6 Policy and Program Issues

In This Chapter...

Overview

This chapter provides information about the importance of improving services to families and discusses some policy implications for effectively joining family therapy and substance abuse treatment. Of special importance in this effort is the inclusion of key stakeholders in the substance abuse treatment and family therapy fields, among them the Federal government, insurance companies, frontline and executive staff members from both disciplines, researchers, consumers, and others who make decisions about service delivery.

This chapter also presents program planning models developed by the consensus panel that provide a framework for the broad inclusion of family therapy into substance abuse treatment. These models cover (1) the issues surrounding staff education about families and family therapy, (2) family education about the roles of families in treatment and recovery from substance abuse, (3) how substance abuse treatment providers can collaborate with family therapists, and (4) methods for integrating family therapy activities into substance abuse treatment programs.

Considerations for substance abuse treatment program administrators, such as guidelines for implementation, ethical and legal issues, and evaluating outcomes are addressed for each of the four program planning models. The chapter also discusses the counseling adaptations and training and supervision issues that arise for substance abuse counselors and other staff when programs promote attention to family issues and family therapy techniques.

Primary Policy Concerns

Though many substance abuse counselors and family therapists have learned to incorporate aspects of each system's approaches, to be instructive this TIP finds it necessary to proceed as if "family therapy" and "substance abuse treatment" have heretofore existed in isolation from each other and as if each were reducible to a specific limited set of

techniques, approaches, attitudes, and points of view. The reader should keep in mind that it is an overly simplified presentation that follows and that the overlap among practitioners and the fields is probably much greater than the artificial separation employed as a vehicle for the presentation of primary policy concerns. With this caveat in mind, the merging of family therapy techniques with substance abuse treatment warrants consideration of three primary policy questions:

- When is family therapy appropriate?
- What are the funding and reimbursement options for family modalities?
- What role does the criminal justice system play in mandating substance abuse treatment with a family focus?

Challenges to Merging Family Therapy and Substance Abuse Treatment

There is considerable evidence to support treatment that taps the power of the family and the community but, at the same time, weaving a different modality with its own distinct values into a treatment program can be a challenge. This may explain in part why many substance abuse treatment programs have been slow to integrate the strengths-based approach essential to effective work with families.

One major impediment to merging the two disciplines effectively is identifying the underlying values of each and then determining whether alternatives would work better. The different values associated with previous forms of substance abuse treatment and family therapy have important implications for combining the two in the future. These implications will affect the entire organizational spectrum. Though the incorporation of family therapy into substance abuse treatment presents an opportunity to improve the status quo, it also challenges these two divergent modalities to recognize, delineate, and possibly reconcile their differing outlooks. At a basic level, for example, agencies can develop common action plans founded on evidence-based research and goals to ensure more success for the client. Such plans could be developed according to the four-tier model described in chapter 4, which guides the development of different levels of family involvement.

Another major policy implication, as noted by O'Farrell and Fals-Stewart (1999), is that family therapy requires special training and skills that are not common among staff in many substance abuse treatment programs. A substance abuse treatment program committed to family therapy will need to consider the costs associated with providing extensive training to line and supervisory staff to ensure that everyone understands, supports, and reinforces the family therapist's work.

For a traditional family therapy approach to be successful, it is necessary to consider how everyone who works in and with a program treats clients and their families. The entire substance abuse treatment program must be examined to verify that the ideas espoused in family therapy are fully integrated into all aspects of the program, including forms, policies, procedures, and mission statement. Further, in providing some level of family involvement or therapy within substance abuse treatment, other problems may need to be resolved, such as

- Substance abuse counselors and family therapists sometimes have different goals.
- Research to support the integration of classic family therapy into substance abuse treatment is not definitive, although recent research studies have shown support for certain types of family-based treatments with certain types of client/family groups.
- Conflicting interests and standards regarding confidentiality must be reconciled.

Given the complexity of incorporating full-scale family therapy consistently in substance abuse treatment and the finite resources with which many substance abuse treatment programs are working, family involvement may be a more attractive alternative. Family involvement and

family therapy are two points on a continuum rather than completely distinct.

What Are the Funding and Reimbursement Options for Family Modalities?

The documented cost savings and public health benefits associated with family therapy support the idea of reimbursement (O'Farrell et al. 1996*a*, *b*). However, like the substance abuse treatment system, the American health care insurance system focuses care on the individual. Little, if any, reimbursement is available for the treatment of family members, even less so if "family" is broadly defined to include a client's nonfamilial support network. For example, under Medicare, family therapy is a covered expense, when done by a licensed and certified Medicare mental health provider, but the system does not certify and therefore does not reimburse family therapists. With Medicaid, administered by States, reimbursement policies vary. Also, the Elementary and Secondary Education Act does not recognize family therapists as qualified mental health or substance abuse services providers.

If a family wants services, and the client is unwilling to participate, the family should not be excluded. Ideally, family members should be able to receive appropriate services, if requested. What must be changed so that families can receive those benefits? Who would fund a more inclusive process? The known and interactive barriers—reimbursement and attitudes—must be resolved in order to include families more fully in the treatment process. Regardless of the context in which family therapy is delivered, if the operational policy of States or insurance companies is not to reimburse, then policy discussions need to develop processes to remove that barrier. Recent evidence of the effectiveness of family involvement, as well as clinical and research evidence that supports family therapy for substance abuse treatment (Liddle et al. 2001; Stanton and Shadish 1997), may eventually move funders to alter payment systems so that families can be included.

What Role Does the Criminal Justice System Play in Mandating Substance Abuse Treatment With a Family Focus?

The criminal justice system is a major source of referrals to substance abuse treatment, especially among people with low incomes. Such legally coerced referrals come with powerful leverage that strongly affects the treatment process. Providers should be prepared to address several issues: If a treatment program requires family member participation and the client refuses to involve them, or the treatment episode is not successful, what are the consequences to both client and family? What happens if a family-focused approach is in place and the family does not show up? Do you punish the client? If such questions are not anticipated and answered adequately, the result may be harm to, rather than assistance for, the client and/or the family.

There is considerable evidence to support treatment that taps the power of the family and the community.

Program Planning Models

Including family therapy issues in substance abuse treatment settings at any level of intensity requires a systematic and continuous effort. The four program planning models presented in this section—staff education, family

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education and participation, provider collaboration, and family integration—were developed by the consensus panel and provide a framework for program administrators and staff/counselors. The framework identifies key issues: guidelines for implementation, ethical and legal issues, outcomes evaluation, counseling adaptations, and training and supervision. Some programs may be limited to educating staff about family therapy and how family issues relate to substance abuse, treatment, and recovery.

Many programs already involve families in the treatment process in some way, and those programs might wish both to promote ongoing staff education about family therapies and to increase or improve the ways in which families participate in the substance abuse treatment program and continuing care. A program might decide to create or expand its collaborations with family therapy providers and other social service agencies. Although integrating family therapy into substance abuse treatment might require a significant investment of time and resources, the consensus panel hopes that treatment programs can use the integration models suggested to facilitate such changes.

Staff Education

The goal for educating staff about family therapy and family issues is to increase staff (and therefore client) awareness of the role of family involvement in substance abuse, dependence, treatment, recovery, and relapse. Increasing staff's knowledge of the family as a unit and the influence of the ecological setting within which the substance abuse occurs should be one outcome of the staff education activities. Support for becoming knowledgeable about family therapy issues, as well as for program changes designed to integrate or enhance the delivery of such services to clients and their families, begins with the chief administrative and clinical staff. These staff members need to demonstrate their value of such knowledge and activities and that they are willing to commit the necessary resources in an ongoing fashion.

Issues for substance abuse treatment program administrators

Program administrators must assess the amount of effort and support required to develop staff education activities related to family issues. When the agency does not have in-house resources, it might be best to seek input from the entire staff about any staff knowledge of resources in the community and/or specific providers worth considering for participation in the educational activities. To be sure, program administrators will need to gauge the compatibility of outside presenters' views of addiction against the substance abuse treatment program's viewpoints and materials. Although viewpoints regarding substance abuse and its treatment need not be identical for all family therapy presenters, the program administrator might wish to give advanced thought to how to address issues that could arise over conflicting views. Administrators need to be aware of the costs that are involved; sometimes the resources are not readily available and can be costly, especially in areas where access to care is restricted.

In some locations there might be numerous inexpensive or even free educational activities that relate to family issues and family therapy—from local college courses to evening presentations given by various community

organizations. In other locations it may be much more difficult and expensive to access direct presentations, and program administrators may seek resources through e-learning possibilities. Of course, this TIP itself and other State and Federal resources, such as one of the regional Addiction Technology Transfer Centers (http://www.nattc.org), which receive funding from the Center for Substance Abuse Treatment (CSAT), are good places to start.

Though it is unlikely that there will be any legal or ethical issues associated with providing education on family issues to substance abuse counselors or staff, it is certainly the best practice in terms of credentialing to check with licensing or certification agencies. This will ensure that any professional invited into one's agency is in good standing and has the background and training that are represented in the person's resume. As far as outcome evaluation, many presenters have their own "pre- and post-" questionnaires to demonstrate that participants have acquired certain information from the presentation. Certain accrediting organizations require such program evaluation components in order for a presentation to be eligible for consideration as continuing education credits. Of equal, if not greater, importance would be formal or informal mechanisms for obtaining participants' own assessments of the educational activities.

And finally, some time and attention will need to be devoted to help staff digest the family therapy education they receive, especially in terms of their comfort level about what the training implies as far as their counseling or treatment. Along these same lines, staff might have concerns about the amount of training and supervision necessary to employ any or all of the techniques described or suggested. Again, resources to meet these concerns might be available in-house, in the community, or through distance learning possibilities. Designing a set of educational and training activities so that these activities can help staff satisfy their various education requirements and compensation for any extra time devoted to such endeavors are important ways to support staff interest and appreciation of family therapy educational training. The provision of opportunities for ongoing supervision could be a powerful way to communicate a program's commitment to families and the family's role in treatment and recovery and to show support of staff in becoming familiar with new techniques and approaches.

Issues for staff and trainers

Treatment center staff—from substance abuse counselors to supervisors, nurses, and physicians—are likely to have varied backgrounds in terms of familiarity with family issues and/or family therapy. Therefore, educational activities will need to be appropriate for the participants. Many substance abuse treatment counselors will be familiar with the "family disease model" of substance abuse. Such familiarity is likely to range from being familiar with certain terminology to using the family disease model in individual and group substance abuse treatment, including family involvement. Some counselors or staff will be trained and thoroughly familiar with one or more family therapy treatment systems.

In addition to being sensitive to staff's level of familiarity with the material, trainers must also understand and be sensitive to staff culture. Ways of adapting material for staff to understand and development of new strategies of teaching are the responsibilities of the trainer. Staff may not have the basic knowledge to adapt the new material and might need assistance in understanding how the information is meaningful and applicable to their populations and cultures.

Family Education and Participation

Many substance abuse treatment facilities offer "family counseling" as part of the therapies employed by the treatment program (Office of Applied Studies 2002*a*). However, the nature of such family counseling can vary widely from one facility or treatment provider to another. The consensus panel recognizes that some

treatment programs may have no or limited family involvement and other programs may vary in the extent of family participation. The consensus panel's focus is on family education and involvement that is informed by the full range of family therapy information and the possibilities presented throughout the TIP. Consequently, family education and participation stresses the importance of the family in substance abuse treatment and calls for changes in the intake assessment process, education of the family, counselor training and caseloads, confidentiality issues, and special followup and outcome measures.

Assessment is one of the most important components of any substance abuse treatment program. When focused on families, an assessment instrument generates data that can help the substance abuse professional identify resources in the family that may promote treatment success. Collecting data about the client's family serves several purposes:

- It yields a more thorough, and perhaps more accurate, family history.
- It presents an opportunity to confirm and clarify information on the client.
- It can provide insight into the context where substance abuse most often occurs and where it may have started or accelerated.
- It sets the tone for a continuing focus on the family.
- It identifies family resources to help plan long-term care.
- It documents specific information that can determine treatment goals.

The importance of enhancing family involvement can be emphasized by staff. The following types of questions encourage further discussion about family dynamics and involvement, emphasizing a strengths-based model. However, staff should be careful about asking for details in a way that may be experienced by the client as an interrogation:

- Who can support you in treatment?
- Do you know someone who is abstinent who can support you?
- Who in the past has been the most helpful to you?
- Tell me about a safe place where you can live.
- Who is taking care of your children while you are in treatment?
- Does anyone in your family use substances?
- Is anyone in your family recovering from substance abuse?
- Have your family members noticed a decline in your substance use?
- How would your family react to your recovery from substance abuse?
- What does your family think about you being here? Did you tell them? Why or why not?
- Is substance use an important part of your family life?
- Who in your family has jobs? Goes to school?
- Who is the last person in your family who saw you cry?
- Where did you eat dinner last Sunday?

Education of the family proceeds along a continuum that includes strategies such as providing Internet access, informal referral and educational opportunities, and printed materials such as pamphlets, videotapes, and reference books. Some tools can help families understand their importance in substance abuse treatment. Modified genograms, for example, help families understand substance abuse from the focus on its history to the larger context of clients' lives (see chapter 3 for more information on genograms). Another example is psychoeducational groups, which can focus on families' strengths and help family members change common behavior patterns that may contribute to conflicts. A family therapy directed strengths-based perspective may help families learn skills to solve conflicts and identify common feelings or thoughts related to substance abuse and families. Psychoeducation can be conducted in groups with several families in a single session, making the approach highly cost-effective. From a clinical perspective, psychoeducational groups may increase a family's sense of support and reduce stigma within and between families.

Family involvement in treatment can also be construed as a continuum based on the level of background and training required for staff to implement family activities into treatment. From the perspective of the treatment process, the introduction of family activities requires accommodation from traditional program activities and orientation. Minimal family activities, such as the construction of a genogram, require limited counselor training and virtually no changes in any other substance abuse program aspects. Family therapy techniques that require a detailed examination of community influences and contingencies for rewarding recovery activities might require significant staff training, significant shifts in program scheduling, and shifts in the relationships among program staff and community resources.

Issues for substance abuse treatment program administrators

Counselor training and caseloads

If counselors improve their skills and are able to do more complex clinical work with families, such expansion of their roles as counselors will place added burdens on them. Working with families will increase the amount of clinical time for each client so overall adjustments in a counselor's caseload might be necessary, especially when one considers that work with families can at times bring with it a heavy emotional burden. Staff burnout prevention needs to be considered, and difficulties with the stressors associated with additional training, information, and so on need to be monitored.

Confidentiality

Informed consent and confidentiality issues will require careful consideration by program administrators. Ideally, clients in substance abuse treatment will sign informed consent forms, acknowledging their understanding of the potential risks and benefits of family program activities, and family members (including children, when appropriate) will also sign such forms. Informed consent forms can describe in detail, for example, the program or staff responsibilities regarding the reporting of information that is required by law (such as elder abuse, child abuse or neglect, infectious disease, or duty to warn—depending on the particular laws of the State or locale and Federal laws). Additionally, separate confidentiality warnings might be included in the informed consent form so that clients and their families realize and agree that the loss of confidentiality resulting from families meeting in groups is understood and agreed to by all.

In regard to confidentiality, there must be strict adherence to all confidentiality laws, including the specific requirements for any and all releases of information. Substance abuse treatment centers bear a responsibility for ensuring that treatment providers or outside presenters understand the strict requirements of confidentiality imposed by direct Federal laws, State law, and professional ethics within the substance abuse field. For example, if these issues are not clarified, family members may regard sign-up sheets as violating their confidentiality. If family members sign a log sequentially, the program will illegally disclose to client B that client A is in treatment. These issues become especially complicated when a client identifies as "family" people who are neither related by blood nor by law and wishes to include friends or coworkers.

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Outcomes

Evaluating the outcome benefits and drawbacks of family education activities and new ways of incorporating family techniques into the treatment process can be qualitative or quantitative, simple or complex. Simple questionnaires and feedback sessions are what many program administrators want to consider; some administrators might want to pursue more intensive analyses that employ focus groups and performance measurement techniques that are developed by outside experts. Such performance measurements might include a change in the percentage of clients who agree to have their families participate in treatment, an increase in the number of contacts counselors have with family members, monitoring the number of requests for the program's free materials related to families and treatment, and a host of other possibilities.

Issues for staff and trainers

Training and supervision issues are similar to those that arise from staff education, but such concerns can reach a higher level of intensity. Being educated about family issues and family therapy might imply certain changes or expectations for counselor behaviors, whereas the inclusion of family education and family involvement in the treatment process brings the responsibilities and expectations for the counselors to a much higher level. Counselors and staff will be expected to know more, explain nuances to family members, and incorporate any new family program activities into their general style and treatment approach. For this level of family participation, substance abuse counselors will require significant training and supervision. The professional associations of staff members may offer guidance in terms of suggested or required background or training to meet acceptable standards; and, of course, organizations that traditionally include family therapy modalities usually have standard curricula and training requirements that they promote.

Provider collaborations will ensure high-quality referrals, effective outreach, and meaningful partnerships with community resources.

Provider Collaboration

Collaboration goes beyond referral; it indicates that the substance abuse treatment program and the family social service agency have established an ongoing relationship so that the treatment that takes place at one provider agency is communicated to and influences the course of treatment or services at the other. Such provider collaborations will ensure high-quality referrals, effective outreach, and meaningful partnerships with community resources. Such relationships should encourage family participation in both substance abuse and family-oriented services. Of course, determining what a family needs is a decision to be made in the family and not by the substance abuse treatment provider. From this perspective, the provider encourages empowerment within families to determine their own direction.

Given the complexities of informed consent and confidentiality that arise from adding family education to a program's offerings, developing collaborative relationships with family therapy and related agencies is no easy task. Staff members will be called on to be knowledgeable about family-involved treatment models and services and be familiar with community resources. Matching the resources of various providers with a family's needs and providing the family with information about the pros and cons of various alternatives will require a strong community perspective and resource commitment on the part of the substance abuse treatment agency.

Issues for substance abuse treatment program administrators

Resources need to be provided to monitor and ensure that high-quality referrals, outreach, and partnership components are in place within the agency and community. Examples of such resources include

- Family education sessions where families can learn more about substance abuse and family involvement.
- A comprehensive referral system that can facilitate the participation of families and clients in treatment-based, family therapeutic activities.
- Expanded informed consent, which will often be necessary.
- Client and family education about both the benefits and challenges of using any particular provider or service, and clients should understand the relationships among service systems. In addition, program administrators may need to develop "disclaimers" for clients so they understand that a substance abuse treatment agency cannot be responsible for the actions of another agency's staff or policies.

For many provider collaboration arrangements a memorandum of understanding (MOU) can be developed to help clarify and guide the interrelationships. Coordinated efforts include active involvement of substance abuse staff in the therapeutic process and continuous contact with the family therapist at the external agency. Detailed understanding of each other's processes and protocols, as well as detailed MOUs, can avoid redundancies and improve quality—for example, if each program screens for mental health issues, coordinating the screening processes will avoid duplication and unnecessary confusion on the part of clients, especially if the different screening approaches were to yield different results. Another example is how the MOU establishes separate responsibilities for on-call service provision and responses to crises.

To ensure adequate communication flow to meet the challenges of coordinating provider activities, program administrators face allocating personnel resources for a variety of tasks, from documentation and information coordination to joint public speaking and presentations. Someone could be designated as the provider collaboration coordinator—perhaps as part of quality assurance duties or a position that implements, monitors, evaluates, supervises, updates, and educates staff about the relationships with other providers. Staff could be assigned duties related to cross-training efforts and participate in each other's boards, committees, or multiagency efforts.

Program administrators would also have to consider other costs and the taxing of resources by the responsibilities of collaborating with other providers. Confidentiality and informed consent will be repetitive issues, whether it is how to manage group forms of treatment in the other agency or how to address the Health Insurance Portability and Accountability Act (HIPAA) requirements (for more information on HIPAA see the following Web site: http://www.hhs.gov/ocr/hipaa). Additional considerations might include policies for non-clients on the treatment premises, space considerations, security, insurance issues to be sure that one's liability protection remains secure, as well as reimbursement issues.

Evaluation and outcome measurement remain challenges for administrators; yet, provider collaboration might offer opportunities to use instruments developed by other providers, gain feedback from other professionals, and offer clients a chance to express themselves to a neutral party by having one agency survey clients about the client's views of the other agencies. Supervisors from each agency are likely to be interested in the views of each other's personnel. The following evaluative questions can be asked in any outcome scenario that involves referring families to other agencies:

- What family members are actually going to the other agency to which they were referred?

- What does the family like about going to the other agency?
- What aspects of treatment from the other agency are helpful?
- What does the other agency provide that this agency also provides?

Issues for staff and trainers

Staff in both agencies can expand their knowledge about substance abuse education and family resources in the community. Staff members should be informed about family-involved treatment models and provide information using collateral resources to build trust with family members. Supervisors are likely to be called on to help staff accommodate the changes and new information generated by collaboration with other providers.

Staff should learn to avoid "splitting"—that is, where a client regards one provider as "good" and the other as "bad," with the implicit attempt to get the "good" provider to agree that the other provider is incompetent, ineffective, or corrupt. Sometimes a variant of triangulation, splitting regularly results in the client becoming upset or attempting to use the "split" to avoid responsibility or consequences for behavior. In any case, staff profit from being as well informed as possible about the details of the programs and resources of collaborative providers, especially in terms of cultural competency issues. For example, it can be important to know the extent to which a collaborating provider can provide accommodations for people with disabilities, from accessible bathrooms to assistive technologies.

Recommendations for collaboration

Cross-training

Generally speaking, there is a shortage of (1) well-trained substance abuse treatment professionals, (2) well-trained substance abuse treatment professionals knowledgeable about family issues, and (3) well-trained family therapists who are proficient in traditional substance abuse treatment techniques. The integration of family therapy into substance abuse treatment programs will have to address these shortages, a goal that could be accomplished—at least in part—through cross-training. Cross-training needs to be addressed in the educational system as well. Requiring a variety of core class work would enable both substance abuse counselors and family therapists to be better equipped to address both substance abuse and mental health issues.

Though ideally counselors would be adequately trained in both family therapy and substance abuse treatment, that ideal is likely to remain the exception rather than the rule. Family therapists can certainly obtain some training in substance abuse treatment, especially in the areas of screening, assessment, motivational enhancement, and relapse prevention, as well as in specific approaches such as cognitive–behavioral therapy or 12-Step programs. Perhaps the first four levels of involvement with families suggested in chapter 4 could accommodate a training approach for family-oriented substance abuse counselors with various levels of training. Additionally, many family therapy techniques—such as telling family stories—can be of great importance in the process of substance abuse treatment engagement.

Partnerships

A shift from the individual to the family in substance abuse treatment models would necessitate collaboration, partnership, and joint funding at all levels. One such example was announced in July 2002, involving the Department of Housing and Urban Development (HUD), the Department of Health and Human Services, and the Department of Veterans Affairs, who have joined together to end chronic homelessness within 10 years (U.S. HUD 2002). Collaborations such as this one highlight how the Federal government has begun to recognize and address the fragmentation, duplication, and isolation that exist within and among agencies, a model that could be transposed to the family therapy/substance abuse treatment arena.

In the community. One empowering partnership model is a consumer-based collaboration that incorporates community perspectives in the development of substance abuse treatment programs. Inclusion of community members' perspectives can heighten their commitment as key stakeholders, involve them in their own care, and reduce the levels of opposition to substance abuse treatment. It inherently validates the listening process of communities and develops trust. La Bodega de la Familia (see chapter 4 for a more complete description) was the first treatment center accepted unanimously by the community board on the Lower East Side of New York. More than 200 meetings were conducted with community members and police, probation, city council, and community providers, the results of which were used to start the program. This process allowed for the possibility of creating an innovative system of intervention that people want and will use, and does not impose a middle-class family therapy model or a "one-size-fits-all" approach on the community it serves.

It remains to be seen whether a model that shifts the power to the consumer provides reliable outcome or impact data, but it does allow communities to tailor interventions with positive impact. Focus groups and other methods are used to engage communities and learn about how people do or do not use services. A major precaution is that often in an open forum, participants may say what they want, but then do not use the service. It falls on the lead agency to validate the consumer and to operate from the perspective that this is a community-led movement, not a professionally led one. Including consumer voices grounds the validity of the program and shifts the traditional paradigm, while also heeding the voices of substance abuse providers, therapists, and other key stakeholders. An additional benefit is that a consumer-led movement is a strategy that can engage legislators and lay the groundwork for policy shifts related to community-based substance abuse treatment and family involvement.

In the workplace. The workplace is another potential partnership area for family therapy and substance abuse treatment. Many Employee Assistance Programs (EAPs) know and make referrals to family therapists who are also knowledgeable about substance abuse. Ongoing research by EAPs on the effectiveness of such referrals and treatment episodes could stimulate others to be more inclusive of familial involvement in substance abuse treatment.

Staff profit from being as well informed as possible about the details of the programs and resources of collaborative providers.

An ancillary issue to this kind of partnership is the potential need for large numbers of people trained in family-involved or family therapy systems work. For example, if the number of families who are served at Level 4 of the model discussed in chapter 4 increases, there may not be enough well-trained clinicians to provide those services. Also, competencies should be designated to guide training on family issues, general family therapy, and family therapy to treat substance abuse.

Family Integration

Programs at the ideal level are fully functional and culturally competent in their operations, policies, procedures, and philosophical approaches as they relate to the integration of family therapy into substance abuse treatment. At this level, adequate infrastructure, financing, and human resources are available to implement and sustain the integrative project. Program activities are based on the strengths of families and an enhanced view of the family as a positive influence and resource. Social,

individual, and family supports are in place to improve family dynamics and prevent relapse.

At this level, a "family culture" is promoted with certain principles about families and substance abuse treatment present throughout the organization and client interactions. Fully integrated programs have multiple staffing patterns with clinical personnel who are educated, comfortable, and competent in substance abuse treatment and family therapy. These programs also have nonclinical staff educated on the importance of family involvement in substance abuse treatment. All clinical staff are cross-trained in family work, substance abuse, and family case management, as well as knowledgeable about social services and other available resources in the community.

Issues for substance abuse treatment program administrators

The total integration of substance abuse treatment and family-based approaches throughout the organization, its policies, and program practices is a challenge at all levels. Ideally, best practice is formed from evidence-based, family-supported therapeutic modalities that have been replicated across a variety of populations, have been evaluated rigorously, and are monitored for adherence. Culturally competent practices are present throughout the organization, its policies, practices, and procedures at this level. In the course of substance abuse treatment and family therapy, close attention is paid to racial and ethnic influences, class, gender, and spiritual values.

Programs at the ideal level are fully functional and culturally competent in their operations, policies, procedures, and philosophical approaches.

Agency administrators prioritize the integration of families into substance abuse treatment and identify model(s) and therapeutic interventions that best address community needs. Throughout the agency, the staff has a thorough understanding of how family will be engaged in the substance abuse treatment and family therapy processes, and implementation of treatment is well coordinated.

A comprehensive range of program activities are available, including

- Screening and assessment for substance abuse and family issues
- Substance abuse treatment
- Family therapy or family-involved interventions
- Information and outreach, using multimedia approaches such as the Internet and videos
- Community partnerships
- Education and psychoeducation
- Therapeutic home-based interventions and family case management services
- Individual and family counseling and parent education
- Process and outcome evaluation

Linkages are established with social services agencies, or those that interact with child welfare agencies, to provide assistance with transportation, housing, health care, food, and childcare. Infrastructural concerns are also addressed, such as the availability and use of physical space; the use of multimedia, including the Internet and videos; and the availability of bilingual informational materials.

With full integration, the notion and practice of informed consent are rigorously implemented and enforced. Fundamentally, this requirement means each family member receives clear, accurate information about what will happen when, or if, they engage in substance abuse treatment and family therapy. Informed consent protects clients before, during, and

after treatment. Clients should grant informed consent only when an agreement about treatment objectives has been reached; treatment and available services have been explained; and benefits, risks, possible side effects, and complications are discussed thoroughly (Barker 1998). Clients are also informed of the potential risks of forgoing services, possible alternatives to proposed treatment, and information that links evidence-based support with various services (Marsh 2001). In family therapy, each competent participant gives informed consent for therapy to proceed (Barker 1998).

Confidentiality extends to all individuals in treatment. Exceptions include the need to reveal information to protect clients from harm (such as suicide, homicide, and physical and sexual abuse). Every agency is required to have a formal confidentiality policy to avoid violations of laws, statutes, and accreditation requirements. Policies are also subject to outside mandates. Those agencies that receive Federal funding must comply with Federal regulations, or 42 C.F.R., Part 2, which guarantees strict confidentiality of information about people who have been in treatment for substance abuse. Participant-identifying information must not be disclosed either to other participants (including family members) or to other service providers without a specific release form that complies with the regulations. Program staff may disclose confidential information to other staff members in the same program if it is necessary for the provision of treatment. The regulations stipulate exceptions to the prohibition on disclosure, including medical emergencies, mandated reports of child abuse or neglect, and, in States that mandate it, elder abuse and neglect. The balance between individual needs and those of family members can often turn individual family members against each other during conflict. If staff members are required to divulge such information, all family members should be informed of agency policy and practices.

Issues for staff and trainers

At this level, all staff—from the receptionist to the executive director—are trained about the important role of the family as a positive influence in the substance abuse treatment process. They have varying degrees of familiarity with the models described in chapter 4. Clinical staff are trained more thoroughly in the tools and techniques of traditional family therapy and multisystemic approaches, public speaking and presentation skills, the relationship between substance abuse and families and partners, and relating with the surrounding ecosystem.

Staff understand the cultural, social, political, and economic forces that affect the various racial and ethnic groups (CSAT 1999*b*). A culturally competent model of substance abuse treatment and family therapy addresses the sociocultural factors affecting substance abuse patterns among members of various racial and ethnic groups as a crucial prerequisite in providing adequate treatment (CSAT 1999*b*). From this perspective, adequate treatment is characterized by

- Staff knowledge of the native language of the client, whenever possible
- Staff sensitivity to the cultures of the client populations
- Staff backgrounds representative of those of the client population

Staff are trained in culturally competent strategies that promote respect and dignity for clients and encourage them to discuss issues without inhibition or fear of termination.

At this level, all substance abuse counselors are certified and clinicians are licensed family therapists or licensed professionals with advanced training in family therapy. Continuing education about various approaches to family work and substance abuse treatment is necessary and supported. Ongoing training in other topics such as domestic violence, child abuse and neglect, elder abuse and neglect, posttraumatic stress disorder, and cardiopulmonary resuscitation is also recommended. All staff members are

cross-trained in family-based approaches and substance abuse treatment.

Clinical supervisors are licensed family therapists or have completed advanced specialized training and coordinate the work in substance abuse treatment and family therapy. Supervisors should have specific experience in family-based modalities and family therapy. Supervisors also need to be informed about a range of auxiliary topics, including childcare, liability concerns related to children, provision of space, and documentation.

Other Program Considerations

Cultural Competence

An organizational culture that is infused with the values of cultural competence and diversity on every level will highlight and implement such values concretely in staffing patterns, language, and cultural issues related to families and substance abuse. Concerted efforts should be made to hire staff and build an organizational culture that reflects the diversity of the client populations served. Program assessments are achieved by exploring institutional assumptions regarding services for specific racial and ethnic communities. This information is used to reduce bias resulting from institutional misperceptions and cultural ignorance or inexperience. For more information about cultural competence, including organizational cultural competence, see the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT in development *b*).

Outcome Evaluation Procedures and Reports

Some outcome evaluation procedures include the development of standard measures to determine the treatment program's efficacy; data collection and database development, which generally require more intensive procedures; and the examination of the relationship between utilization and outcome for every family member treated.

To determine the substance abuse treatment program's efficacy, tracking procedures can be used to record the number of clients returning to the workforce, those involved with medical service providers, and whether treatment correlates with a reduction in the number of client arrests.

Outcomes for family members are examined by the relationship between utilization and outcome, the number of times the client and family members were seen, and the relationship to outcomes. Because the treatment program is in-house, utilization rates can be monitored closely.

Culturally competent evaluation plays a significant role in facilitating outcome evaluation. To be effective, culturally competent evaluation relies heavily on an in-depth understanding of the role that culture plays in substance abuse (Cervantes and Pena 1998). Evaluators should incorporate cultural factors such as acculturation, language, family values, and community attitudes into evaluation design (Cervantes and Pena 1998). Additionally, culturally relevant instruments are critical to the overall evaluation effort. Knowledge of the sociocultural, demographic, and psychological factors specific to the cultural group is necessary. If the evaluation design does not include cultural differences, incorrect conclusions may be drawn about program effectiveness (Cervantes and Pena 1998). An understanding of risk and protective factors as they relate to culture is important in evaluation efforts as well as understanding resiliency factors in a culture.

Long-Term Followup

Monitoring rearrests, recidivism, and readmission to substance abuse treatment programs can serve as measures of long-term functioning. Collection of long-term followup data is difficult and rare in healthcare treatment research in general, and especially in the substance abuse field. Vaillant (1995) provides

family related outcome measures such as marital happiness. Though Hser et al. (2001) present significant long-term research outcomes in narcotics treatment, the consensus panel knows of no such long-term followup with a focus on family.

Directions for Future Research

Since its advent in the 1950s, family therapy has been characterized as having theoretical roots that are anecdotal, intuitive, and empirical, rather than scientific (Barker 1998). That opinion may stem mainly from (1) the separation between researcher and therapist, which exists in all mental health disciplines, and (2) the development of family therapy as an outgrowth of studies conducted on family research into schizophrenia, the mostly unscientific results of which were then extrapolated to a wider range of family problems (Barker 1998). In the absence of a well-articulated conceptual framework, it is impossible to draw definitive conclusions about the efficacy of family therapy (Collins 1990). Research in several areas could serve to address this issue.

New Treatment and Therapy Models

Many advances are being made in the field of family-based treatment for adolescent drug abuse that can serve as pilot models for adult treatment. One valuable insight has been the general shift from focusing exclusively on individual or family variables to change or improve treatment outcomes for adolescents and adults to more complex, multicomponent interventions that incorporate more dimensions and domains in and outside the family (Liddle and Dakof 1995*a*). This movement has culminated in the perspective that multicomponent, comprehensive, community-based, multisystemic approaches must be supported to reap the best outcomes. Ideally, such comprehensive coordinated efforts can be meshed with other related ones—domestic violence, for example—to develop a coordinated community response to a variety of issues that can fit well with multisystemic responses to substance abuse and family involvement. Unfortunately, within the family therapy and family-focused intervention domains, the need for more comprehensive strategies is often outweighed by the complexity of making them viable and implementing them within communities. Cultural and linguistic barriers and a lack of trained bilingual and bicultural staff make this task even more challenging.

Another possible research area relates to the critical need to describe, measure, and report on the process of therapy itself. Investigators would have to make sure that the therapy methods chosen are actually being implemented, making it possible to determine outcomes and identify reliable, therapeutic methods that can help families make desirable changes. As newer forms of family therapy emerge, it is unknown whether radically new approaches to research will be required.

> An organizational culture that is infused with the values of cultural competence and diversity on every level will highlight and implement such values concretely.

Assessment and Classification

A second area for future research is in the assessment and classification process used to determine the type, duration, and intensity of family therapy. Currently, no valid, reliable, acceptable way to categorize families by the way they interact has emerged (Barker 1998). Developing one has been difficult primarily because the diversity of families defies easy categorization. Blended families, gay and lesbian families, adoptive families, as well as

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those with divergent religious beliefs and cultural norms and values, are just a few variations (Barker 1998). Despite attempts at categorization, classifications have relied typically on uncritical understandings of developmental models that purport to designate the particular stage families *should have* reached, based on the ages of children and the stage the family *has* reached (Barker 1998).

Classical definitions notwithstanding, what researchers and therapists need to classify and assess are *relationships* and the measurement of change in relationships in valid, reliable ways. Should success be measured in terms of the presenting problem of the client or in terms of the change in the family system? Specifying the goals and interventions used would permit clearer comparisons of the two approaches (Collins 1990). Further, how do culturally competent understanding and values regarding the role of families figure into traditional models of family development? The need for more explicit categorizations and assessment methods must be addressed.

Outcome Measurement

A third research area concerns the need for outcome research. Many researchers have proposed guidelines for the design of family therapy research, including the need for studies to have clinical relevance, standardized treatment manuals, and resolve the debate between the reliability of comparative studies and "within-model comparisons" (Barker 1998). Collins (1990) recommends consideration of objective outcomes (not just self-reported information) and the measurement of a wide range of outcomes, such as the ability to hold a job, manage finances, or stay married.

Prevention

Prevention strategy is another area that holds promise for future research. A small but growing number of programs are testing whether family-based interventions can serve as prevention or early intervention strategies (particularly with problem drinking). Family therapy researchers could benefit from more clearly defining what a healthy family is as much as what a dysfunctional family is. All these efforts are important in exploring whether preventive strategies can improve family functioning and prevent family pathology. Prevention opportunities exist in schools (truancy, deviant behaviors, expulsion), in the workplace (poor attendance, identified mental health and substance abuse problems), and in churches (families might ask for help around a specific family problem from a pastor, priest, or other spiritual leader).

Technology

A fifth research area relates to technological advances that have the potential to benefit substance abuse treatment efforts, namely the Internet and e-mail. King and colleagues (1998) explored the use of the Internet as a tool to assist family therapy, especially where family members are geographically separated. The researchers also studied the potential value and use of e-mail and writing to facilitate family therapy.

The advantages of e-mail communication in family therapy include allowing family members to contribute whenever their schedules permit, delay responses until they have been fully thought out, and create a permanent record, which reduces the risk of misunderstanding. One drawback for e-mail communication is possible misinterpretation due to lack of tonal cues. Other uses of writing in family therapy include personal narrative, programmed writing, and letter writing, all of which can be

communicated via e-mail. The use of e-mail may make family therapy possible at times when it would otherwise not be feasible.

Another key element that is being used is remote telemedicine. This use of cameras and monitors has been an excellent way to overcome some of the barriers in rural areas where both coverage and transportation have in the past prevented consistent involvement in treatment.

Additional Possibilities

Clear information is also needed in the following areas:

- How effective are various approaches to family therapy in substance abuse treatment?
- How should family therapy be tailored to be appropriate with specific populations?
- How do agencies increase the rate of engagement of families? What role does cultural competence play in the engagement and retention of clients?
- Does the classic family therapy model fit across ethnic groups? If not, what are more feasible options?
- How can competence with families be developed?
- How can the resources of families and communities be identified and mobilized?
- What family differences are important in the treatment of youth, adults, and specifically children?
- What kinds of research and models can increase our understanding of the family role in relapse?
- How will these efforts be funded?
- What changes need to take place for both private and public payment of these services?

The oversimplification of the above might lead some readers to feel as if there is a wide gap between family therapy and substance abuse treatment and that it is a giant leap to move from doing one to doing the other. However, this is not the case. Many people have amended and augmented their customary way of doing their job with input from the other field, and it is certainly not the intent of this TIP to leave the reader with the idea that drawing from the other field requires great change or effort. Rather, the exact opposite is the goal.