FROM INDIVIDUAL TO FAMILIES
A CLIENT-CENTRED FRAMEWORK FOR INVOLVING FAMILIES

Developed for Mental Health and Alcohol & Other Drugs Services by
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INTRODUCTION

Mental Health (MH) and Alcohol and Other Drugs (AOD) services are increasingly expected to work collaboratively with the families and social networks of clients. An individual's family and social relationships are a key domain in recovery oriented practice and play an important role in the client's recovery in their multiple roles as individuals, family members and parents (Department of Health, 2011). The impact of mental health and drug and alcohol problems is also now recognised as extending beyond the diagnosed individual to include families. As a consequence, services have a responsibility to families to help ameliorate this impact, and to support family members who are in a caring role.

This document provides a framework for a comprehensive service response to a client's family, social network or kinship group in the context of client-centred care and sets out key issues in implementing this framework. This framework has a focus on adult mental health and alcohol and drug services but is likely to be relevant to a range of settings. These include other settings that work with individual adults such as aged person's mental health and disability services, as well as family and child & youth mental health services.

The framework aims to help adult oriented organisations translate research evidence into practice and build on what they are already doing to involve families and children in client treatment and care. The ideas presented can guide both individual services and groups of services within a catchment area in determining how they can best involve and respond to the needs of families.

Drawing on research findings about family involvement in mental health and alcohol and other drugs treatment, this document is further informed by The Bouverie Centre's experience of facilitating the implementation of family based approaches in a range of human service organisations – a particular example being the Beacon Strategy[1]. The development of the framework was underpinned by a trialogue[2] approach that values the perspectives of clients, carers and practitioners. As such, the views of clients, family members (directly and indirectly through various peak bodies) and practitioners informed this document.

The overall aim of the Client-Centred Framework for Involving Families is to promote family involvement in the treatment and care of an individual in order to achieve better outcomes both for clients and families. The framework assumes that while the individual adult client remains the focus of care, MH and AOD services have an important role in assisting families to identify and address their own needs. This is especially important where there are vulnerable members such as dependent children, symptomatic partners or elderly parents. While the focus here is on delivery of services, the importance of client and family participation in service development and organisational governance is recognised and encouraged.

[1]In 2008 the Victorian Department of Health commissioned The Bouverie Centre to deliver a workforce development strategy for 'family inclusive practice' in the AOD sector, and in 2011 this work broadened to include the mental health sector. The resulting Beacon Strategy engaged 27 AOD and eight mental health agencies and generated a large body of practical knowledge about family approaches and how to implement them. [2]'Trialogue' is a term coined by Brendan O'Hanlon to describe the three dimensional view of a situation when the perspectives of clients, family members and practitioners are sought, respected and seen as inter-related, which underpins this document.

WHY A FRAMEWORK FOR FAMILY SENSITIVE PRACTICE IS USEFUL FOR WORKERS

In mental health, well researched family interventions provide strong evidence of improved outcomes for both the person with the diagnosis and other family members (Carr, 2009; Pharoah, Mari, Rathbone, & Wong, 2010). Likewise, research has found similar benefits from involving families in the treatment and care of individuals with a substance use problem (Copello, Templeton, & Velleman, 2006; Velleman, Templeton, & Copello, 2005). There is also emerging evidence of the value of programs designed specifically to assist parents and their children with mental health and substance abuse problems (Beardslee, Gladstone, Wright, & Cooper, 2003; Solantaus, Paavonen, Toikka, & Punamäki, 2010).

The importance of including families is now reflected in treatment guidelines (Dixon et al., 2010; McGorry, 2004; National Collaborating Centre for Mental Health, 2010) and in State and National policy. The Victorian Department of Health identified family inclusion as a key policy direction for its alcohol and other drugs services (Department of Health, 2012b), the reform of Psychiatric Rehabilitation and Support Services (Department of Health, 2012a) and the development of the Mental Health Act 2014 (Vic). The Fourth National Mental Health Plan, 2009-2014 addresses family inclusion (Australian Health Ministers, 2009) while Standard 7 in the National Mental Health Standards "recognises, respects, values and supports the importance of carers to the wellbeing, treatment, and recovery of people with a mental illness" (Australian Government, 2010, p. 16). The report of the Protecting Victoria's Vulnerable Children Inquiry recommends supporting specialist adult services to develop family sensitive practices (Cummins, Scott, & Scales, 2012) as a central way that Mental Health and Alcohol and Other Drugs services can enact their role in reducing the risk of child abuse and neglect, where parents have a mental health or substance use problem.

Despite supportive practice guidelines, enabling policy, and examples of agencies working well with families, many services both overseas and locally have relatively limited contact with family members (O'Hanlon & MacRae, 2009; Riebschleger, 2005). Moreover there is evidence that families' experiences of mental health services are not always positive (McAuliffe et al., 2009; Rose, Mallinson, & Walton-Moss, 2004). Improving client outcomes through family involvement is a challenge for most services, given their legacy of being individually focused in clinical practice, administrative structures and organisational culture (Fadden, 2006).

A Vision

Mental Health and Alcohol and Other Drugs Services actively engage family members and significant others in their clients' assessment, treatment and care. In the process, the needs and wellbeing of children and carers are acknowledged and addressed in ways that promote better outcomes for everyone, including the client.

KEY TERMS

'Family' in this document includes the client and those with a significant personal relationship with the client. This includes biological relatives, partners, ex-partners, people in co-habitation, offspring, parents, siblings, friends, carers, community and others who play a significant role in the person's life. The term refers equally to same-sex partners and same-sex-parented families. 'Family Member' and 'carer' are also used, depending upon the context.

In other words, 'family' for us is a shorthand term for 'family, significant others and social networks'.

The term 'client' is generally used, because it is more acceptable across the full range of mental health and alcohol and other drugs services. However, it is appreciated that the terms 'consumer' and 'customer' are preferred by some and acknowledged that the term 'patient' is appropriate in some settings.

'Client-centred' means that the client's views and choices will be explored, valued, acknowledged, respected and incorporated in identifying 'who is family' and a family's level of involvement in treatment, care planning and decision making. In instances where conflict emerges, the rights and needs of all parties will be respected and professional skill and judgement exercised within a human rights context.

'Family sensitive practices' are generally those attitudes and behaviours that communicate to families that their needs are recognised and that the organisation is committed to assisting them. Even an individual client can be treated in a family sensitive manner.

'Family inclusive practices' are activities which directly involve members of the client's family and social network in their care and treatment.

We also use 'family involvement' as a generic term referring to the entire range of ways in which people in an individual's family and social network are acknowledged and involved in their loved one's treatment and care. In this document it refers to both family sensitive and family inclusive practices.

A CLIENT-CENTRED FRAMEWORK FOR INVOLVING FAMILIES

A central intent of the family involvement framework is to bring together the varied existing service responses to families in a coherent whole. The framework articulates a pathway between the various service options for families. This can provide clarity for clients, families, practitioners and importantly service managers who are charged with the responsibility of service planning and development. In particular, the framework can inform the way in which services can be best organised to address the needs of families.

For example, the framework can inform decisions about the balance between offering generalist and specialist interventions or whether services are provided 'in-house', in partnership with other services or accessed via referral to other agencies. It can also inform organisations about staff recruitment and development decisions in relation to service responses to families, and can help determine how many and which staff require training in what specific family modalities.

The following framework - represented diagrammatically - proposes three levels of practice provided within a broader family sensitive organisational culture. This culture is an essential foundation for the engagement of families at the three levels:

- Level 1 Family Sensitive Practice (Working with Individuals in a Family Sensitive Way);
- Level 2 Structured Inclusion and Needs Assessment (Single Session Family Consultations); and
- Level 3 Specialist Family Interventions.

In relation to practitioners, the particular value of the pyramid is that it articulates what is within and outside of their scope of practice. This enables practitioners to be clear with families about the purpose and extent of their working relationship. In turn this reduces the likelihood of practitioners feeling overwhelmed, working or feeling pressured to work outside their competence. For example, practitioners who are operating within the Family Sensitive Practice level (Level 1) would offer support and relevant information to families but not attempt to address family dynamics or longstanding difficulties associated with past trauma. On the other hand, a practitioner with advanced training in working with families and a clearly allocated role (Level 3) could conduct intensive and change oriented interventions with families.

The pyramid of family involvement on the following page draws directly on the work of Mottaghipour and Bickerton (2005), and has much in common with other frameworks which attempt to articulate a comprehensive service response for families (Dausch et al., 2012; Gruenert & Tsantefski, 2012). In contrast to earlier attempts to promote family interventions, these recognise that no one service response will meet the diverse and changing needs of families. While different families require varying forms of involvement, most families experience and benefit from acknowledgement, information sharing, short-term planning and problem solving.

THE PYRAMID OF FAMILY INVOLVEMENT

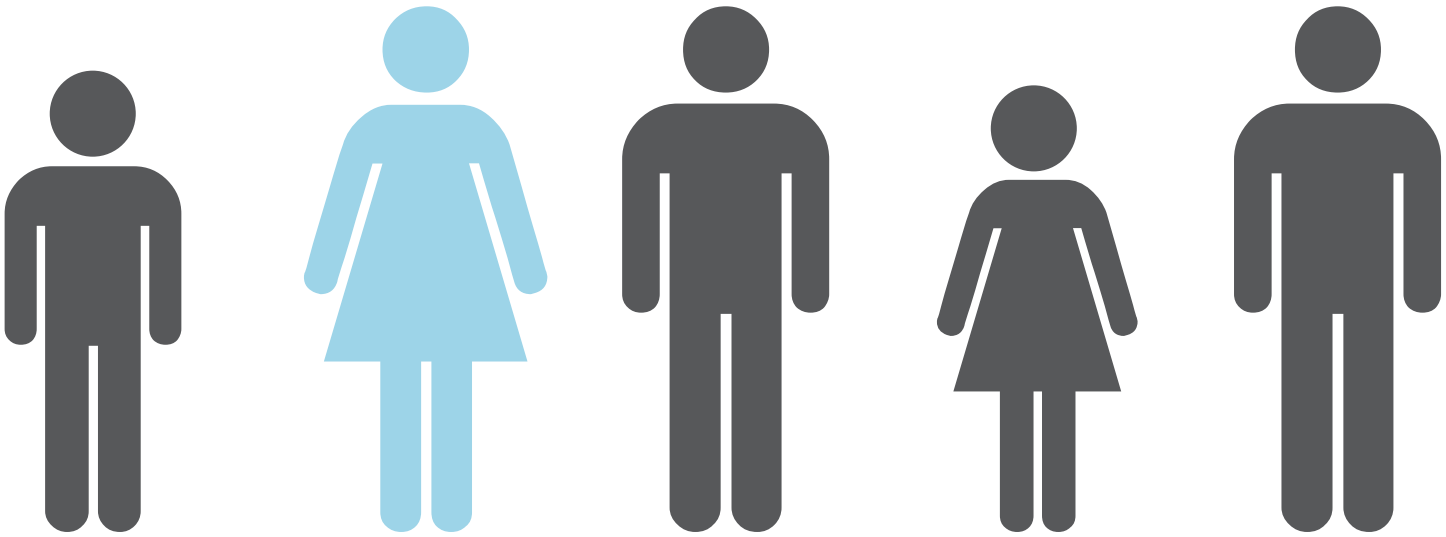
KEY:

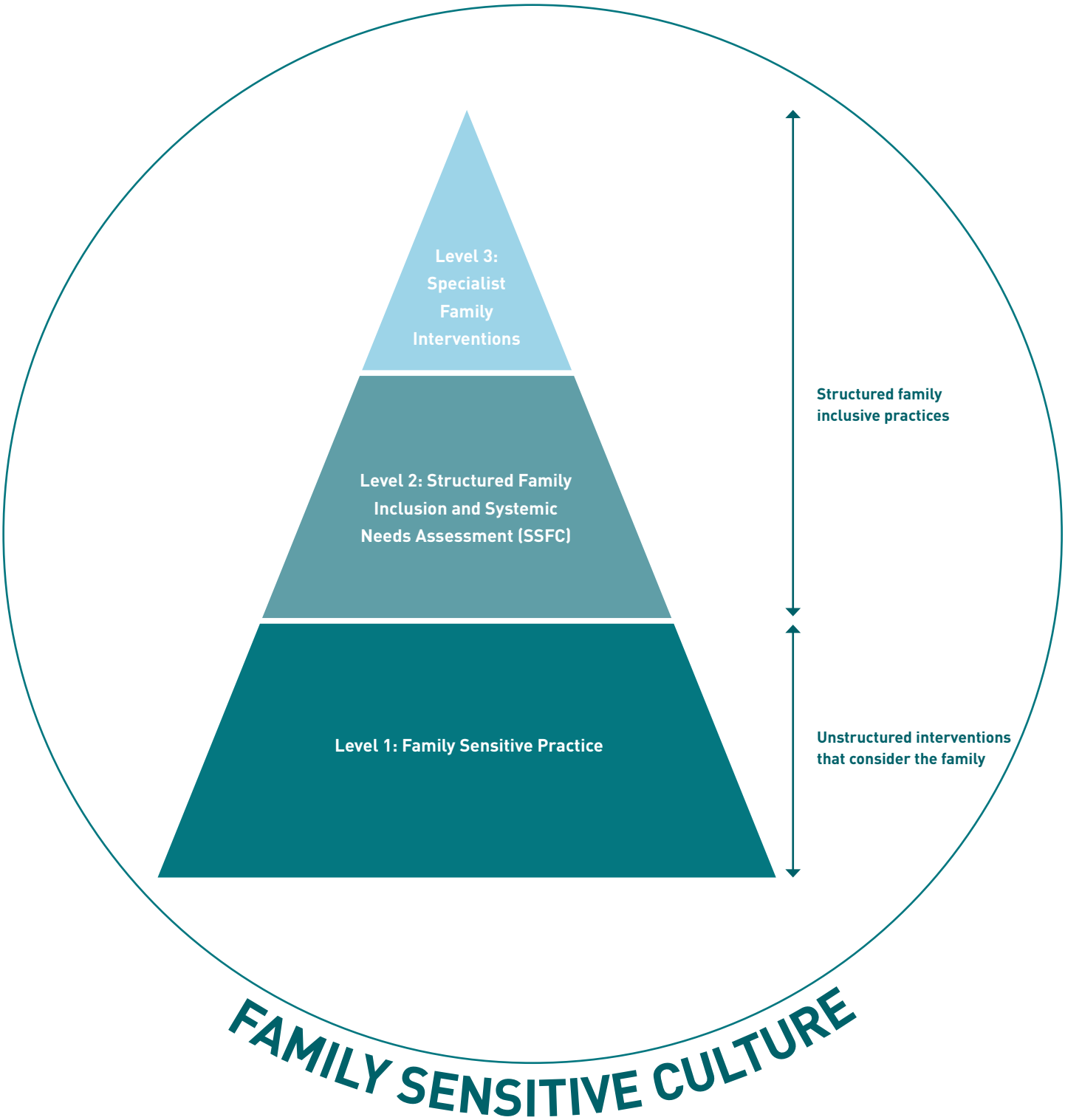
Family Sensitive Culture encapsulates the attitudes, beliefs, and values expressed in the systems and processes of an organisation

Level 1 Family Sensitive Practice articulated and demonstrated in every role within an organisation.

Level 2 Structured Family Inclusion and Systemic Needs Assessment with an emphasis on providing Single Session Family Consultations (SSFC) across the organisation.

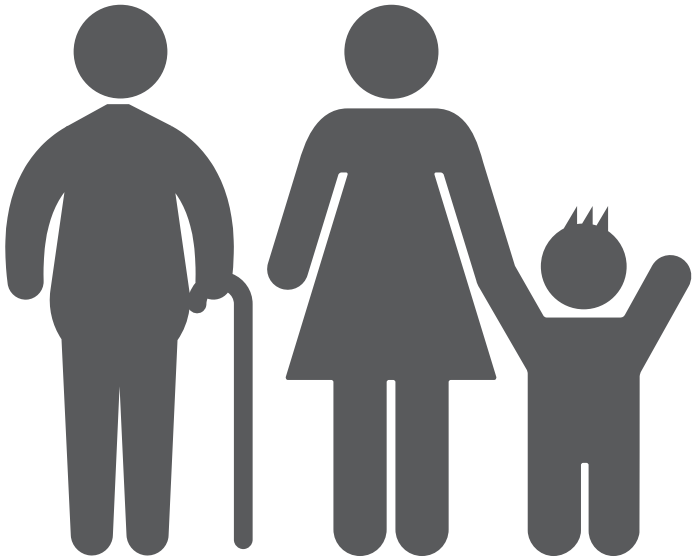
Level 3 Specialist Family Interventions e.g. family therapy, multiple family groups. Interventions that are available in, or shared between organisations within a catchment area.




Level 3: Specialist Family Interventions
Level 2: Structured Family Inclusion and Systemic Needs Assessment (SSFC)
Level 1: Family Sensitive Practice
Structured family inclusive practices
Unstructured interventions that consider the family
FAMILY SENSITIVE CULTURE

FOUNDATION OF THE FRAMEWORK: A FAMILY SENSITIVE CULTURE

The term 'culture' encapsulates an organisation's attitudes, beliefs and values, and the systems and processes that express these. An organisation with a 'Family Sensitive Culture' promotes and sustains effective relationships between clients, family members, carers, practitioners and other staff members. The culture extends from the first contact through to follow-up and is embraced by staff in administration, clinical delivery, management and policy. Indeed service leadership is critical in creating an environment in which working with families is authorised and valued.



A Family Sensitive Culture creates an environment that unambiguously welcomes all family members, including children, and encourages a range of thoughtful responses to families. This applies whether practitioners are working systemically with individuals or seeing several family members, whether they are doing assessment interviews or discharge planning. For core services, this culture encourages a family sensitive design of the physical environment, organisational policies and procedures, so involving families becomes 'the way we work here.'

LEVEL 1: FAMILY SENSITIVE PRACTICE

Family Sensitive Practice has been defined as 'any work role that is performed in a way that is inclusive, understanding and respectful to families and other carers, including their social and cultural role'(Young, Riess, & O'Hanlon, 1998). As such, it covers practices that include the way in which practitioners work with an individual client and when they have incidental and less formal contact with family members. When working with individuals, practitioners can ask clients questions that create awareness of the importance of family and other relationships for both the client and the practitioner. Unplanned and informal contact with families can be an opportunity for practitioners not just to gather information, but also to acknowledge the role of family members and communicate messages of inclusion and respect.

The following are examples of Family Sensitive Practices:

- A welcoming waiting room stocked with drinks, snacks, magazines for men and women, children's books, toys and games and a change table in the toilets or parents' room.
- Administrative staff members who are always courteous and warm to family members.
- Carer and consumer consultants are welcomed within the organisation's decision-making processes and have a clear role endorsed by managers and practitioners.
- Organisational processes include families and the client's social networks, for example KPIs and outcome measures, data collection and resourcing.
- Clients and families are involved in governance and service development.
- Intake processes that incorporate questions about who comprises 'family' for the client including who they live with and those who might be particularly vulnerable such as dependent children or elderly parents.

Basic Principles of a Client-Centred Framework for Involving Families

- A client's preferences are the starting point for family involvement, but it is recognised that families have rights to the information required to carry out a caring role and to have their own needs acknowledged and addressed. This is particularly important in assessing the needs of vulnerable children or elderly carers.
- Hearing everyone's experiences and points of view contributes to a broader understanding and hence more effective treatment.
- Working with family members and significant others is an essential part of client care rather than an 'add-on' or exclusively specialist activity, especially where children are involved.
- A non-pathologising and non-blaming approach, combined with natural curiosity about each person's experience, an open mind and human warmth are recognised as fundamental to working effectively with distressed families in a client-centred way.
- Issues of privacy and confidentiality are addressed in a way that facilitates family involvement.

The following are examples of how practitioners can work in a family sensitive manner.

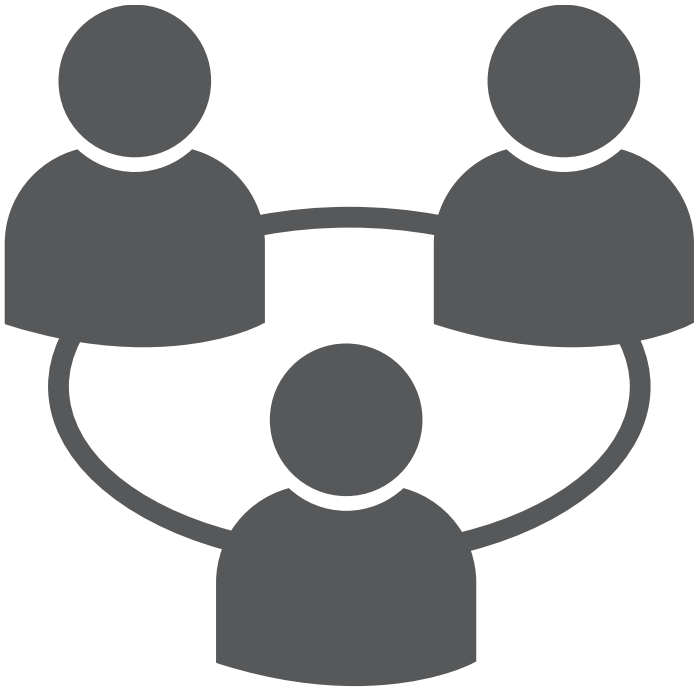
- A practitioner asks a client about who is in their family, who they might look to for support and how family members might understand the client's difficulties.
- A practitioner rings a mother to say that her son has arrived safely at the inpatient unit.
- A nurse or social worker offers assistance to a family member who looks lost and ill at ease when visiting their relative on an inpatient unit or rehabilitation centre.
- A practitioner may respectfully ask about the cultural identity of the client and their family as a starting point for talking about how to offer culturally sensitive family visits.
- A practitioner routinely offers information about peer support and practical help such as financial advice and respite care to families.

The particular value of Family Sensitive Practice is that it can be undertaken flexibly and in a range of circumstances as the practitioner undertakes their usual work role. While it may require practitioners to change their attitudes towards families it does not require advanced training or major restructuring of existing work roles, although a family sensitive attitude will usually change the way that role is enacted. It has the advantage that it is relevant to all staff and can 'reach' most family members including those who might be reluctant to be involved in more formal meetings or in specialist family based treatments. Family Sensitive Practice also promotes mutual respect and trust between practitioners and families. This creates a context for the engagement of families in more structured and purposeful processes offered at Level 2 and 3 of the pyramid. In many ways, it provides the foundation on which other services to families can be built. The concept of Family Sensitive Practice is relevant to Levels 2 and 3 of the pyramid because inclusion of families in formal meetings or in specific family interventions can occur in a manner that is not sensitive to the needs and preferences of families. For example, a family might be included in a hastily convened and poorly conducted discharge meeting which is experienced negatively by those family members attending. Sensitivity to each family member's experience underlies Family Sensitive Practice.

LEVEL 2: STRUCTURED FAMILY INCLUSION AND NEEDS ASSESSMENT - SINGLE SESSION FAMILY CONSULTATION (SSFC)

At Level 2 of the pyramid of family involvement, the focus is on bringing family members together in a formally convened meeting for a range of different purposes. This typically occurs when families or members of a client's social network are invited to attend and participate in a relatively formal or structured session - usually where the client is also present. This is a 'step up' from involving families by welcoming them, keeping them informed of events or discussing family issues with a client (Level 1). Level 2 'Family Inclusive Practices' differ from Family Sensitive Practices largely in the degree of intention, formality, active participation and the structure of what is offered. Many organisations conduct family meetings as part of their work with clients. What happens inside these meetings reflects the practitioner's training and clinical orientation.

In the framework presented here the Single Session Family Consultation (SSFC) is the preferred practice model that informs a family meeting process. The SSFC is a time limited and structured process for meeting with a client and the family and is focused on achieving realistic and negotiated goals. SSFC was developed by The Bouverie Centre by combining Family Consultation, a model developed to meet the needs of families affected by mental illness, with Single Session Therapy that focuses on maximising the value of one or more counselling sessions (Jewell et al., 2012; Talmon, 2012; Wynne, 1994). This approach has a strong emphasis on the process being consultative, needs driven and strengths oriented. This approach creates a framework that aims to routinely include families in treatment and care and respond to their needs.



THE SSFC PROCESS

The key steps in the SSFC process are outlined in the diagram below, followed by further description of the process.

CONVENING

- Discuss the idea of family work with the client
- Contact family members
- Negotiate useful agenda for the session

CONDUCTING THE SESSION

- Welcoming
- Scoping the issues
- Decide on focus for the session
- Share helpful ideas with the family
- Develop a plan to address family needs

FOLLOW UP

- Planned phone call to family & client
- Client & family's experience of the session and any progress since
- Invite feedback from the client & family about the session
- Make decision together about next steps

NEXT STEPS

- Complete - Open door, and/or
- Another SSFC, and/or
- Family support groups, and/or
- Referral to specialist family program

A particular advantage of the SSFC approach is that sessions do not commit the client or family members to ongoing participation but they can set the scene for longer-term work if this is mutually agreed upon. Alternatively, SSFC can be offered on an as-needed basis, a format that suits the preferences of many families. SSFC enables practitioners to match family need to available services, including more specialised options, available in Level 3.

In practice, SSFC can be best thought of as a process for convening and conducting the session, and following up with the family. In the convening process, particular attention is given to preparing all potential participants to make the most of the time when family members are together. There is a strong focus on negotiating the involvement of family or other social network members with the client. This aims to increase the likelihood that the session delivers a useful outcome for the client and does not threaten the relationship between the practitioner and client. The SSFC session itself includes stages of welcoming, scoping the issues, deciding on a focus, addressing the identified issues and agreeing to clarify how family members will be involved and their needs addressed. A follow-up telephone call is made to families following the session to gauge their experience of the session and to check on progress in relation to issues identified during the SSFC and to clarify the next step.

In the context of MH and AOD services, SSFCs usually help families in the following ways:

- Hearing the families' story and acknowledging the impact of MH/AOD problems on all family members.
- Creating greater understanding through sharing information about the nature of MH/AOD problems and their impacts on individuals and families.
- Helping families work out how to best support their relative within the resources they have available.
- Problem solving day to day difficulties that inevitably arise or are linked to what family members want to achieve during the session.
- Achieving clarity about the nature of family involvement in the person's treatment.
- Planning to help families access additional resources including other family interventions that may be available to them.

From an implementation perspective, the SSFC has a number of important advantages. For example, SSFC can build on an organisation's existing processes for meeting with families or can be used to routinely involve families. Although SSFC, like any new practice, requires training and support, SSFC training can be completed in two days and is therefore cost effective when training large groups of staff.

LEVEL 3: SPECIALIST FAMILY INTERVENTIONS

While some specialist family interventions can be undertaken within the SSFC structure, they may also be offered by specialist programs or by specially trained staff. These interventions are often (although not always) longer term and more intensive in nature. Interventions at this level include those that have an established evidence base in improving client and family outcomes.

Some of the more common interventions at this level include:

- Behavioural Family Therapy (Fadden, 2006; Mueser & Glynn, 1999);
- Multi-Family Groups (McFarlane, 2002);
- Couple/marital therapy;
- Systemic family therapy;
- The 5 step family intervention (Orford, Templeton, Patel, Copello, & Velleman, 2007);
- BEST and BEST Plus (Toumbourou & Bamberg, 2008; Toumbourou, Blyth, Bamberg, & Forer, 2001).

With appropriate training and organisational support, the client's usual practitioner may directly deliver these interventions providing continuity of care. In locations where resources to offer specialist programs are scarce, organisations may cooperate to ensure that a full range of options is available across their region or catchment area. In some instances it may not be viable to deliver these interventions within a region, in which case help might need to be accessed from specialist state-wide services.

Providing specialised interventions is important in meeting the diverse needs of families. In addition, these interventions provide a career pathway for practitioners who demonstrate a strong interest in working with families and want to develop their skills in areas of specialised practice.

FRAMEWORK BENEFITS

This framework for involving families recognises that the individual client is the main focus of most MH and AOD services but also gives families a voice within the organisation and in the care and treatment of their loved one. Because practitioners trained in this framework acquire the skill of being able to provide support both for their client and the client's family, all family members will likely derive benefit.

Once implemented, this framework benefits all clients and their families because staff have the knowledge and skills to engage positively with families and involve them in the treatment and care of their loved ones. As depicted in the pyramid of family involvement, the majority of families benefit from the opportunity to participate in sessions such as an SSFC at some point in the course of their relative's treatment. A smaller percentage will opt to participate in one or more specialist treatment options.

The framework allows for the fact that families often move between forms and intensity of involvement. A family may first accept an invitation to participate in an SSFC or other family meeting and later participate in more specialised interventions before having another SSFC or possibly no further formal sessions, but simply supported by the culture of family sensitive practice they encounter throughout the organisation. The SSFC can assist families to move between the various treatment options, for example, when it is used to discuss achievements, explore progress (or lack of it), make plans for further specialised sessions or rectify lapses of the organisation's Family Sensitive Practice.

Workers may find the framework a useful guide for specifying the purpose of a particular episode of family involvement within an overall regime. It may help them think about their own skill set and assist them to identify family inclusive practices which they are already sufficiently trained to undertake and those which might require further training and supervision. Most practitioners already have or can fairly easily acquire the knowledge and skills to conduct SSFCs, but specialist interventions require substantial additional training.

FAMILIES CAN BE THE SITE OF BOTH TRAUMA AND OF RECOVERY AND HEALING.

Sometimes there will be contra-indicators for including particular family members in a client's treatment and care, especially if practitioners do not have highly specialised training, for example in cases of intra-familial sexual and other abuse, domestic violence and neglect. In some situations, it may be necessary to distinguish between non-offending and offending parents and to exclude one family member even if that person wishes to participate. The practitioner may also exclude family members where a client uses violent or abusive behaviour (while still utilising a family sensitive approach), depending on the age of the client and the context and rationale for convening the family session.

While every family member has needs and rights, the practitioner's response to the family cannot be allowed to jeopardise their relationship to the client, given that this relationship is essential in achieving positive outcomes.

The following statements guide our thinking in this difficult area:

- 'Nothing about me without me'. The client is the starting point for negotiations about family involvement. (However, this may not apply where there are significant concerns about the safety of children or other family members).
- Families can have needs even when the client doesn't want their involvement, and family sensitive and inclusive practice entails consideration of these needs.
- For a variety of reasons, not all families will opt to be included in their relative's care; however the service can keep the door open to future involvement for such families.
- Families are understood as being essentially motivated by survival rather than malevolence. When members behave in destructive ways, an appreciation of the family situation can help workers address this destructiveness more effectively. However, in certain circumstances, some forms of family involvement will not be in the client's – or some family members' – best interests.
- An approach in which both the client and the family are heard can often reveal compatible hopes and wishes between clients and families or carers, even at times of tension and conflict.

IMPLEMENTING THE CLIENT-CENTRED FRAMEWORK FOR INVOLVING FAMILIES IN MENTAL HEALTH AND ALCOHOL AND OTHER DRUGS SECTORS

Most MH and AOD services in Victoria have implemented practice changes before. They know that single strategies – such as stand-alone training or re-drafted policy statements – are unlikely to achieve meaningful change. Instead, even in the best circumstances, the process is usually complex, challenging and time consuming (Proctor et al., 2009).

There is a rapidly developing body of literature about how to best implement practice change in health and other human services. The reader is encouraged to consult the relevant references at the end of this document which will help inform efforts to implement various forms of family involvement.

The following points are a distillation of what has been learned in Victoria over several years of assisting MH and AOD organisations to develop ways of involving families as part of their core work.

1. Identifying the problem: What is the problem (and can we solve it now)?

An identified problem helps create a rationale and incentive for change. A problem can be self-defined (e.g. we don't respond to families as well as we could; we need to improve the outcomes for our clients) or externally defined (e.g. we aren't delivering best practice in effective family approaches outlined in research; we are not complying with State and Federal policies which require engagement with families).

The new initiative needs to be seen as part of the solution to the identified problem. Managers, in particular, should be able to articulate how the proposed innovation addresses the identified problem – especially how it might solve a problem for staff (Young, Weir, & Rycroft, 2012). Implementation is more likely to be successful when the innovation is seen as providing a relative advantage to the organisation or to staff and when the amount of risk involved is balanced by potential benefits (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004; Rogers, 2003). Clearly, change facilitators need to promote the advantages of an innovation such as family involvement to the organisation.

Sometimes everything is lined up but the timing is not right. Restructuring or relocation plans, competing projects, financial difficulties and new policies can all make it hard or impossible to introduce new practices.

2. Is the change congruent with our values?

Practitioners are unlikely to be enthusiastic about implementing an approach that does not seem to fit with their values (Rogers, 2003). Those promoting change will be more effective if they actively link the values underlying the innovation with both the values underlying the practitioners' approach and the core values of the service.

In one AOD organisation, the manager was interested in introducing SSFCs, but senior staff resisted, thinking it would compromise their primary commitment to individual clients. After considerable discussion, staff realised that the family inclusive approach was consistent with their views about client-led practice. After introducing SSFCs, they reported that actively involving families actually made individual work with their clients more meaningful and more effective, especially when they confronted complex or difficult situations.

IMPLEMENTING THE CLIENT-CENTRED FRAMEWORK FOR INVOLVING FAMILIES IN MENTAL HEALTH AND ALCOHOL AND OTHER DRUGS SECTORS

3. Create an 'authorising environment'.

Many elements combine to create an 'authorising environment' which supports and encourages the uptake of a new practice. An authorising environment provides the conditions where each person in an organisation is given the appropriate authority to participate in and to support the change.

Leadership

Support from key leaders in the organisation is crucial to successful implementation. Not all managers in a chain of command need to be actively supportive, but the support of people in senior positions in particular, creates conditions for others to take the initiative. Senior staff can also make the administrative and clinical process changes needed to adopt the new practice.

Functional structures

An organisation must have functional structures that allow for problems that arise during implementation to be addressed. A group specifically set up to introduce family sensitive and inclusive practices can provide a key forum for identifying and solving implementation problems. Such groups are most effective when they maintain good communication with existing central forums such as staff and leadership meetings.

Policy

A supportive policy environment promotes change. It helps make a direct link for both practitioners and managers between family sensitive or family inclusive practices and State and Federal policy drivers for these practices. Clear policy is also a powerful starting point to help staff navigate difficult issues such as confidentiality and dilemmas such as 'who is the primary client?'.

As pointed out by Kitson, Harvey & McCormack (1998), it is often difficult to be a 'prophet in one's own land'. Implementation can sometimes be best promoted and supported by external facilitators or experts who work across professional and organisational boundaries to introduce new information, attitudes, skills and ways of working. Select external experts who respect internal champions and existing structures but who also have the confidence and authority to challenge any constraints.

> **A service manager allows practitioners to work after hours in order to promote easier access for families to participate in a family intervention. The manager initiates the industrial change process required for this to occur. She also instructs her program managers to change key clinical processes to enable the routine identification of families at intake and arranges for internal distribution of departmental policy documents supporting family involvement.**

4. Who's driving and who's steering?

Implementation is more effective when there is a designated person or group in the organisation responsible for implementing and sustaining the new practice (Mueser & Fox, 2000). These people need dedicated and protected time to perform this role.

If possible, identify 'champions' in the service with a demonstrated commitment to and enthusiasm for the new way of working. It helps to include them in the organising group or as practice leaders to support their peers in adopting the new practice, and this also acknowledges the work they have been doing.

Most practitioners participating in a project to provide a family intervention had difficulty identifying more than one family to engage in the work. Julie, however, could identify six or seven families and was worried about how she was going to see them all. Julie routinely made contact with families when she picked up a new client and maintained regular contact. She found it easy to approach them about the new intervention and most agreed to participate. Julie was subsequently identified as a champion and given dedicated time to support her colleagues in their work with families.

5. Training isn't enough: support practitioners to get in there and do it!

Training in family work is necessary but by itself will not guarantee sustainable change. In order for training to be effective, it should be approached with implementation in mind. That means ensuring that after staff receive basic training, they are expected to attempt the new work as soon as possible. Start with something 'doable' and resist the tendency to spend too much time developing policy and procedures or promoting the new practice without doing any of the 'real work'.

Implementation is likely to be more successful if staff trying out the new approaches (in the framework) are able to work together and are afforded some time to reflect on their new practices.

It is a good investment to establish ongoing support for staff to develop their skills. Encouraging staff to co-work is another way of supporting staff taking on new ways of working. The uptake of new family practices is much more successful if a service arranges for additional training as needed and clinical supervision – with the latter incorporated into 'mainstream' supervisory processes once the practice is established.

6. Focus your energy.

Implementation is more effective when concentration is given to one aspect of the framework at a time, as a strategy for tackling eventual widespread change. The aspect of the framework that is implemented will depend upon the organisation's current situation. For many, introducing the SSFC provides the biggest gains for the least effort. It is relatively easy for staff to learn how to conduct SSFCs, especially if they can watch others before attempting it themselves. Introducing SSFCs can immediately address many of the issues faced by families and can also stimulate the development of a more family sensitive culture and more family inclusive practices. Strategies to create a foundational family sensitive culture can also be a good starting point if followed by the development of more specialised family based services.

A group of practitioners participated in a two day training program. Their feedback about the training was extremely positive; however, a month later, only one practitioner had seen a family using the new approach. At a supervision group, the practitioners revealed that they were anxious about seeing families and particularly worried about whether they could follow the steps taught in training. A plan was developed for practitioners to work in pairs so they felt more supported, which led to a gradual increase in the number of families seen. After a time, practitioners identified that they were unsure how to deal with strong emotions in family meetings, so additional conflict management training was organised.

At a regional clinic, a few practitioners were keen to introduce an education program for families about substance use, but this program was expensive and required training through a facility in Melbourne. Due to budget constraints it was not feasible to implement this approach, however the organisation was committed to improving their service responsiveness to families so needed to find an alternative way to address this. A few staff at the organisation had previously used SSFCs in other settings, and suggested that this approach might be suitable. A decision was made to start trialling the use of SSFCs and then report back to the staff meeting after three months. After a few families were seen using the SSFC approach, a brief in-service training was provided by the more experienced staff to their colleagues using a demonstration DVD. The experienced staff also offered to conduct some co-work sessions to help build confidence with those who had less family work experience.

7. Monitor what is really happening.

As implementation is difficult, there is a tendency to avoid asking tough questions about real practice change. Services that are disciplined about setting targets and measuring outcomes are usually more effective implementers. Measuring the end goal may be confronting, but it is essential to keep the implementation strategy honest and grounded.

Realistic targets for uptake of the new practice give an organisation something concrete to aim for. These targets should be informed by client demographics, caseload or workload considerations, research and practice knowledge about the uptake of family interventions.

As a pre-condition of undertaking a training program in working with families, practitioners signed an agreement with their manager that they would commence working with at least one family within three months. Number of families seen were made available to practitioners, with successes celebrated and challenges explored in a non-blaming but direct way to inform new strategies of implementation.

A service commits to a certain number of families to be engaged in Single Session Family Consultations. Despite genuine enthusiasm from staff, after nine months it is apparent that very few families have participated in these consultations. A review identifies that practitioners have proposed the intervention to 80% of the service's clients, most of whom declined involvement. As over half the clients live alone and many are estranged from their families, the service decides to reduce the target number but also to offer a SSFC at the point of intake to the service. This approach increases the uptake of SSFCs to a level close to a more realistic target.

8. Keep it alive.

Sustaining innovation requires ongoing renewal. Longer term strategies to maintain a family sensitive or inclusive vision involve cementing the approach into job descriptions; induction processes and professional development; developing the approach further through research; creating opportunities for reflective clinical discussion; continuously evaluating the service through client and family feedback; and advanced training in the philosophy and values underlying family sensitive and family inclusive practices.

It is also helpful to create opportunities for all staff members to share experiences, acknowledge progress, identify problems and recognise individual achievements. In other words, regularly celebrate the achievements of individual practitioners, the organisation or service as a whole and possibly an entire region or network. Special celebratory events contribute to maintaining and renewing energy for the new practice.

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