# Family Eclipse Program

# Odyssey House Victoria:

## Final Evaluation Report


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## Structure of the report

The report is presented in six sections. Section One provides a detailed summary of the evaluation in the form of an executive summary. Section Two documents the rationale and methodology. Section Three provides details of the consultation with staff and clients. Section Four provides details of the data on the effectiveness of the program. Section Five includes the conclusions and recommendations.

# TABLE OF CONTENTS


ACKNOWLEDGEMENTS ..... 2
TABLE OF CONTENTS ..... 3
EXECUTIVE SUMMARY ..... 4
- Introduction ..... 4
- Program Description ..... 4
- Evaluation Participants ..... 4
- Evaluation Methodology ..... 5
- Findings ..... 6
- Summary of key findings regarding the effectiveness of the program ..... 8
- Conclusions ..... 9
- Recommendations ..... 9

INTRODUCTION ..... 10
- Evaluation Methodology ..... 11
- Sample ..... 11
- Measures ..... 12

CHARACTERISTICS OF PARTICIPANTS ..... 15
EVALUATION FINDINGS ..... 22
- Feedback from families ..... 22
- Summary of Treatment Outcomes ..... 26
- Outcomes on Family Functioning ..... 28
- Outcomes for Young People ..... 30
- Outcomes for Significant Others ..... 33
- Consultation with staff ..... 40

CONCLUSIONS ..... 49
- Recommendations ..... 49

REFERENCES ..... 50

# EXECUTIVE SUMMARY

## Introduction

This report outlines an evaluative study conducted to explore the effectiveness of the Family Eclipse Program at Odyssey House Victoria.

The Family Eclipse Project was set up by Odyssey House Victoria in 2008 to provide improved outcomes for young people with substance use and mental health issues and their families. The project arose from a growing awareness of the need for services for affected families, which not only assists families to develop coping strategies, but also educates them about the interaction between mental illness, substance abuse and family dynamics. This program has a unique mandate and plays an important role in enhancing family inclusive practice within this target group.

## Program Description

The Family Eclipse Program is a counselling program involving the young person with co-occurring mental health and substance use disorders, together with their family. The work includes substantial education to and liaison with mental health and drug and alcohol services.The program is of flexible duration according to the needs of the family and includes case management and crisis support in the context of family counselling. It is informed by a family behavioural therapy framework and incorporates psycho-educational components and other therapeutic approaches such as motivational interviewing and strength based family interventions. Specific session content may include any of the following:

| | | |
|---|---|---|
| ➢ Parenting boundaries | ➢ Sleep education | ➢ Communication skills |
| ➢ Conflict resolution | ➢ Anger management | ➢ Problem solving |
| ➢ Emotional regulation | ➢ Stress vulnerability | ➢ Self care |
| ➢ Drug and mental health education and the interactions between them | | |

The young person and their family are assessed separately prior to family counselling sessions. These are held weekly or fortnightly and then reduce in frequency once the young person's symptoms have stabilised and the family is experiencing improvements in functioning. Individual sessions with family members or family subsystems are employed as necessary to progress the work and improve engagement.

## Evaluation Participants

A total of 47 families consented to participate in the evaluation of the program. Two families were excluded from the analysis because of limited data. Of the 45 remaining families (139 participants in

total), 45 were young people (aged 16-24 years) with co-occurring drug use and mental health conditions, and 94 were their Significant Others (family members, caregivers, partners). Twenty-two families are still in treatment and hence were not able to participate in the completion and follow up interviews. In this respect, it was not possible to conduct analyses on the full sample and results need to be considered as preliminary.

Our profile of these participants prior to them beginning the Family Eclipse project revealed that:

- Young people in our sample reported a range of mental health problems, with the most common diagnoses being depression and anxiety;
- Substance use issues were significant for our group of young people, with the drugs being used most frequently by this group at baseline being alcohol, cannabis, and amphetamines;
- The families involved in this study reported very poor family functioning in the areas of communication, affective responsiveness, affective involvement and general functioning;
- All participants in this study reported very low general quality of life and low levels of social connectedness, and these issues were more pronounced in our group of young people than they were for Significant Others.

## Evaluation Methodology

A mixed methods approach was adopted to evaluate the program. This approach involved:

- A focus group with family eclipse staff;
- Interviews with clients who attended the program ;
- Collection of outcome data (via clinical interviews and self-report questionnaires) for 45 families at three time points: pre-treatment, program completion and 3 months after program completion.

Participants who took part in the study were assessed on a range of key indicators (see below).

- *Family Functioning* was assessed through items of the Family Assessment Device (FAD)
- *Alcohol and Drug Use* was assessed for young people using responses to four items from the Addiction Severity Index.
- *Current Mental Health Symptoms* were assessed using the Behaviour and Symptoms Identification Scale-32 (BASIS-32; Eisen, Grob & Klein, 1986);
- *Quality of Life (QOL) and Wellbeing* was assessed using the brief, 26-item version of the World Health Organisation's QOL measure (WHO QoL-Bref, World Health Organisation, 1996);
- *Social Connectedness* was assessed using the *Friendship Scale* (Hawthorne, 2006);
- *Caregiver Burden* was assessed using the *Experience of Caregiving Inventory* (ECI: Szmukler, Burgess, Herrman, Benson, Colusa & Bloch, 1996).

Statistical analyses were conducted to assess change over time on these variables for both young people and their Significant Others. Because of the small sample size of young people at Program Completion and Follow up (i.e., 11 participants), we were restricted to using only t-tests and non-parametric analyses with this group to explore whether there were any significant changes on these measures between assessment points. We conducted multivariate analyses with the data obtained from our group of Significant Others as the bigger sample size allowed for the underlying assumptions of these statistical tests to be satisfactorily met. Analyses conducted for the young people are limited by the small sample and hence findings should be considered preliminary.

# Findings

## Summary of key findings from interviews with clients

- Clients reported high levels of satisfaction with the program;
- Families reported a range of benefits including improvements in communication between family members;
- A number of areas for improvement were raised such as being able to have follow up sessions and some raised the need for greater information about dual diagnosis being available to parents in the broader community.

## Summary of key findings from consultation with staff

### *Staff recruitment and agency liaison and referral*

- Slow recruitment due to small cohort of available family therapists with skills in mental health and alcohol and other drugs, and further hindered by limited renumeration available from a NGO.
- Co-location of staff at a variety of agencies across regions was an important component to support family access to the service and has the potential to enhance referrals, however it adds to increased travel time and dislocation for Family Eclipse therapists.
- Referrals to Family Eclipse take time to build up momentum, i.e. agencies need time to understand and appreciate the benefits of family inclusive practice.
- Part of the role of the Family Eclipse therapist was to advocate for the family's potential role as resource in the context of the young persons' individual therapy (which generally occurred in the absence of the family). At times this tension created a barrier to referrals.

### *Staff experiences of the program*

- Family therapy work in the context of a young person who has a dual diagnosis is complex and extremely demanding and requires sophisticated skills in engaging the difficult-to-reach. Staff reported the need to be flexible, highly skilled in family therapy and have a thorough understanding of mental health and substance use disorders.

- While complex to organise (easier when the young person is in residential drug treatment), multi-family groups appear to have the potential to powerfully impact on families.

- Once in therapy together, changes can be easily observed when the family dynamics start to improve and families are capable of making substantial progress

- The young people attending were often very disengaged from their families. The Family Eclipse Program had a positive impact on intra-family communication.

- The Family Eclipse program provides a unique service that complements the work of youth services; there is no other program within the area of young people and mental health which has that mandate.

### *Challenges and recommendations*

- Therapist time was taken up by education and networking activities to potential referring agencies, to support referrals for this particular client group. This provided challenges in terms of time and ideally an additional staff member could be recruited who would act as a program development coordinator. This person would develop a strategy to efficiently advertise the program, liaise with services and provide education tailored to suit the different strata of relevant service professionals across the medical, health and community services.

- The complexity and isolated nature of the work would lend itself to working in therapist pairs particularly in providing a second perspective in the family sessions and immediate post session debriefing.

- A proportion of young people in need of assistance had no formal mental health diagnosis or were just outside the age limit to access the program and thus could not be included in the program. Discretion could be used to broaden the age range of the target client group, and/or young people with less serious mental health issues could be included in the program catchment, to reflect the flexibility required by this client group for success and ensure that vulnerable young people and their families did not miss out on necessary interventions.

## Summary of key findings regarding the effectiveness of the program

Analyses regarding the effectiveness of the Family Eclipse program revealed a number of statistically significant improvements for young people and their families 3 months after completing the program. These results are summarised below according to the major variable of interest and are presented in full later in this report. It should be noted that given the small sample sizes for the young people at the follow up time point (11 young people), it is very difficult to detect significant changes and hence results for the follow up component should be considered as preliminary.

### *Family Functioning*

- *Young People* – Young people reported improvements in their perceived levels of general family functioning at Program Completion. While this improvement was not sustained to levels of significance at the three-month follow-up point, we found an overall trend for scores on this and all other subscales of the FAD to improve over time for young people.
- *Significant Others* – Significant others in our study did not report a statistical significant improvement in family functioning although there was a general trend for scores to improve over time.

### *Outcomes for Young People*

- *Mental Health* - Young People experienced significant reductions in mental health symptoms for all the subscales of the BASIS-32 upon completing the Family Eclipse Program. However, three months later this result was maintained for only one of the BASIS-32 subscales at Follow-up (Impulsiveness).
- *Drug Use* – Reported frequency of drug use varied by substance/drug and over time for Young People. Cannabis use significantly declined amongst young people who completed the Follow-up phase of this study
- *Quality of Life and Social Connectedness* – Young People reported improvements on all dimensions of Quality of Life upon completing the Family Eclipse Program, however only improvements to perceived overall health were maintained at Follow-up. Similarly, perceived levels of social connectedness improved upon immediate completion of the program, but this was not maintained at Follow-up .

### *Outcomes for Significant Others*

- *Mental Health* –. Significant Others reported fewer problems/symptoms of relating to self and others, depression and anxiety, daily living, psychosis, and overall mental health after participating in the program and this was maintained at least three months after program completion.
- *Quality of Life and Social Connectedness* – Significant improvements were found on three of the four domains comprising the WHO Quality of Life measure. Our group of Significant Others reported better perceived psychological health, social relationships and environment

over time. No changes were found in perceived levels of social connectedness over time for this group of participants.

- *Caregiver Burden* – Significant reductions were found in the reported negative experiences of care-giving by our sample of Significant Others over time.

## Conclusions

Preliminary results from this evaluation of the Family Eclipse Program are very promising. However, outcome data needs to be interpreted with caution due to the current small sample size at the 3 month data collection point. While our small sample size limited our capacity to detect significant changes over time for our group of young people, our analyses still revealed some improvement amongst this group in perceived general family functioning, reported mental health symptoms, quality of life and social connectedness upon completing the program. The overall trend in young people's results between Baseline and Follow-up, even though largely non-significant, was towards improvement. It is possible that with a larger sample size, we would detect a range of significant improvements in functioning 3 months after program completion. Significant Others reported a range of positive outcomes in terms of improved mental health symptoms, quality of life and a reduction in caregiver burden after completing the program.

## Recommendations

- Given the promising findings and the program's unique mandate, it is strongly recommended that funding for this program continues. The program has now begun to develop momentum within the service sector. It now requires further consolidation and continued support in order for its full potential to be realised.

- Monitoring client outcomes would be a vital component of the continuation of this unique service. These outcomes can then be disseminated to the wider service community to inform and enhance practice change for this client group who often fall through the gaps.

- It is recommended that the program design whereby family clinicians are embedded within appropriate agencies is an effective strategy and increases client acessibility to the service and promotes family inclusive practice within the agencies.

- Family work with this group is challenging and referral pathways take time to establish, hence it is recommended that ongoing resources be provided to support both referral and liaison with youth mental health and drug treatment agencies, and for direct service provision to families.

# INTRODUCTION

Significant proportions of clients who have a dual disorder live with family members or see family members on a regular basis (Mueser et al., 2003; Niv, Lopez, Glynn & Mueser, 2007). Families can reduce the effects of stress on the client but they can also unintentionally contribute to or maintain ongoing substance abuse. Family stress, such as tension, conflict and poor communication, has a negative effect on the course of dual disorders, increasing the likelihood of relapses and hospitalisations (Mueser et al., 2003; Niv et al., 2007). The strain of substance abuse and psychiatric illness can further contribute to family stress and worsen the dual disorder (Mueser et al., 2003). Research shows that family members react more negatively to a dual diagnosis patient, which can result in an increase of substance abuse and psychiatric symptoms, thereby producing a vivacious cycle (Niv et al., 2007). This research highlights the great need for services for affected families, which not only teaches families coping strategies, but also about the interaction between mental illness, substance abuse and family dynamics.

Family involvement in treatment has been supported by a great deal of empirical evidence which shows the effectiveness of family therapy on substance abuse and mental illness. Moore (2005) reviewed family and peer interventions in treating mental illness and substance use disorders separately. Research shows that including families in treatment helps to engage treatment-resistant individuals, promotes psychiatric stability and treatment adherence, reduces relapse and substance use, and improves the well-being of clients and family members (e.g. Clark, 2001). Short-term benefits of involving families in treatment includes reduced family stress, improved monitoring of the disorder, fewer relapses and hospitalisations and housing stability (Mueser et al., 2003). Long-term benefits involve family members developing resources and skills for maintaining their relationship with the dually diagnosed relative, fostering recovery, and ultimately strengthening the family (Mueser et al., 2003).

There is limited data in Australia which addresses the question of the effectiveness of family therapy with young people who have co-occuring substance use and mental health disorders. The current evaluation, although preliminary in nature due to the small sample size, provides some unique insights into family inclusive practice within youth mental health.

## Evaluation Methodology

A mixed methods approach was adopted to evaluate the effectiveness of the program. This approach involved three components:

- Consultation with staff;
- Feedback from clients ;
- A longitudinal study which evaluated key outcomes for clients attending the family eclipse program. The key outcomes expected to improve as a result of attending the family eclipse program were:
    - Improved family functioning
    - Reductions in mental health symptoms and drug use
    - Improvement in quality of life and social connectedness
    - Reductions in caregiver burden experienced by parents/guardians
    - High levels of satisfaction reported by clients

## Sample

The evaluation sample is drawn from participants of the Family Eclipse Program and includes the young people (aged 16-24 years) with co-occurring drug use and mental health conditions, and their Significant Others (family members, caregivers, partners).

Every family member who participated in the Family Eclipse program and completed therapy on was invited to participate in the evaluation as a routine part of their baseline assessment. If they agreed, they provided a written consent, which they were able to rescind at any time.

Table 1 displays the number of participants who took part in this study at each of the three assessment periods (baseline, program completion, 3 month follow up). Twenty-two families remain in treatment and hence it was not possible to collect completion and follow up data on these participants. In this respect the analyses of the data remain preliminary until the final data collection is complete.

Table 1. Participant Numbers by group at Baseline, Program Completion, and Follow-up

| Time Period | Young People (n) | Significant Others (n) | Total (n) |
|---|---|---|---|
| Baseline (Time 1) | 45 | 94 | 139 |
| Program Completion (Time 2) | 21 | 50 | 71 |
| **Follow-up (Time 3)** | **11** | **28** | **40** |

## Measures

All participants completed questionnaires via telephone or face-to-face interview at Baseline, Completion and Follow-up. Each questionnaire included a range of questions regarding participant demographics, program satisfaction as well as the measures designed to assess the major variables of interest in this study: alcohol and drug use, mental health, wellbeing and quality of life, social connectedness, family functioning, and caregiver burden. A description of each these measures is given below, beginning with the measures given to young people across all three time periods. Additional measures and differences for Significant Others are then listed following this.

### Family Functioning

*The Family Assessment Device* (FAD: Epstein, et al., 1983) is a self-report scale compromising of 60 items which family members rate on a 4-point scale (strongly agree to strongly disagree) with respect to how well each item describes their family functioning. The FAD was designed to measure the six dimensions of the McMaster Model of Family Functioning, and to provide an additional measure of overall family functioning. Each of the FAD subscales is scored so that higher scores indicate greater family dysfunction. The scores range from 1 (healthy) to 4 (unhealthy).

We asked all clients to complete four of the six subscales:

- Communication is defined as the exchanges of information among family members. The focus is on whether verbal messages are clear with respect to content and direct in the sense that the person spoken to is the person for whom the message is intended or whether the communication in the family is indirect and vague.
- Affective Responsiveness is defined as the ability of individual family members to experience appropriate emotions and to respond to a range of situations with appropriate quality and quantity of emotion.
- Affective Involvement is defined as the value placed on the family members concerns and the degree to which family members are involved and interested in the activities of other family members. The healthiest families have intermediate levels of involvement, nether too little or too much.
- General Functioning is defined as the overall health and pathology of the family.

## Measures given to young people at all assessment points

### ❖ Alcohol and Drug Use

Young people's drug and alcohol use was measured using the frequency of alcohol and drug use questions within the drug section of the Addiction Severity Index (ASI: McLellan, et al., 1996). The ASI was developed for use in the clinical setting in the course of conducting outcome evaluation studies. We used four questions from the ASI 'Drug/Alcohol Use' section asking Young People's age at first use, their lifetime use (in years), and their frequency of use (in the past 30 days). For alcohol only, we asked one question regarding their amount of use (average number of drinks in a single sitting).

### ❖ Mental Health

A range of interview questions were included to assess client's psychological history, diagnoses, and treatment at baseline. In addition to this, at each assessment period we measured current mental health symptoms by administering the Behaviour and Symptoms Identification Scale-32 (BASIS-32) (Eisen, et al., 1986) is a 32-item self-report instrument measuring symptoms, behaviour and functioning. The measure was developed for psychiatric outcome evaluation. The survey measures the degree of difficulty experienced by the individuals during a one-week period on a five-point scale ranging from no difficulty to extreme difficulty. It has been shown to have acceptable reliability, validity and sensitivity to change. Five subscales can be calculated for the BASIS-32: Relation to Self and Others, Depression and Anxiety, Daily Living and Role Functioning, Impulsive and Addictive Behaviour, Psychosis, in addition to a total functioning score. Just as each item is rated on a 5-point scale (from 0 for least difficulty to 4 for greatest difficulty), subscale and overall Average scores also range from 0 to 4. The lowest possible score is 0 (if every item is rated as "no difficulty"). The highest possible score is 4 (if every item is rates "extreme difficulty").

### ❖ Wellbeing and Quality of Life

The World Health Organisation Quality of Life - Bref (WHOQOL-BREF; World Health Organisation, 1996) is an abbreviated version of the WHOQOL-100. It contains 26 questions which produce a quality of life profile. The questionnaire can also produce four domain scores which denote an individual's perception of quality of life in the following areas: physical health, psychological, social relationships and environment. Domain score range is 0-100; item range is 1-5. Higher scores indicate better quality of life. Population norms are presented in the table for comparison purposes.

### ❖ Social Connectedness

All clients were asked to complete the *Friendship Scale* (Hawthorne, 2006), which measures felt social isolation. It is a 6-item measure, with a score range of 0 to 24. A high score represents social

connectedness and a score of "0" complete social isolation. The range is divided into 5 categories to represent varying degrees of social isolation or connectedness, as follows:

0-11 Very socially isolated
12-15 Isolated/low-level social support
16-18 Some social support
19-21 Socially connected
22-24 Very socially connected

## Measures given to Significant Others

Measures given to the group of Significant Others differed only slightly from that given to young people (See above). No data was collected regarding alcohol and drug use for this group, and one additional measure was included to measure caregiver burden. Details of this measure are given below.

### ❖ Caregiver Burden

We measured caregiver burden using the *Experience of Caregiving Inventory* (ECI: Szmukler, et al., 1996). The ECI is a 66-item self report questionnaire which measures carers' appraisal of the caregiving experience. Carers are required to indicate on a 5-point scale the extent to which they have thought about each item during the previous month. The scale yields a total negative score (range 0–208) and a total positive score (range 0–56), consisting respectively of eight negative and two positive subscales. The negative scales are: difficult behaviors, negative symptoms, stigma, problems with services, effect on the family, need to backup, dependency, and loss. Personal experiences and good aspects of the relationship contribute to the overall positive score. This instrument has established reliability and validity.

## Procedure

All clients participated in a comprehensive assessment which involved a clinical assessment, completion of baseline measures and development of treatment goals. The clinical assessment involves an adapted version of Mueser et al.'s (2003) *Functional Assessment Interview* for the dually diagnosed young person and the *Family Member Interview* for family members. At the completion of treatment all clients were asked to once again complete the series of measures assessing our variables of interest, plus a program satisfaction questionnaire. Some families who had engaged in treatment for a significant length of time were asked to complete a review interview which replicated the completion interview. Finally, this data was again collected 3 months after treatment completion. The study received ethics approval from the relvant University ethics committee.

# CHARACTERISTICS OF PARTICIPANTS

The participant characteristics at Baseline (Time 1) are shown in the tables below. As can be seen in these tables, mothers comprised the majority of our group of Significant Others taking part in the Family Eclipse Project, with fathers representing the second largest group of Significant Others to take part. Most of the young people participating in this study were male. The majority of young people reported that they were not in a relationship, and only a few reported having had children.

Table 2. Participant age (in years) and family membership status of Significant Other at Baseline

| | N | Average age | Age range |
|---|---|---|---|
| Young people | 45 | 19.2 | 15 – 24 |
| Significant Others | 94 | 42.3 | 16 - 77 |
| Mother | 43 | | |
| Father | 27 | | |
| Sister | 8 | | |
| Brother | 7 | | |
| Grandparent | 3 | | |
| Partner | 3 | | |
| Cousin | 1 | | |
| Aunt | 1 | | |
| Step-parent | 1 | | |

Table 3. Gender and Marital Status of Participants at Baseline

| | Young people (n=45) | | Family member (n=94) | |
|---|---|---|---|---|
| | N | % | n | % |
| Gender | | | | |
| Male | 26 | 57.8 | 39 | 41.5 |
| Female | 19 | 42.2 | 55 | 58.5 |
| Marital Status | | | | |
| Single | 36 | 80.0 | 20 | 21.3 |
| Relationship | 4 | 8.8 | 2 | 2.1 |
| Defacto | 2 | 4.4 | 8 | 8.5 |
| Married | 0 | - | 49 | 52.1 |
| Separated | 0 | - | 2 | 2.1 |
| Divorced/Widowed | 1 | 2.2 | 3 | 3.2 |
| Children | | | | |
| Has children | 3 | 6.7 | | |

### *Referral Source*

Information was gathered regarding the source of the referrals made of young people to the Family Eclipse Project. In examining the data from the 45 young people who took part at baseline, it was noted that most referrals came from Alcohol and Drug Services (44.4%), and from within Odyssey House (22.2%).

Table 4. Referral sources for young people, n=45

| **Referral Agency** | **Number referred (% )** |
|---|---|
| ARAFEMI | 3 (6.7) |
| Child Protection | 1(2.2) |
| Schools | 2 (4.4) |
| Mental Health | 6 (13.3) |
| Odyssey Services | 10 (22.2) |
| Pamphlet | 1 (2.2) |
| AOD Services | 20 (44.4) |
| **Youth Community Houses** | **2 (4.4)** |

We examined the Baseline (Time 1) results to get a sense of the participants' functioning prior to beginning the Family Eclipse Project. We first explored variables relating to family functioning

before conducting some descriptive analyses on the major variables of interest in this study and comparing the results by group (Young People or Significant Other).

### *Family Functioning*

As family functioning was our key area of interest in this study, we first explored the baseline results of the FAD. We found a high degree of family dysfunction at Baseline, with families scoring above the cut-off on all subscales of the FAD..

Table 5. Average Family Scores and Cut-Off Scores for the FAD at Baseline, n=45

| FAD Subscale | Family Score | Cut-Off Score* |
|---|---|---|
| Communication | 2.32 (60.8) | 2.2 |
| Affective Responsiveness | 2.36 (55.6) | 2.2 |
| Affective Involvement | 2.37 (73.3) | 2.1 |
| General Functioning | 2.36(86.7) | 2.0 |

*Greater than or equal to cut-off score= unhealthy functioning in that dimension; less than cut-off score = healthy functioning on that dimension.

### *Mental Health and Alcohol and Drug Use*

We carried out a number of descriptive analyses at Baseline to develop an understanding of the mental health issues and drug and alcohol issues facing the Young People in our Study. These results are presented below.

### Mental Health

In exploring the mental health history of the young people in our sample, we found that most had been officially diagnosed with at least one psychological disorder in the past. Of the 45 participants, 88.9% (n=40) reported having been given a single diagnosis, 53.3% (n=24) had been given diagnoses of two different psychological disorders, and 20% (n=9) had been given three diagnoses. Table 8 outlines the frequency of various diagnoses given to the young people in our sample. Trauma experiences were also common amongst young people, with 60% (n=27) reporting having been involved in a traumatic event.

In relation to the Significant Others, 38.3% (n=36) reported having received treatment for a psychological disorder in the past.

Table 6. Summary of the types of psychiatric diagnoses reported by Young People at Baseline

| Psychiatric Diagnosis | n=45 (%) |
|---|---|
| Depression | 19 (42.2) |
| Anxiety | 17 (37.8) |
| Bipolar Disorder | 10 (22.2) |
| ADHD | 5 (11.1) |
| Borderline Personality Disorder | 5 (11.1) |
| Depression/Anxiety | 4 (8.9) |
| Schizophrenia | 2 (4.4) |
| Autism Spectrum Disorder | 2 (4.4) |
| Psychotic Episode | 2 (4.4) |
| Drug Induced Psychosis | 2 (4.4) |
| Paranoia | 1 (2.2) |
| Conduct Disorder | 1 (2.2) |
| Obsessive Compulsive Disorder | 1 (2.2) |
| Post Traumatic Stress Disorder | 1 (2.2) |
| Dysthymic Disorder | 1(2.2) |

The overall average age for being diagnosed with a psychological disorder was 16.3 years. When asked to report past and current treatments for psychological disorders, 62% (n=28) stated that they had been prescribed pharmacotherapy at some point for their psychological disorder(s) and 35.6% (n=16) had been hospitalised for a mental health condition. It was also noted that 46.7% (n=21) had been in trouble with the law at some time prior to coming in to the Family Eclipse Project.

## Drug and Alcohol Use

In relation to alcohol and drug use at Baseline, Table 7 presents the data obtained regarding the frequency, duration and types of drugs used by young people in this study. The drugs used most commonly and at the earliest age by our sample, were alcohol and cannabis.

Table 7. Young people's drug and alcohol use at Baseline, n=45

| Drug Type | Average age at first use (years) | Average no. of years used | Average no. of days used in the past 30 days | Average no. of drinks per day when drinking | n(%) |
|---|---|---|---|---|---|
| Alcohol | 13.4 | 4.3 | 6.7 | 6.6 | 39 (86.7) |
| Alcohol to intoxication | 14.4 | 5.0 | 6.6 | 9.9 | 28 (62.2) |
| Heroin | 16.9 | 2.1 | 6.9 | | 8 (17.8) |
| Sedative/Hypnotics | 19.7 | 1.4 | 5.7 | | 7 (15.6) |
| Cocaine | 17.0 | 1.1 | 1.2 | | 7 (15.6) |
| Cannabis | 14.0 | 5.5 | 12.1 | | 34 (75.6) |
| Hallucinogens | 16.0 | 1.0 | 0.3 | | 9 (20.0) |
| Methadone/Bupranorphin | 16.4 | 2.2 | 2.1 | | 23 (51.1) |
| Amphetamines | 16.7 | 3.0 | 0.5 | | 11(24.4) |

### *Quality of Life and Social Connectedness*

All participants completed the WHO-QOLBref and Friendship Scale to provide some information about their levels of quality of life and perceptions of social connectedness. Results are presented below comparing the results of Young People and Significant Others at Baseline.

### Quality of Life

Results at Baseline indicated that our sample reported scores that were lower than the population average on almost all of the domains of the WHO-QOLBref, and that young people were worse off than our group of Significant Others on all domains. Average scores (and transformed values giving a score out of 100 based on WHO-QOL scoring guidelines), are presented below.

Table 8. WHO Quality of Life scores Young people, Significant Others at Baseline, and WHO--QOLBref Population Norms

| | Young People n = 43 | Significant Other n=85 | Population norms |
|---|---|---|---|
| QOL Domain | Average Score (transformed score) | Average Score (transformed score) | Average |
| Overall perception of QOL | 3.05 | 3.5 | 4.3 |
| Overall perception of health | 2.70 | 3.3 | 3.6 |
| Physical Health | 23.98 (63) | 26.6 (69) | 80.0 |
| Psychological Health | 16.59 (44) | 21 (63) | 72.6 |
| Social Relationships | 9.31 (50) | 10.4 (56) | 72.2 |
| Environment | 27.79 (63) | 30.6 (75) | 74.8 |

## Social Connectedness

The Friendship Scale was given to participants as a measure of the degree to which they perceived themselves to be socially connected or isolated. Results are presented in Table 9 and indicate that on average, young people had low levels of social support at baseline, while their Significant Others reported some degree of social support (ranges : 0-11 very socially isolated; 12-15 isolated/low-level social; support; 16-18 some social support ; 19-21 socially connected; 22-24 very socially connected).

Table 9. Descriptive Statistics for Friendship Scale results, young people and family members

| Young People n=43 Average Score | Significant Others n=84 Average Score |
|---|---|
| **13.86** | **16.2** |

In examining the breakdown of the responses given by young people regarding their social isolation, we found that 25.6% (n=11) reported that they were *very socially isolated*, and 42.6% (n=18) reported scores that indicated that they were *socially isolated or had low-levels of social support*. These scores indicate that perceived social isolation is a significant problem for the young people with comorbid mental health and drug and alcohol issues in our sample. A breakdown in levels of social isolation by group is presented in Figure 1.

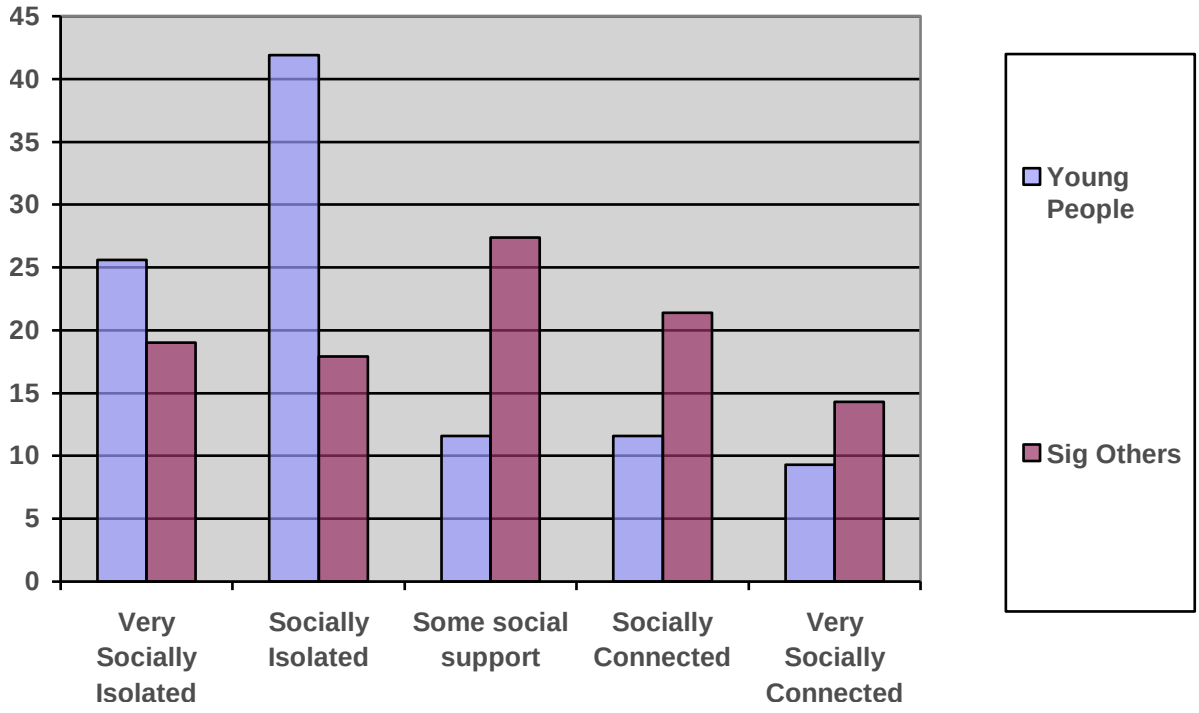


Figure 1. A comparison of the breakdown of reported levels of social isolation (% at each level of Friendship Scale) at Baseline for Young People (n=43) and Significant Others (n=84)

### *Caregiving Burden*

We assessed the caregiving experience of the group of Significant Others in our sample by administering the ECI. Average scores for both the total positive and total negative subscales are given in Table 10, and we found that on both dimensions, our group scored in the midrange for both subscales. This indicates that prior to completing the Family Eclipse Program, our Significant Others did not report a highly positive of highly negative experience of caring for the young person affected by comorbid psychological and drug and alcohol issues.

Table 10. Baseline Scores and Scoring Range for the ECI, n=81

| ECI Dimension | Time 1 Average | Score range |
|---|---|---|
| Caregiver Burden – Negative score | 106.1 | 0-208 |
| Caregiver Burden – Positive score | 27.8 | 0-56 |

# EVALUATION FINDINGS

## Feedback from families

As part of the evaluation, families were asked to respond to a number of qualitative questions about their experience of and satisfaction with the program. This information was then analysed thematically and the results are presented below.

The analysis of results indicated that the majority of participants were satisfied with the information and service received, and most could identify a range of positive effects of the program on personal and family skills (see Table 11).

Table 11: Percentage of families who reported being satisfied at program completion and three month follow up.

| | Completion | Follow up |
|---|---|---|
| Satisfaction with information and service | 88.4% | 85% |

Specific comments indicated the work done with clinicians was valued and appreciated:

> *"Very satisfied. I found (therapist) was well informed, respectful, supportive, informative. She wasn't patronising. She was respectful of (young person) so that was most important."* (Mother, 027)

> *"The program and (therapist) were a huge support for us when we were in crisis and despair. Like a lighthouse in a storm."* (Mother, 057)

> *"After many years of councellors (sic) nothing has worked as well for my family as Eclipse has…..Family Eclipse program and (therapist) (Odyssey House) saved and repaired my family."* (Young person, 057)

> *"For my husband and I to be include d was important for us – his behaviour h as an impact on the whole family."* (Mother, 027)

Sometimes families were aware they had not been able to fully participate, which had an impact on their satisfaction.

> *"We weren't really consistent with it – would have been better if Dad's work schedule hadn't gotten in the way'.* (Young person, 032)

There were some families who indicated the program did not offer what they wanted or expected.

> *"Made me more frustrated and I took it out on him* (husband)*. Didn't focus on other family aspects – younger family members (*young person's *sisters). … Going over the same thing all the time. I'd end up more agitated, more pissed off. It kept going around in my head….I want to clear it out of my head."* (Mother, 047)

> *"I didn't receive real help for him. I don't need help for me. Lots of information but so much was directed to me, not him."* (Father, 039)

Satisfaction was impacted on by feelings of exhaustion and being overwhelmed by their young person's circumstances.

> *"We have gone through a hell of a lot. It's not fair on the rest of the family."* (Mother, 047)

## Specific skills learned:

When asked to consider what has changed since being involved in the FEP, families reported changes in their own behaviour and that of other family members:

> *"I try to be calmer. I try to model behaviour that I hope he'll follow ….. I say 'I won't tolerate it'. I say 'I won't be disrespected'. He's trying a lot because of that and he feels better in himself. It's like lifting a fog from his true nature. It's been a big improvement. (Clinician) set this in motion in their one-on-one. She encouraged him to take responsibility rather than a victim of circumstances. I felt overwhelmed…. I have more confidence in my son now, he's getting more sensible. (Clinician) would be very proud of him."* (Mother, 027)

### *Communication*

> *"We recognise certain things about each other and how to communicate – keeping eye contact, etc…. It's made my family easier to deal with, they're off my back somewhat."* (Young person, 032)

> *"I have learnt how to better simple communication i.e. asking a question, praise & requesting ect* (sic)" (Young person, 057)

> *"(Therapist) being able to help us all to talk. She could understand what I was trying to say and reiterate it to them so they'd understand….Because my partner and mother now understand, I can communicate it a lot better."* (Young person, 051)

### *Supportive environment for change*

> *"I like (clinician)'s approach – very patient, encouraging. If she ever got frustrated, she never let it show….. It's allowed (son) and I to discuss things in a safe environment – no one to dominate the situation."* (Father, 032)

> *"The frameworks helped me to put our troubles and my daughter's behaviour in context. …The handouts and exercises in communication were a good reminder. It helped me to focus on some positives. Talking through problems with a facilitator skilled in this area has helped us remain calm."* (Mother, 057)

> *It gave us neutral ground to say things to each other. He (young person) could say things easier."* (Mother, 045)

> *"It's allowed (young person) and I to discuss things in a safe environment – no one to dominate the situation."* (Father, 032)

### *Tools for understanding*

> *"Helped me with some tools to help the kids and gave me an understanding of where (young person's) head was at. … Helped the kids understanding my point of view."* (Mother, 045)

> *"I understand the cycle he goes through, his triggers, how to deal with him better. I pick up a lot more now."* (Father, 032)

*"…To know how our behaviours affected him took a long time. Parents were excluded. At that age are so private, it can be hard for parents to know how to help…..Understanding addiction and mental health as interconnected has opened up new ways of looking at things"* (Mother, 027)

### *Self care*

*"I used to have problems overanalysing things – I've learnt not to look too deeply into things that aren't my issue. I have to let go, I can't fix the world. I learned to step back, to recognise my own burnout. I think that's one of the biggest lessons I've learnt – to self care."* (Mother, 045)

Family feedback indicated the skills they learnt were kept in mind:

*"It's easier to learn than to practice but I'm definitely trying"* (Young person, 051)

*"I like to think about the problem first – this is a big shift for me."* (Young person, 032)

*"I try! Lots of times we don't but if we remember, we try."* (Mother, 024)

## Areas for improvement

Some families suggested ways in which the program needed to or could improve their work.

One mother indicated she would have appreciated being included in a multi-family therapy group:

*"I would find it really beneficial to talk to other parents. I feel quite isolated, I struggle. This helped us tremendously, but sometimes I feel like I'm flying blind."* (Mother, 045)

Additional follow up was suggested by one family member:

*"It would be helpful to keep in contact at later points – my relationship with (young person) at one point depended on the steps he took. He'd stopped using but hadn't gotten back into life. Seeing him progress into that gives us (he and I) an avenue to connect again – reintroducing him to the family".* (Father, 032)

Another spoke of the difficulty of finding assistance for the family or hinted the service was not well known.

*"Took me a long time to find help. It can be hard to know where to look."* (Mother, 024)

*"….the best support I've ever encountered. More people should be aware of it."* (Young person, 057)

Some parents had comments that were more generally applicable to treatment services.

One parent recommended services facilitate the provision of at least minimum information to reduce worry for families:

*"More information needs to be made available to parents – we need to know what's going on….He could be 40, he's still my child, I still need to know what's going on. I ask where he is,*

*no one can tell me. I don't know if he's safe. It may be a good idea to include some kind of permission (written) for him to check when he talks with you to say "You may tell my family I'm here" or something like that. Parents need to know where their kids are."* (Father, 039)

## Summary of Treatment Outcomes

As this was a longitudinal study, we were able to explore the impact of the program by comparing results at Program Completion (Time 2) and Follow Up (Time 3) with the scores obtained at Baseline (Time 1). Statistical analyses were conducted to assess change over time on these variables for both young people and their Significant Others. Because of the small sample size of young people at Program Completion and Follow up (i.e., 11 participants), we were restricted to using only t-tests and non-parametric analyses (Wilcoxon Signed Rank Test) with this group to explore whether there were any significant changes on these measures between assessment points. We conducted multivariate analyses with the data obtained from our group of Significant Others as the bigger sample size allowed for the underlying assumptions of these statistical tests to be satisfactorily met. Analyses conducted for the young people are limited by the small sample and hence should be considered preliminary. Key results of these analyses are presented below, followed by a detailed description of all findings.

### *Key Findings : Family Functioning*

- Young People – Young people in our study were found to report improvements in their perceived levels of general family functioning at Program Completion. While this improvement was not sustained to levels of significance at the three-month Follow-up point, we found an overall trend for scores on this and all other subscales of the FAD to improve over time for young people. Most importantly, two of the FAD subscale scores (Communication and Affective Responsiveness) had reduced to levels very near to the FAD cut-off scores, suggesting a trend towards improvement in reported family functioning in these areas to almost normal levels on average for young people.

- Significant Others – Significant Others in our study reported no significant change to their perceived levels of Family Functioning at both Program Completion and Follow-Up. While scores on all of the FAD subscales did not change over time for this group of participants, we did observe a general trend for scores to improve over time. Moreover, at Follow Up, Average scores on the Communication subscale had dropped beneath the FAD cut-off score, and remained below cut-off for the Affective Responsiveness subscale. Scores on the General Functioning subscale had also reduced to levels very near to the FAD cutoff score at Follow-up, suggesting a trend towards improvement in reported family functioning to almost-normal levels.

### *Key Findings: Outcomes for Young People*

- Drug Use – Reported frequency of drug use varied by substance/drug and over time for Young People. Most significantly, cannabis use significantly declined amongst young people who completed the Follow-up phase of this study

- Mental Health - Young People experienced significant improvements in all reported symptoms of mental health (as measured by the BASIS-32) upon completing the Family Eclipse Program, however, this significant result was maintained for only one of the BASIS-32 subscales at Follow-up (Impulsiveness).

- Quality of Life and Social Connectedness – Young People reported improvements on all dimensions of Quality of Life upon completing the Family Eclipse Program, however only improvements to perceived overall health were maintained at Follow-up. Similarly, perceived levels of social connectedness improved upon immediate completion of the program, but this was not maintained at Follow-up and young people reported generally very low levels of perceived social support.

### *Key Findings: Outcomes for Significant Others*

- Mental Health – Significant reductions were found on all but one of the BASIS-32 subscales (impulsive/addictive). Our group of Significant Others reported fewer problems/symptoms of relating to self and others, depression and anxiety, daily living, psychosis, and overall mental health over time.

- Quality of Life – Significant improvements were found on three of the four domains comprising the WHO-QOLBref measure. Our group of Significant Others reported better perceived psychological health, social relationships and environment over time.

- Caregiver Burden – Significant reductions were found in reported negative aspects of caregiving by our sample of Significant Others over time.

## Outcomes on Family Functioning

### Young People

Paired sample t-tests were carried out to compare scores at Baseline and Program Completion, and non-parametric tests were conducted with data at Baseline and Follow-up (due to the small sample size at Follow up for Young People). Results of the t-tests indicated that there was a significant change from Baseline to Program Completion in scores obtained on the General Functioning subscale of the FAD for young people, $t(19) = 2.75$, $p<.05$, suggesting that young people perceived that their general family functioning had improved when they completed the Family Eclipse program. However, no differences were found in Communication, $t(19) = -0.63$, $p>.05$; Affective Responsiveness, $t(19)=0.79$, $p>.05$; or Affective Involvement, $t(19) = .14$, $p>.05$. When examining scores at Baseline and Follow-up, we also found that there were no significant differences for young people on any of the dimensions of the FAD across these time periods: Communication, $z = - 0.22$, $p>.05$; Affective Responsiveness, $z = -0.77$, $p>.05$; Affective Involvement, $z = -1.37$, $p>.05$; or General Functioning, $z = -0.36$, $p>.05$.

While changes in FAD subscale scores over time were largely non-significant for our group of young people, you can see in Table 17 that there was an overall trend for scores to reduce over time. Moreover, scores on the Communciation and Affective Responsiveness subscales had reduced by Follow-up to levels very near to the FAD cutoff score, suggesting a trend towards improvement in reported family functioning in these areas to almost normal levels

### Significant Others

To explore whether there was any change on any subscales of the FAD over time for our sample of Significant Others, a Repeated Measures MANOVA was conducted. Results of this test indicate that there were no changes over time for Significant Others on any of the FAD subscales.

While changes in FAD subscale scores over time were statistically non-significant for our group of Significant Others, there was an overall trend for scores to reduce over time. Moreover, at Follow Up, Average scores on the Communication subscale had dropped beneath the FAD cut-off score, and remained below cut-off for the Affective Responsiveness subscale. Scores on the General Functioning subscale had also reduced to levels very near to the FAD cutoff score at Follow-up, suggesting a trend towards improvement in reported family functioning to almost-normal levels.

Table 12. A comparison of FAD cut-off scores to FAD scores obtained from Young People (YP) and Significant Others (SO) at Baseline, Program Completion, and Follow Up

| | **Baseline Average (SD)** | | **Program Completion Average (SD)** | | **Follow-Up Average (SD)** | | **FAD Cut-Off Score** |
|---|---|---|---|---|---|---|---|
| FAD Subscale | **YP** | **SO** | **YP** | **SO** | **YP** | **SO** | |
| Communication | 2.33 (0.47) | 2.26 (0.39) | 2.37 (0.48) | 2.14 (0.37) | 2.24 (0.57) | 2.15 (0.32) | 2.2 |
| Affective Responsiveness | 2.51 (0.59) | 2.14 (0.48) | 2.37 (0.44) | 2.03 (0.52) | 2.20 (0.67) | 2.06 (0.44) | 2.2 |
| Affective Involvement | 2.41 (0.46) | 2.23 (0.44) | 2.46 (0.40) | 2.19 (0.49) | 2.18 (0.57) | 2.15 (0.45) | 2.1 |
| **General Functioning** | **2.43 (0.55)** | **2.24 (0.47)** | **2.27 (0.46)** | **2.06 (0.44)** | **2.23 (0.60)** | **2.05 (0.37)** | **2.0** |

## Outcomes for Young People

To explore the impact of the Family Eclipse Project on the young people who participated in the program, a number of analyses were conducted to determine the extent of change between baseline and program completion, and between baseline and 3-month follow-up in four key areas of enquiry: a) Drug Use and Mental Health, and b) Quality of Life and Social Connectedness.

### Drug Use

Baseline results for drug use were presented earlier in this report. At Program Completion and Follow Up, young people participating in this study were asked to report whether they had used any alcohol or drugs in the past 30 days. From those who responded to this question, we found that 13 (61.9%) participants admitted to using drugs or alcohol in the past 30 days at Program Completion, and 3 (18.8%) stated that they had not. At the three-month follow up assessment, 10 (83.3%) of the 12 young people participating at this phase admitted to using drugs or alcohol in the past 30 days. Two young people stated they had not used any drugs or alcohol in this time.

As the most common drugs used by the group of young people who completed the final Follow-Up phase of this study were alcohol, cannabis, and speed/amphetamines, we have presented the Average usage these drugs across time periods in Table 13. Although we did not conduct statistical analyses of drug use due to a small sample, you can see that Cannabis use dropped markedly between Baseline and Follow-up, and the other drugs changed only slightly over this time period.

Table 13. Young People's reported frequency of drug use at Baseline, Program Completion and Follow-up, n=12

| Drug | Average No. of Days Used in Past 30 Days Baseline | Average No. of Days Used in Past 30 Days Program Completion | Average No. of Days Used in Past 30 Days Follow-up |
|---|---|---|---|
| Alcohol | 8.00 | 10.00 | 10.36 |
| Alcohol to Intoxication | 7.50 | 3.17 | 8.18 |
| Cannabis | 18.72 | 16.33 | 9.87 |
| **Speed/Amphetamines** | **0.5** | **4.67** | **2.44** |

### Mental Health

Young people's current psychological symptoms were assessed at each time period by administering the BASIS-32. Paired sample t-tests were carried out to compare scores at Baseline and Program Completion, and non-parametric tests were used to compares scores at Baseline and Follow-up on all subscales and the total score of the BASIS-32.

Results of the t-tests indicated that young people in this study experienced significant improvements in their mental health on all subscales of the BASIS-32 between Baseline and Program Completion – Relation to Self and Others, $t(20)=3.81$, $p<.01$; Depression/Anxiety, $t(19)=2.90$, $p<.01$; Impulsive/Addictive, $t(18)=4.28$, $p<.01$; Daily Living and Role Functioning, $t(18)=3.09$, $p<.01$; Psychosis, $t(18)=3.21$, $p<.01$; and Overall BASIS-32 Score, $t(18)=3.75$, $p<.01$.

Unfortunately most of these results were not mirrored at Follow Up and only one of the five subscale scores (Impulsive) was significantly lower at Follow up when compared to Baseline, $z = -2.04$, $p<.05$. Results of the non-parametric tests for all other subscales indicated that while scores were lower at Follow Up than they had been at Baseline, these changes were non-significant: Relation to Self and Others, $z = -1.41$, $p>.05$; Depression/Anxiety, $z = -1.23$, $p>.05$; Daily Living and Role Functioning, $z = -1.82$, $p>.05$; Psychosis, $z = -1.64$, $p>.05$; and Overall BASIS-32 Score, $z = -1.82$, $p>.05$. It is likely that the small sample size hindered the detection of any significant differences and hence interpretation of theses findings needs to be made with caution.

Young People's Average scores on each of these subscales across the three time periods are presented in Table 14. Lower scores reflect better psychological functioning.

Table 14. A comparison of Average scores on the subscales of the BASIS-32 for young people at Baseline, Completion, and Follow up

| BASIS-32 Subscale | Baseline Average (SD) n=42 | Completion Average (SD) n=20 | Follow Up Average (SD) n=12 |
|---|---|---|---|
| Relation to Self/Others | 1.84 (0.73) | 1.23 (0.72) | 1.37 (1.08) |
| Depression/Anxiety | 1.68 (0.89) | 1.21 (0.92) | 1.43 (1.25) |
| Impulsive/Addictive | 1.62 (0.95) | 0.69 (0.65) | 0.91 (0.84) |
| Daily Living/Role Function | 1.91 (0.82) | 1.32 (0.84) | 1.26 (1.26) |
| Psychosis | 0.84 (0.83) | 0.51 (0.60) | 0.64 (0.79) |
| **BASIS-32 TOTAL** | **1.60 (0.67)** | **1.01 (0.69)** | **1.09 (0.98)** |

We also asked young people at Program Completion and Follow up a number of questions regarding their current management and care of their mental illness. Of the 21 participants who took part at Time 2 (Completion), 12 (57.1%) indicated that they had a current mental health concern/psychiatric illness (two were 'unsure'), three (14.3%) young people indicated that they had been hospitalised because of their mental illness, eight (38.1%) were currently being prescribed medication for a mental illness (the majority of whom took this medication 'mostly' or 'always' as prescribed, n=7). At Time 3 (Follow Up), we found that seven (58.3%) of the 12 participants indicated that they had a current mental health concern/mental illness (one was 'unsure'), two (16.7%) young people indicated that they had been hospitalised because of their mental illness, six (50.0%) were currently being

prescribed medication for a mental illness (the majority of whom took this medication 'mostly' or 'always' as prescribed, n=4).

Finally, when asked about current legal issues, five of the 21 participants at Time 2 (Completion) reported having been charged with an offence since beginning the Family Eclipse Program. At Time 3 (Follow Up), only one of the 12 participants reported having been charged with an offence since completing the program.

## Quality of Life

We assessed young people's perceived Quality of Life by administering the WHO-QOLBref at each of the three assessment points. To determine if there had been any significant changes over time on this measure, paired sample t-tests were carried out on all QOL subscales and compared Baseline scores to those at Program Completion, and non-parametric tests were conducted to compare Baseline scores to those at Follow Up. Results are presented below (higher scores indicate higher perceived Quality of Life).

Results of the t-tests indicated that young people reported experiencing significant improvement in their perceived Quality of Life on all domains between Baseline and Program Completion – Overall Quality of Life, $t(19)= -3.57$, $p<.01$; Overall Health, $t(19) = -4.60$, $p<.01$; Physical Health – $t(19) = -2.24$, $p<.01$; Psychological – $t(19) = -4.83$, $p<.01$; Social Relationships – $t(19) = -2.89$, $p<.01$; Environment, $t(19) = -1.99$, $p<.01$.

Non-parametric tests comparing Baseline scores to those at Follow Up found that scores on the overall perception of health significantly changed at Follow up for our sample of Young People, $z = -2.11$, $p<.05$. However, these tests revealed no significant change over time for scores on the following subscales/domains of the WHOQOL for Young People between Baseline and Follow Up: Overall Quality of Life, $z = -1.61$, $p>.05$; Domain 1 (Physical Health), $z = -0.87$ , $p>.05$; Domain 2 (Psychological Health), $z = -0.85$, $p>.05$; Domain 3 (Social Relationships), $z = -1.08$, $p>.05$; and Domain 4 (Environment), $z = -0.49$, $p>.05$. Once again due to limited sample size results need to be interpreted with caution.

Table 15. A comparison of Average scores on the WHO-QOLBref at Baseline, Completion and Follow Up for Young People

| QOL Subscale | Baseline Average (SD) n=42 | Program Completion Average (SD) n=20 | Follow Up Average (SD) n=11 |
|---|---|---|---|
| Overall Quality of Life | 3.04 (0.82) | 3.65 (0.99) | 3.36 (1.36) |
| Overall Health | 2.70 (0.94) | 3.70 (0.66) | 3.55 (1.13) |
| Domain 1 – Physical Health | 23.99 (5.53) | 26.25 (5.17) | 26.54 (7.34) |
| Domain 2 – Psychological | 16.60 (3.76) | 19.95 (4.10) | 18.36 (5.64) |
| Domain 3 – Social Relationships | 9.31 (2.63) | 10.10 (2.43) | 9.36 (2.73) |
| **Domain 4 – Environment** | **27.80 (4.52)** | **29.95 (3.65)** | **29.18 (7.56)** |

### Social Connectedness

To assess Young People's perceived level of social connectedness at all three time periods, we administered the Friendship Scale. Paired sample t-tests were carried out to compare scores at Baseline and Program Completion and these revealed a significant improvement in reported levels of social connectedness over this initial assessment period for Young People, $t(20) = -3.26$, $p<.01$.

However, non-parametric tests no significant change over time for scores on the Friendship Scale between Baseline and Follow up for Young People, $z = -.05$, $p>.05$.

Table 16. A comparison of Average scores on the Friendship Scale at Baseline, Completion and Follow Up for Young People

| Scale | Baseline Average (SD) n=43 | Completion Average (SD) n=21 | Follow Up Average (SD) n=12 |
|---|---|---|---|
| **Friendship Scale** | **13.87 (4.93)** | **16.90 (5.03)** | **14.25 (6.02)** |

## Outcomes for Significant Others

To explore the impact of the Family Eclipse Project on the Significant Others who participated in the Family Eclipse program, a number of analyses were conducted to determine the extent of change between baseline, program completion, and 3-month follow-up. A summary of our key findings is presented below, followed by full details of all of our analyses under each of our key areas of enquiry for this group: a) Mental Health, and b) Quality of Life and Social Connectedness; and c) Caregiver Burden.

## Mental Health

To determine the impact of the Family Eclipse Project on the current psychological health of our sample of Significant Others, Repeated Measures MANOVAs were conducted for each of the subscales and total score on the BASIS-32. Because several of the subscales within this measure had significantly non-normal distributions for the group of Significant Others (Time 1 Psychosis subscale and Time 2 Psychosis and Impulsive), data on these scales was transformed via a square root calculation. Once this transformation was complete, the data satisfactorily conformed to a normal distribution and these transformed versions of the subscales were included in the multivariate tests.

### ❖ Relationship to Self and Others

The repeated measures MANOVA for this subscale indicated that the group of Significant Others experienced significant overall reductions in problems relating to themselves and to others over time – $F(2,44) = 7.40$, $p<.01$. An examination of post-hoc comparisons revealed that there was no improvement on this subscale between Baseline ($M = 1.14$) and Program Completion ($M = 0.99$), however a significant improvement was noted between Baseline and Follow-up ($M=0.66$), $p<.01$, suggesting that improvements on this subscale took some time to emerge. Post hoc comparisons also indicated that the difference between scores at Program Completion and Follow up was also significant, $p<.05$.

### ❖ Depression/Anxiety

The repeated measures MANOVA for this subscale indicated that the group of Significant Others experienced significant overall reductions in problems relating to depression and anxiety over time – $F(2,46)= 7.39$, $p<.01$. An examination of post-hoc comparisons revealed that there was no improvement on this subscale between Baseline ($M = 1.13$) and Program Completion ($M = 0.98$), however a significant improvement was noted between Baseline and Follow-up ($M=0.59$), $p<.01$, suggesting that improvements on this subscale took some time to emerge. Post hoc comparisons also indicated that the difference between scores at Program Completion and Follow up was also significant, $p<.05$.

### ❖ Impulsive

The repeated measures MANOVA for this subscale indicated that the group of Significant Others experienced no change in problems relating to being impulsive – $F(2,44)= 2.29$, $p>.05$.

### ❖ Daily Living

The repeated measures MANOVA for this subscale indicated that the group of Significant Others experienced significant overall reductions in problems relating to daily living – $F(2,46) = 3.28$, $p<.05$.

An examination of post-hoc comparisons revealed that there was no improvement on this subscale between Baseline (M =1.00) and Program Completion (M = 0.89), however a significant improvement was noted between Baseline and Follow-up (M=0.65), p<.05, suggesting that improvements on this subscale took some time to emerge. Post hoc comparisons indicated that there was no significant difference between scores at Program Completion and Follow up.

### ❖ Psychosis

The repeated measures MANOVA for this subscale indicated that the group of Significant Others experienced significant overall reductions in problems relating psychosis over time – $F(2,46)= 3.77$, $p<.05$. An examination of post-hoc comparisons revealed that there was no improvement on this subscale between Baseline (M = 0.26) and Program Completion (M = 0.28), however a significant improvement was noted between Baseline and Follow-up (M=0.06), p<.05, suggesting that improvements on this subscale took some time to emerge. Post hoc comparisons also indicated that the difference between scores at Program Completion and Follow up was also significant, p<.05.

### ❖ TOTAL BASIS-32

The repeated measures MANOVA for this subscale indicated that the group of Significant Others experienced significant overall reductions in their overall mental health, $F(2,42)= 7.32$, $p<.01$. An examination of post-hoc comparisons revealed that there was no improvement on this subscale between Baseline (M = 0.79) and Program Completion (M = 0.70), however a significant improvement was noted between Baseline and Follow-up (M=0.44), p<.01, suggesting that improvements on this subscale took some time to emerge. Post hoc comparisons also indicated that the difference between scores at Program Completion and Follow up was also significant, p<.05.

Reported Average scores on all subscales of the BASIS-32 over time are presented in Table 17 Lower scores reflect better mental health functioning.

Table 17. A comparison of Average scores on the BASIS-32 subscales across Baseline, Completion and Follow up for Significant Others

| BASIS-32 Subscale | Baseline Average (SD) n=83 | Completion Average (SD) n=49 | Follow Up Average (SD) n=26 |
|---|---|---|---|
| Relationship to self/others | 1.15 (0.90) | 0.83 (0.83) | 0.65 (0.69) |
| Depression/Anxiety | 1.13 (0.92) | 0.79 (0.88) | 0.56 (0.69) |
| Impulsive/Addictive | 0.29 (0.39) | 0.19 (0.38) | 0.16 (0.19) |
| Daily Living/Role Functioning | 1.13 (0.99) | 0.72 (0.75) | 0.65 (0.56) |
| Psychosis | 0.28 (0.54) | 0.23 (0.54) | 0.06 (0.15) |
| **BASIS-32 TOTAL** | **0.83 (0.66)** | **0.57 (0.62)** | **0.44 (0.38)** |

## Quality of Life

To explore whether there was any change in reported levels of quality of life over time for our sample of Significant Others, a Repeated Measures MANOVAs were conducted for each of the four domains and two general items comprising the WHO-QOLBref. Results of these tests are outlined below.

### ❖ Overall Quality of Life

The repeated measures MANOVA for this subscale indicated that the group of Significant Others experienced no significant overall reductions in perceived quality of life over time, $F(2,44)= 2.86$, $p>.05$.

### ❖ Overall Perception of Health

The repeated measures MANOVA for this subscale indicated that the group of Significant Others experienced no significant reductions in their overall perception of their health over time, $F(2,44)= 0.28$, $p>.05$.

### ❖ Domain 1 – Physical Health

The repeated measures MANOVA for this subscale indicated that the group of Significant Others experienced no significant reductions in perceived physical health over time, $F(2,44)= 2.89$, $p>.05$.

### ❖ Domain 2 – Psychological Health

The repeated measures MANOVA for this subscale indicated that the group of Significant Others experienced significant improvements in their perceptions of psychological health, $F(2,44)= 3.52$, $p<.05$. An examination of post-hoc comparisons revealed that there was no improvement on this

subscale between Baseline (M = 21.35) and Program Completion (M = 21.44), however a significant improvement was noted between Baseline and Follow-up (M=22.96), p<.05, suggesting that improvements on this subscale took some time to emerge. Post hoc comparisons also indicated that there was no significant difference between scores at Program Completion and Follow up.

### ❖ Domain 3 – Social Relationships

The repeated measures MANOVA for this subscale indicated that the group of Significant Others experienced significant improvements in their perceptions of their social relationships, F(2,46)= 3.74, p<.05. An examination of post-hoc comparisons revealed that there was no improvement on this subscale between Baseline (M = 10.84) and Program Completion (M = 10.90), however a significant improvement was noted between Baseline and Follow-up (M=11.79), p<.05, suggesting that improvements on this subscale took some time to emerge. Post hoc comparisons also indicated that the difference between scores at Program Completion and Follow up was also significant, p<.05.

### ❖ Domain 4 – Environment

The repeated measures MANOVA for this subscale indicated that the group of Significant Others experienced significant improvements in their perception of their environment, F(2,44)= 4.18, p<.05. An examination of post-hoc comparisons revealed that there was no improvement on this subscale between Baseline (M = 31.73) and Program Completion (M = 31.46), however a significant improvement was noted between Baseline and Follow-up (M= 33.52), p<.05, suggesting that improvements on this subscale took some time to emerge. Post hoc comparisons also indicated that the difference between scores at Program Completion and Follow up was also significant, p<.05.

Table 23 presents the Average scores on the QOL domains and subscales for Significant Others across the three time periods.



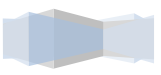

Table 18. A comparison of Average scores on the WHO-QOLBrief at Baseline, Completion and Follow Up for Significant Others

| QOL Subscale | Baseline Average (SD) n=85 | Program Completion Average (SD) n=49 | Follow Up Average (SD) n=25 |
|---|---|---|---|
| Overall Quality of Life | 3.53 (1.08) | 3.69 (1.02) | 3.96 (0.89) |
| Overall Health | 3.31 (1.20) | 3.49 (1.14) | 3.52 (1.23) |
| Domain 1 – Physical Health | 26.63 (4.73) | 27.84 (4.73) | 29.28 (4.61) |
| Domain 2 – Psychological | 20.97 (4.19) | 22.06 (4.12) | 23.12 (3.73) |
| Domain 3 – Social Relationships | 10.45 (2.46) | 11.08 (2.62) | 11.74 (2.32) |
| **Domain 4 – Environment** | **30.63 (4.87)** | **31.96 (5.07)** | **33.72 (3.71)** |

## Social Connectedness

To explore whether there was any change in reported levels of social connectedness over time for our sample of Significant Others, a Repeated Measures MANOVA was conducted using data from the Friendship Scale. This test revealed no significant changes in levels of perceived social connectedness over time, $F(2,46) = 0.61$, $p>.05$. Average scores indicated that the group of Significant Others in this study perceived some social support at all three time periods (see Table 19).

Table 19. A comparison of Average scores on the Friendship Scale at Baseline, Completion and Follow Up for Significant Others

| Scale | Baseline Average (SD) n=84 | Completion Average (SD) n=46 | Follow Up Average (SD) n=26 |
|---|---|---|---|
| **Friendship Scale** | **16.17 (5.08)** | **18.08 (4.63)** | **18.31 (4.69)** |

## Caregiver burden

Caregiver burden was assessed using the Experience of Caregiving Inventory. To determine if our group of Significant Others experienced changes in their experience of caregiving over time, a repeated measures MANOVA was conducted. This analysis revealed that while there was no change over time in the positive aspects of caregiving, $F(2,44) = 0.53$, $p>.05$, significant reductions were noted in the level of negative aspects of caregiving – $F(2,44)=11.92$, $p<.01$. An examination of post-hoc comparisons revealed that there was significant improvement on this subscale between Baseline ($M = 111.95$) and Program Completion ($M =93.13$), as well as between Baseline and Follow Up ($M = 78.11$). While scores on this scale had continued to decline between Program Completion and Follow

up, this difference was not found to be statistically significant, suggesting that the greatest reduction in negative aspects of caregiving occurred early as a result of the Family Eclipse Project.

Table 20. A comparison of Average scores on the ECI subscales at Baseline, Completion and Follow up for Significant Others

| ECI Subscale | Baseline Average (SD) n=80 | Completion Average (SD) n=49 | Follow Up Average (SD) n=24 |
|---|---|---|---|
| Total Positive Score | 27.75 (8.60) | 26.32 (11.08) | 24.71 (8.14) |
| **Total Negative Score** | **106.11 (36.36)** | **83.15 (41.92)** | **80.93 (42.54)** |

Data was recorded regarding the total number of contacts/sessions each family had during recruitment and over the course of the Family Eclipse Project. The average number of sessions is presented in the table below. These results show that on average, while there were on average over six contacts per family to engage them in the program, the majority of the session time was family sessions. Individual sessions most commonly involved the young person.

Table 21: Average number of therapist sessions

| | Sessions | | |
|---|---|---|---|
| | **Engagement phase** | **Individual** | **Family** |
| Average | 6.6 | 4.3 | 8.6 |

At completion of the program and three months later (follow up), participants were asked to reflect on the program and consider the impact it had. These results indicated that the majority of participants were able to identify positive effects of the program on personal and family skills.

Table 22: Percentages of benefits from program participation perceived by families at program completion and three month follow up

| | Completion | Follow up |
|---|---|---|
| Improvement in knowledge of mental health issues | 53.5% | 60.0% |
| Increased confidence in knowing how to provide support to someone displaying symptoms of mental illness | 86.1% | 77.5% |
| Increased awareness of effective communication and problem skills | 62.8% | 53.8% |
| Positive impact on family strength and resilience | 83.7% | 71.8% |
| Increased emotional health and wellbeing | 81.4% | 64.1% |

## Consultation with staff

A two hour focus group was conducted with current (n = 4) Family Eclipse staff members and a parallel interview with a past (n = 1) staff member to gather information about their experiences of the program and their method of working with families. It was audio recorded and the content transcribed to facilitate thematic analysis on the following questions:

1. What was the primary work of the family intervention and how was it implemented?
2. What were some of the issues to be addressed in the broader service system and regarding the therapeutic interventions?
3. Comments on the sustainability of the program.

### The wider service system

The first stage of activating the Family Eclipse program was to recruit clinicians. This took almost twelve months, partly because of insufficient remuneration for the required professional skill set (mental health knowledge, drug and alcohol knowledge and family therapy training) and the complexity of the work.

> *"The first lot of interviews I think we recruited one person. We advertised. We extended the response rate so effectively re-advertised. We ended up recruiting one person. We re-advertised. There just wasn't a lot of applicants… I don't think people had the skill set…."* (FEP clinician)

> *"I do think that if clinicians are experienced they can go on as much as a journey with the family. They can go on that journey too in helping that family because there are no clear kind of cures or no programs or kind of particular techniques that have been seen to be superior to any others in this kind of work and there is very little documentation studies research into this kind of work ."* (FEP clinician)

At the time of writing, the most experienced team members, apart from the manager, have worked with Family Eclipse for eighteen months. Staff turnover was impacted by the lack of long term funding and the demands of the work. The second stage of the work involved extensive promotion and education sessions with mental health and AOD services to build partnerships and a referral base. Agencies had varying ideas of what was family inclusive practice and barriers between AOD & MH services interfered with referrals (e.g. some expressed a tension between young people needing protection from families versus families being a resource to them). Partnership development was repetitive, very time consuming and the Family Eclipse staff were concerned they lacked the expertise to do it well.

> *"Well initially I found the networking quite painful in the way … there was a lot of educating the other agencies to start off until we actually narrowed down and got key people that we actually*

*started to work with. When we first started it was like we kind of threw a net out and was introducing the program …. a lot of dead ends which got a bit frustrating."* (FEP clinician)

Building the FEP service profile took time. The networking was essential and the services who formed the most solid partnerships, were generally those who understood and embraced family inclusive work. Commonly workers selected families to refer to Family Eclipse clinicians; the active networking means that the workers knew the person doing the work. In many cases, referrals were often personality driven. Co-location with some referring services, particularly Headspace, assisted with building good relationships, resulting in steady referrals because, for example, supervision sessions would prompt referrals, Family Eclipse clinicians were known and it was easier for families to come to appointments at their accustomed service.

It was also noted that some services had a dominant view that their job could involve 'protecting' clients from their families and thus did not refer to FEP.

*"Often families are seen as the cause of the person's problems and you know people have different levels of training and different levels of understanding. I think perhaps would see them as a hindrance. …… they are still that person's family and they are going to be in their life so working out how to live together is a good thing. Again it comes down to the individual worker's attitudes and how family inclusive the agency is trying to be."* (FEP clinician)

Finally, a lack of secure funding for the program interrupted treatment planning for some families.

*"…people feel really insecure and then they look for other work and then you have to train up a stack of new people to start or other agencies, you can't give them a definitive answer, you don't know what to tell your families."* (FEP clinician)

## Practice issues

The Family Eclipse program is a free service which works in parallel with existing health and community services and focussing on the family system rather than the individual. Family Eclipse staff work across multiple sites ranging from Dandenong to Sunshine and run day and evening sessions. This approach is important for the success of FEP, but it places demands on the clinicians.

*"Last Thursday I had a client in Sunshine in the morning – went to Sunshine. Had one in Moorabbin at lunch time and had one in Richmond in the afternoon and then came back here."* (FEP clinician)

### *Flexible, creative approaches*

FEP clinicians emphasised that flexibility is an essential component of the work. Clinicians need to be highly organised, resilient and opportunistic, providing both individual and family therapy, the former

increasing their case load significantly, but providing invaluable opportunities for maintaining rapport, particularly with young people.

> *"You try to be flexible. There is no other option".* (FEP clinician)

> *"I do more individual work than I would probably do with any other families because …with this particular age group adolescents it is a bit harder to engage and then keep them interested if it is only family sessions all the time. I will sometimes have individual sessions just to keep them motivated and interested and engaged."* (FEP clinician)

One example of clinician flexibility was having a therapy session while driving the young person from one place to another:

> *"That is a really good time to speak to people as well because you are side by side and you are doing something else, so there is a distraction and people can be a little bit more relaxed and more likely to talk and it is not as scary as therapy because it's not 'therapy' you are just chatting."* (FEP clinician)

In some cases, families had complex issues and consequently were attending appointments with multiple services, which interfered with motivation to attend family therapy, requiring more engagement skills from the clinician.

> *"Some of the family's feedback was that they were dealing with so many services that it was like a full-time job for the client to see mental health practitioner, drug and alcohol, financial counsellor and then some support so it is a lot for people to see and sometimes adds to the client's anxiety as well as it is very difficult for the parents to drive them and take them everywhere. Sometimes it is just full on."*

Progress can be startling and team members have been surprised at how quickly things could improve once the family had a shared vision.

> *"I am just inspired by a lot of the families because they are literally just on tenderhooks. Every single person is just traumatised by having a young person with dual diagnosis of substance issues. It is really nice to see how they just hang in there."* (FEP clinician)

### *Challenges for staff*

Demands on Family Eclipse staff are high. They require mental health and AOD expertise with family therapy training and need to develop good PR and media skills. They function as solo practitioners much of the time, are required to 'hot desk' it at some locations and may have limited access to resources when co-located.

*"They (co-located services) are quite supportive. It's a good relationship. It is just when you go there it is still not your service. You don't have your things on your desk. You don't have your place."* (FEP clinician)

At times there is insufficient opportunity for immediate debriefing after a session, although they receive regular family therapy and psychiatric supervision. Mandatory paperwork is substantial and repetitive in parts. It is seen as frequently interfering with client engagement and is difficult to prioritise in the face of family need.

*"Sometimes it takes - because our assessment process is quite comprehensive, so it takes a while to actually start the family work. That can be a bit of a barrier for a family. Sometimes you lose the family before you even get to the end of the paperwork."* (FEP clinician)

This opinion was reinforced by families:

*"I felt we needed to really openly discuss why we were there, rather than do lots of written stuff (i.e. mandatory paperwork). I feel we need to get the important stuff quicker – needs to be more direct. In his mind (son) had given us 2-3 sessions. He was doing it to appease the family so we needed to move more quickly. We danced around too much……Rather not fill out forms so early." (Mother)*

The clinicians argued for increasing the age range of the target clients and providing sufficient resources for clinicians to conduct sessions in pairs, preferably in a designated family counselling space to facilitate engagement.

## Family Eclipse Interventions

### *Content*

Family Eclipse clinicians described the most common work with families involved setting aside the usual issues involving the young person, as these were being managed by the referring service. Instead the focus was on strengthening parental sub-system and working with families on coping, stress management, parenting and developmental stages. Parenting boundaries, sleep education and communication skills were frequently occurring topics, family roles (in some families a child has stepped up to undertake parent responsibilities), anger management, problem solving and conflict resolution between the young person and the parents, emotional regulation (e.g. working out ways to reduce/moderate strong emotions), stress reduction (e.g. exercise, prioritizing, breathing especially for anxiety). In addition to relapse prevention and drug reduction education, session content also included drug and mental health education and the interactions between them, and education about vulnerability to Mental Health issues and stress vulnerability (vulnerability to mental health problems

that is not evident/problematic until the person becomes highly stressed or has drug use; a component of the Behavioural Family Therapy model).

These topics were often presented in combination, eg. Patterns of interaction are part of communication but also implicated in relapse prevention. Stressful interactions could trigger increased drug use. In an hour with a family a clinician generally does 'ten different things' weaving together relapse prevention, education, mental health information, emotional regulation etc.

> *"I start with one thing and end up with another…..You're amazed what resources you can bring into a session".* (FEP clinician)

While the therapeutic framework for the clinical intervention provided by Family Eclipse was Behavioural Family Therapy, one clinician spoke of the need to put her own imprint on the way she worked with a family to improve effectiveness and engagement. "*You need the model to fit you rather than the other way round*", otherwise the process was stilted and neither the clinician nor the families were comfortable. While all the FEP clinicians were informed by Behavioural Family Therapy, it was accepted by the team that each brought other therapeutic orientations including traditional family therapy, Cognitive-Behaviour Therapy and Problem-focussed, solution oriented work.

### *Complexity*

The work is highly complex. Much of the work was in separating out the different issues and understanding the relationships between them. The clinician above commented that planning never works – "it's too rigid" and you don't feel comfortable formalizing your work too much. Often the clinician is working with fragments of families and seeing people individually. Families present with many concurrent issues (financial, health, legal) and crisis intervention or brief interventions are often the starting point.

> *"It is hard. It is a really, really difficult client group ….. There is lots of blaming and tension and siblings tend to get left out or drawn in or whatever. … So (a) that Averages it difficult to engage people, so you get fragments of families usually and (b) it is really difficult to get the family together, so typically what happens, even though ideally you want to work with the whole family together in the room at the same time. Sometimes you see individual family members separately and it becomes quite confusing and messy…."* (FEP clinician)

> *"The families we are working with are really complex apart from mental health and drug and alcohol they have all sorts of other issues going on already financial issues, like step family issues, health issues and legal issues and life is very juggling and they have other children. There is so much going on for the families. So it is really hard to contain all of it, work with them and facilitate the problems of the family".* (FEP clinician)

It can be difficult to see the overall outcomes until time has passed, on the other hand, improved family interactions more easily observed than individual change.

### *Engaging families*

When first engaging, the starting point is often problem solving how to get people interested in the family sessions and the best option for getting a family member to participate.

> *"It is problem solving in itself just to get the family on board. You may get one interested person and then you need to work out how do I get everyone else on board".* (FEP clinician)

> *"One family who is finishing soon, it took me about three months to get them in the room together. They did not engage initially … meeting with one and then thinking about … it is lots of work and calls".* (FEP clinician)

It is a great deal of work to bring a family together for these sessions. It is necessary to work at a different pace with each person, depending on where their stage of change and the degree to which the family circumstance is affecting them. Parents often want an immediate start, whereas young people need more time.

It is important to address what the families want from the service, because engagement is a central concern. Family members may have concerns about blame or misunderstandings about what is being offered (which also applies to the referring worker). Once source of tension for the clinician is balancing their expectations and goals with those of the family, while recognising the broad range of levels of motivation and engagement across and within families. For this reason, significant time is allocated for engagement. Families with a young person who has a co-occurring disorder, are usually dealing with many services/ appointments. Some are exhausted and do not engage or do so with limited motivation. Inter-generational issues also interfere. Logistically, organising family members to come together at the one place and time is complex and time consuming and evening appointments are in demand.

One clinician commented that one of the most powerful inducements for young people is letting them know the sessions are future focused, learning from the past, but not rehashing negative events or blaming. That treatment is about the family learning new skills rather than the young person having to change their behaviour. Ultimately they all want a positive family environment. At the very least the young person wants to be able to continue to live at home until they have the resources for independent living. The question is then, what can the family learn to make this possible/bearable? The second hurdle is the assessment process. Some young people get sufficiently interested to come to treatment but subsequently quit because the assessment process is long and structured and the young person loses interest.

If the family is motivated, this model works. The degree of success depends on their stage of change, how realistic they are and how open to learning. If the family is exhausted and not motivated the future focus helps. The other issue is keeping small immediate goals at the fore. If the young person is willing to talk with the clinician, that's progress because it Averages they are aware things are not good. If they miss an appointment but they call to tell you, that's progress. It is essential for Family Eclipse workers to keep both short and long term goals in mind.

### *Crisis work*

Crisis work has to take priority in treatment, because until the crisis has passed, the family are not able to do any other work. The crisis remains at the forefront of their mind and they are not able to think about other issues. With some families, once the crisis is over they do not want to continue treatment while others are well-engaged by the experience. Crisis management is generally therapeutically productive because it doesn't occur in isolation. In the process of managing a crisis, the therapist will include education, modelling, debriefing etc. Even if the education component is only 5 minutes, it is still education and the practical application makes it more salient. The way in which the family manages the crisis provides valuable information about them and aspects of the crisis can be used to move towards the future. It is not uncommon for families to disengage when the crisis has passed.

### *Family therapy*

The strength in families can be inspiring. Families persist despite significant challenges and sometimes toxic interactions. They are capable of substantial progress and often sessions not going as planned provide beneficial outcomes. If one family member is interested the clinician can build on that to involve the whole family and part of the complexity for the worker is judging when and how to approach the different family members. Part of the reward of the work was that physical changes can be easily observed when the family dynamics start to improve, from the way the family interacts.

> *"I think you can see more results with a family than you can with an individual because even communication in a family is a lot more visible in the sessions than what individual changes you are making when you are working individually with a person individually with a person….. in a family it is obvious when things aren't going great, but it is obvious when things are going quite well too."* (FEP clinician)

One clinician noted that the most difficult aspect of the work is when you get a family member who refuses to change and does not see the need to do things differently.

## Multi-family interventions

Family Eclipse ran one multi-family group when the program first began, with families who had a young person resident in Odyssey's Therapeutic Community. One of the participating clinicians described it as "*fantastic... It was one of the most effective things we did…..a truly therapeutic group*". He commented that the group had highly successful outcomes which he attributed to the sharing of information and hope across the group that worked. In his opinion the cross generational and cross family groups were catalysts for change. People were able to hear things from others that they were not able to hear from their own family members and to accommodate other perspectives. The multi family group led to recovery and positive action that parents could be involved with. The group focused on relationships and communication – "*the relational space was really outed and challenged*". The family intervention is about relationships rather than the co-occurring disorders. The purpose of the Family Eclipse program is to strengthen the family's ability to manage the dual diagnosis. Before they are involved with FEP, parents are distressed are disempowered and worried their child will come to significant harm. The young people have a different perspective and often do not appreciate the risk, believing they can handle it. "*I'm independent but give me everything.*"

This therapist said that families worked hard and were motivated by the group experience to complete homework tasks, which he regarded as essential to progressing the therapy. It was experiential skills based work with themes in every session.

Overall the Family Eclipse program was seen as effective; it made changes that were unlikely to happen otherwise. The participating therapist's view was that when families first made contact with Family Eclipse, the young person is relying on their family for 'everything they've got' and parents are focused on their child's incompetencies and perpetuating them and take inappropriate responsibility for their child's behaviours.

> *"Parents can get a bit controlling and I think we've become much better with that. Some things you can change, some things not…..I'm not as negative. … He's moving towards independence taking responsibility. We were on the verge of taking responsibility for his consequences….I'm letting go a bit….given he's working now and he's showing more strength, he'll be able to cope. I've realised I can't intervene too much – he'd never be told anyway. He's moving away from it (drugs) on his own anyway."* (Mum, 027)

In the intervention the problem is honoured and spoken about and the focus placed on the family's resilience. Over time a relationship is built with the therapist that focuses on information and options. Families are encouraged to be connected with each other away from the problem. When stressed, the tendency is to focus on a problem and it overtakes their lives. This cycle is broken. Once people are disengaged from their stress, they start to see things they could do differently.

Unfortunately, setting up multifamily therapy was much more difficult for families who did not have young people in residential rehabilitation. Firstly, there were rarely enough referrals to start a group; the minimum number required was four families. Two or three times the team thought it had sufficient families ready to go and then one family would disengage. Secondly, referred families were spread out across Melbourne which made it difficult to identify a reasonably convenient location for therapy. Finally, when young people were not engaged in a program (such as the therapeutic community) they were often not sufficiently stable with their drug use to be able to participate in therapy and if the work was intense, young people could debrief within the TC whereas nothing was guaranteed if they were living elsewhere

# CONCLUSIONS

Results from this preliminary evaluation of the Family Eclipse Program are very promising. Staff and client feedback was positive. Many families reported the positive impacts of being included in their child's treatment as empowering. The family work is complex and challenging and requires a particular skill set. Referrals to the program were initially slow as agencies learnt to appreciate the unique aspects of family inclusive practice in the context of treating the young person's mental health and substance use disorders. While the small sample size limited our capacity to detect significant changes over time for our group of young people, the analyses revealed significant improvement amongst this group in perceived general family functioning, reported mental health symptoms, quality of life and social connectedness upon completing the program. Young people's results between Baseline and Follow-up, though largely statistically non-significant had an overall trend towards improvement. It is possible that with a larger sample size we could see some additional significant benefits emerging for participants at this assessment point. Significant Others reported a number of positive outcomes as a result of participating in the family eclipse program. Analyses revealing significant improvements in mental health symptoms, quality of life and caregiver burden over time.

Overall, the results are very encouraging and provide a valuable database from which further studies and program development can grow. This capacity building aspects of this unique program should not be underestimated.

## Recommendations

- Given the promising findings and the program's unique mandate, it is strongly recommended that funding for this program continues. The program has now begun to develop momentum within the service sector. It now requires further consolidation and continued support in order for its full potential to be realised.

- Monitoring client outcomes would be a vital component of the continuation of this unique service. These outcomes can then be disseminated to the wider service community to inform and enhance practice change for this client group who often fall through the gaps.

- It is recommended that the program design whereby family clinicians are embedded within appropriate agencies is an effective strategy and increases client acessibility to the service and promotes family inclusive practice within the agencies.

- Family work with this group is challenging and referral pathways take time to establish, hence it is recommended that ongoing resources be provided to support both referral and liaison with youth mental health and drug treatment agencies, and for direct service provision to families.

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