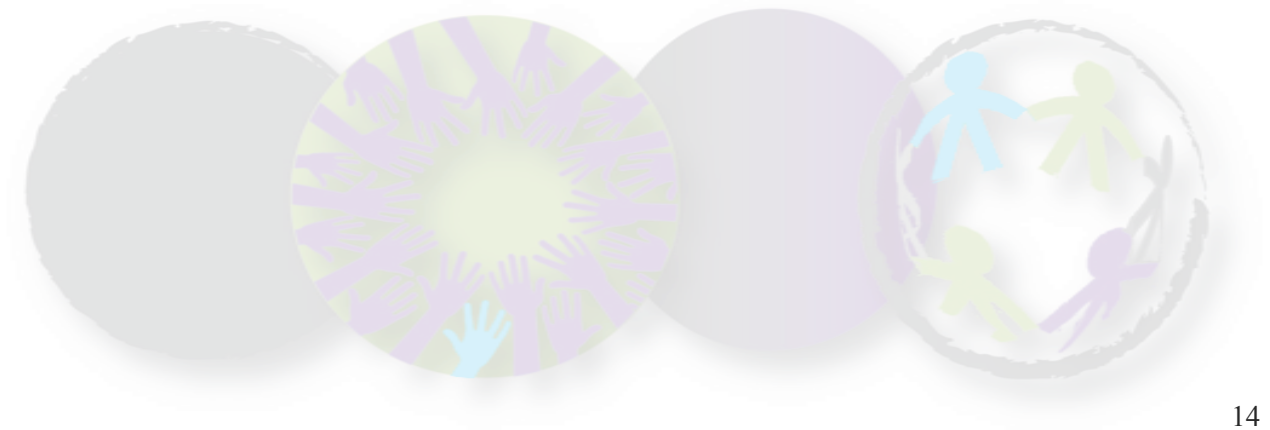
almost reached community norms in relation to improvements in their Quality of Life (see full report for further details).

Importantly, given the key aims of the program, the young person reported statistically significant improvements in communication and emotional expression amongst family members – which again was close to community norms (indicating normal family functioning). This is a critical feature and protective factor in terms of prevention of long term harm both for the young person and the family. It is of note that the findings above are consistent with other family therapy programs involving young people with a mental health and substance use disorder (Yuen & Toumbourou, 2008). Interestingly, although there were statistically improvements in cannabis use, this was not the case for alcohol, which is broadly consistent with the findings of a recent review of family therapy intervention for this population (Austin et al., 2005). It is likely that given the permissive alcohol culture for this group, in addition to the risk taking nature of this population, reductions in substance use may require a longer term perspective. What is critical to note is that young people perceive family functioning as having improved. Given the carer function that families play, which is not only helpful for the young person but reduces the burden on the health services system, this is a highly successful outcome.

## Outcomes for Other Family Members

Family members reported statistically significant improvements in Quality of Life, family functioning and a reduction in anxiety, depression and stress with daily living. The consistency between these gains and those gains reported by the young person lend further support to the positive outcomes of this program. Very few evaluations examine the mental health and Quality of Life outcomes of families, because they tend to focus primarily on the young person (e.g., Austin et al., 2005). In this respect this evaluation provides a unique dataset and an insight into how a family therapy program for a young family member with a dual diagnosis can improve the Quality of Life and mental health of their family (Yuen & Toumbourou, 2008). This improvement then serves as a protective factor for the family in general given the caretaker role that families have in these situations (Yuen & Toumbourou, 2008).

This reduction in the negative impacts on the family is further supported by the statistically significant reductions in negative caregiver burden as measured by a formal and valid questionnaire. Family members reports of family functioning were above the cut off score three months after treatment completion - indicating that families were functioning in a manner consistent with community norms (see full report for an explanation). Overall, these findings suggest that the family members are more able to understand and manage with the stress of having a family member with a chronic debilitating mental health disorder, complicated by substance use issues.



# Staff and Client Consultations

## Client Feedback

Clients reported high levels of satisfaction overall (88% satisfaction at completion of the program, 85% at a follow up interview conducted by an independent researcher 3 months later). Some families expressed an awareness that they could have benefited further from treatment if they had been able to resolve difficulties in attendance or felt less overwhelmed by their young person's circumstances. Many made reference to skills or ideas learned in the program and spoke about the safe space the therapist provided, to enable them to consider issues affecting the family.

Suggested areas for improvement included offering follow up sessions and greater information about dual diagnosis being available to parents in the broader community.

## Staff Consultations

### Initial Implementation Phase

A focus group was conducted with staff in the first year of the program. The main themes identified were: Engaging in the work was complicated by the slow build-up of referrals; difficulty recruiting eligible staff within budget constraints; needing to be highly flexible and skilled in family therapy; and have a thorough understanding of mental health and substance use disorders. They observed that the young people attending were often highly disconnected from their families, which complicated the process of bringing the family together for sessions. This often meant that considerable time had to be placed into the engagement process. Co-location of staff at agencies across regions was an important component in supporting family access to the program and had the potential to enhance referrals. However, it was time consuming for staff to travel to different agencies.

### Establishment Phase

A focus group was conducted by the same interviewer with Eclipse staff three years and six months later, when the program had established itself. The Eclipse team supervisor, a consultant AOD psychiatrist, was included in the session to comment on impressions gained from his sessions with staff. Many of the original themes were reinforced, in particular the need for flexible and skilled staff; difficulties in maintaining program referrals in the face of staff turnover in referring agencies; disconnected families requiring substantial and careful engagement techniques and the complexities of providing a highly mobile service working through other agencies.

A clear message from this time point was the powerful benefit of systemic thinking on the work as a means of effectively understanding and assisting families to transition to more functional systems. This and the high level of therapist skills were viewed as critical factors in the success of the Eclipse program in working with highly complex and often very traumatised families, who had extensive histories of grief and loss. Family Eclipse clinicians and their supervisor observed that while some AOD and MH services acknowledged, to a modest degree, the role of families in supporting their clients, they usually failed to address the profound impacts on the family of both substance use and chronic mental illness of a family member. Nor did they take into account the ways in which family inclusion could improve the lives of all family members. Services reported that the Family Eclipse program had an impact on the whole organisational culture in making Family Inclusive practice part of established practice.

# Conclusion

The Family Eclipse program has developed good momentum within the service sector. Family work with this high risk group of young people is challenging and referral pathways take time to establish. Results from the current evaluation study indicate that the outcomes of the Family Eclipse program are impressive, particularly given the levels of impairment demonstrated by young people and their families at first contact and the conservative level of resources it accessed.

Young people and their family members demonstrated statistically significant improvements in most outcome domains, including **family functioning, anxiety and depression symptoms and Quality of Life**. These treatment gains were maintained or in some cases, improved at three months post treatment, indicating potential for enduring improvement for participating families. This suggests that strategies and skills learned during the program continued to build beyond its completion. More importantly, it suggests that the Family Eclipse program is effective in strengthening families, preventing further vulnerability to both mental illness and substance abuse in the community. It is important to note that although Cannabis use did drop significantly during treatment, it increased again post treatment, strongly suggesting that a longer term approach is required with respect to expectations regarding the young person's alcohol and drug use. Equally, the young person's alcohol use did not reduce during or after treatment. These non-significant reductions are consistent with other family interventions (see literature review summary), and hence are not unique to the Eclipse program. The findings regarding substance use need to be considered in the context that young people present with multiple mental health problems and that building resilience and strength in the family system will strongly enhance the chances of the young person reducing their misuse of substances.

Nonetheless, it is important to consider the limitations of this study. First, the follow up rate was approximately 60% which is lower than the ideal of 80% but nonetheless impressive given the client group of young people. Second, there was no comparison group of individuals who either received no treatment or another form of treatment to enable a point of comparison. Therefore, it is possible that those families who were not followed up did not report the same level of significant gain. Secondly it is not possible to confidently attribute the improvements to the Eclipse program given there was no group who did not receive treatment to compare to. However, given the positive findings of this program are consistent with quite a large number of randomised controlled trials of family therapy interventions (see Austin et al., 2005 for a review) one can be fairly confident that the gains reported in this evaluation can generally be attributed to the Family Eclipse Program.

In conclusion, the field is slowly experiencing a paradigm shift in relation to the importance of family interventions when working with young people with mental health and substance use issues (see Frye, Dawe, Harnett, Kowalenko & Harlen, 2008). The outcomes of this evaluation lend strong support to the effectiveness and critical importance of this approach when working with such vulnerable and distressed young people. The family remain an essential support system and it is critical that we strengthen their capacity to assist their young people to manage their mental health disorders. Building capacity in the family system will then reduce the burden on the health care system as well as helping the family to understand how to best benefit from the assistance when required.

There is considerable sector reform occurring at both the state and national level. It is essential given the escalating burden on services, that as a community we support and include families of young people with mental health problems. That is, in providing support and family therapy we are building the families capacity to support these young people long term. Such programs also play a role in preventing, or intervening early in, problems within extended family systems.

# Recommendations

## Recommendations for Government Policy and Service Planning

- Given the promising findings and the program's unique mandate, it is recommended that program funding continues. Further consolidation and continued support will enable its full potential to be realised.
- It is recommended that state and national policy and reforms consider Family Inclusive intervention programs such as Family Eclipse being delivered within youth mental health and alcohol and drug services.

## Recommendations for Service Sector

- It is recommended that the current findings be disseminated to the wider service community to inform and enhance practice change for this complex client group, who often fall through the gaps due to multiple interacting impairments, poor compliance and service limitations.
- We recommend skills sets for clinicians in both AOD and MH sectors that should have as a base (minimum) Family Inclusive practices, but should increase to more systemic family based interventions.

## Recommendations for Family Eclipse Program

- It is recommended that ongoing evaluation, professional development and review be considered a fundamental part of the program. It is preferable if a replication of the evaluation could occur to ensure that best practice is supported by rigorous empirical support.
- It is recommended that families are linked into local community supports in order to maintain the gains achieved during the intervention.
- It is recommended that the young person is aware that they may require longer term alcohol and drug treatment in order to reduce use.

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