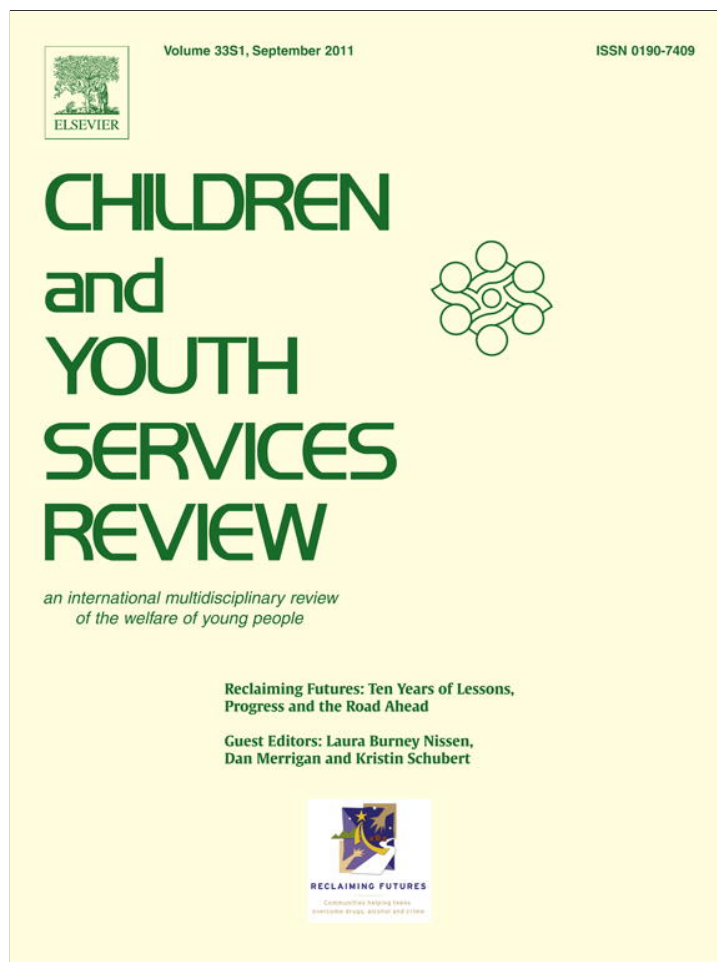


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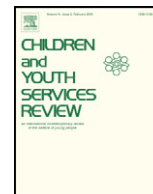
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Family involvement in adolescent substance abuse treatment and recovery: What do we know? What lies ahead?

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ABSTRACT

Families represent the most important resources that young people have in their journey through treatment toward recovery. Unfortunately, family members are often seen as part of the problem and not as part of the solution to adolescent alcohol and other drug (AOD) treatment and recovery. This attitude and misperception can be changed through education, outreach, and engagement of family members. Family involvement and creating a parent-professional collaborative partnership is a step toward improving the outcomes for adolescents in need of treatment and recovery. It is crucial that families understand the treatment process, as well as the hope, process, and reality of recovery. Without information families may not understand the importance of a treatment and recovery plan for their adolescent, the potential adverse consequences, and the impact of these AOD problems on other family members. Families need to learn the continuum of services and supports available, and how family participation improves treatment outcomes and strengthens the recovery process. Family involvement should be an essential part of intake, treatment, and recovery planning, as well as the foundation for effective parent-professional partnerships.

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1. Introduction

Over the last few years, there have been many developments in both the evidence base and the policies surrounding effective family involvement in adolescent services. This article reviews the scope of the problem, what family involvement is and why it is important, lessons learned from the Federal State Adolescent Coordination Grants at the practice, program, and policy levels, and recent efforts by federal, state/tribal, and local officials to strengthen and expand family involvement in adolescent substance abuse treatment and recovery services and supports. This article highlights other systems efforts to improve family involvement—healthcare, child welfare, and juvenile justice among them—and to improve the quality and outcomes of care, and identifies some promising practice examples of states applying the concept of collaborative family partnerships to adolescent substance abuse treatment and recovery. The authors, a family member and a professional, provide a working definition of a “collaborative partnership between family members and profes-

sionals” in the adolescent substance abuse treatment and recovery system. They outline actions already taken by family members, professionals, and allies, discuss the need for leadership and resources to foster further development, and identify some initial next steps following the 2009 meeting of Families of Youth with Substance Use Addiction: A National Dialogue, sponsored by SAMHSA's Center for Substance Abuse Treatment.

2. Scope of the problem

Every year the federal government completes a National Survey on Drug Use and Health (NSDUH). The NSDUH estimates rates of use, numbers of users, and other measures related to illicit drugs, alcohol, and tobacco. The survey collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at the respondent's place of residence. In 2008, 142,938 households were screened, and 68,736 interviews were completed.

During 2008, the NSDUH “Highlights” are as follows (SAMHSA, 2009):

- An estimated 20.1 million Americans aged 12 or older were current (past month) illicit drug users, meaning they had used an illicit drug during the month prior to the survey interview. This estimate represents 8.0% of the population aged 12 years old or older. Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

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- Slightly more than half of Americans aged 12 or older reported being current drinkers of alcohol (51.6%). This translates to an estimated 129.0 million people.
- More than one fifth (23.3%) of people aged 12 or older participated in binge drinking. This translates to about 58.1 million people. Binge drinking is defined as having five or more drinks on the same occasion on at least 1 day in the 30 days prior to the survey.
- Heavy drinking was reported by 6.9% of the population aged 12 or older, or 17.3 million people. Heavy drinking is defined as binge drinking on at least 5 days in the past 30 days.
- An estimated 22.2 million people (8.9% of the population aged 12 or older) were classified with substance dependence or abuse in the past year. Of these, 3.1 million were classified with dependence on or abuse of both alcohol and illicit drugs, 3.9 million were dependent on or abused illicit drugs but not alcohol, and 15.2 million were dependent on or abused alcohol but not illicit drugs.
- Adults aged 21 or older who had first used alcohol at age 14 or younger were more than 5 times as likely to be classified with alcohol dependence or abuse than adults who had their first drink at age 21 or older (15.1% vs. 2.6%).
- The rate of substance dependence or abuse for males aged 12 or older in 2008 was nearly twice as high as the rate for females (11.5% vs. 6.4%). Among youths aged 12 to 17, however, the rate of substance dependence or abuse was higher among females than males (8.2% vs. 7.0%).
- Treatment need is defined as having a substance use disorder or receiving treatment at a specialty facility (hospital inpatient, drug or alcohol rehabilitation, or mental health centers) within the past 12 months. In 2008, 23.1 million people aged 12 or older needed treatment for an illicit drug or alcohol use problem (9.2% of people aged 12 or older). Of these, 2.3 million (9.9% of those who needed treatment) received treatment.
- Based on treatment need, as defined above, 20.8 million people (8.3% of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive treatment in the past year.
- Of the 20.8 million people in 2008 who were classified as needing substance use treatment but did not receive treatment in the past year, 1.0 million people (4.8%) reported that they felt they needed treatment for their illicit drug or alcohol use problem. Of these 1.0 million people who felt they needed treatment, 233,000 (23.3%) reported that they made an effort to get treatment, and 766,000 (76.7%) reported making no effort to get treatment.

In 2008, specifically for adolescents aged 12 to 17, NSDUH indicated (SAMHSA-OAS, 2010):

- 8 million adolescents drank alcohol.
- Nearly 5 million used an illicit drug.
- 4 million smoked cigarettes.
- 10.2% drank alcohol for the first time.
- 6.0% used an illicit drug for the first time.
- 5.1% smoked cigarettes for the first time.

In 2008, 141,683 adolescents aged 12 to 17 were admitted to substance abuse treatment programs, of whom approximately 89% receiving outpatient treatment and 11% receiving residential/inpatient treatment. Principal sources of referrals were (SAMHSA-OAS, 2010):

- 48% from criminal justice
- 15% self-referral or other individual
- 12% from community organization
- 11% from schools
- 7% from treatment providers
- 5% from health care professionals.

3. What is family involvement? Why is it important?

Family involvement has been defined in different ways across child-, youth-, and family-serving systems. The type of involvement, as well as the roles and the expectations for professionals and family members can be understood along a continuum. Terms such as “family friendly,” “family focused,” “family support,” “family centered,” and more recently “family driven” have been used to describe this relationship between family members and professionals.

For the purposes of this paper, family involvement is the active engagement and participation of family members in the practice, program, and policy areas of adolescent substance abuse treatment and recovery services and supports. Certainly there are programs that have viewed family involvement as essential to successful treatment and recovery—some will not even accept an adolescent client without a commitment from family members, including siblings, to be part of the therapeutic process. But it is also true that many providers and policy makers see the adolescent's AOD problems resulting from family denial, enabling, indifference, and/or their own drug use histories. Family members are unfortunately seen as part of the problem and not as part of the solution. This attitude and misperception can be changed through education, outreach, and engagement of family members. Family involvement and creating a parent–professional collaborative partnership is a step toward improving the outcomes of adolescents in the AOD treatment and recovery system.

Other child-, youth-, and family-serving systems have become more effective, compassionate, and successful by understanding that adolescent clients in need of AOD treatment and recovery services and supports are still members of a family system. Whatever the level of family functioning, the problem behaviors have affected all family members. If the therapeutic goals are sustainable outcomes that improve health and well being, then the family, which may or may not be part of the problem, must be part of the solution.

Most policy makers, administrators, and practitioners are familiar with the pioneering work over the past 25 years to increase family involvement in children's mental health² and the person-centered planning in the disabilities field.³ However, in recent years this paradigm shift has spread to other child-, youth-, and family-serving systems as well.

3.1. In healthcare

The Institute of Medicine released *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001), which called for a health care system that:

- Respects patients' values, preferences, and expressed needs
- Coordinates and integrates care across boundaries of the system
- Provides the information, communication, and education that people need and want
- Guarantees physical comfort, emotional support, and the involvement of family and friends.

The Institute for Health Improvement (IHI) has collaborated with the Institute for Family-Centered Care to develop a resource on the importance of “Partnering with Patients and Families” (Johnson et al., 2008) and highlights a successful “Patient-Centered Improvement Guide” (Frampton et al., 2008). IHI is a key driver of healthcare reform efforts and supports (1) the Chronic Care Model (Wagner, 1998), which addresses self-management, decision support, delivery system design, clinical information system, organization of health care, and

² The Federation of Families for Children's Mental Health (www.fcmh.org) is an excellent example of this work.

³ The National Association of State Directors of Developmental Disability Services (www.nasddds.org) has been at the forefront of this work; see especially Smull, Borne, and Sanderson (2009).

community, and (2) the Triple Aim Design (IHI, 2009), which address the patient experience, population health, and per capita costs. Both efforts place strong emphasis on the patient and family being active partners in the delivery of services to improve the quality of care and the outcomes.

Another healthcare organization, the Institute for Patient- and Family-Centered Care (IPFCC, 2010a), lists the following core concepts of patient- and family-centered care:

- Respect and dignity
- Information sharing
- Participation
- Collaboration.⁴

To better understand the different expectations and roles along the continuum of family and professional relationships, IPFCC (2010b) describes the difference between family-focused and family-centered care as follows:

While both approaches acknowledge involvement with the family as a fundamental element of care, there are key differences. In family-focused care, professionals often provide care from the position of an “expert”— assessing the patient and family, recommending a treatment or intervention and creating a plan for the family to follow. They do things to and for the patient and family, regarding the family as the “unit of intervention.” Family-centered care, by contrast, is characterized by a collaborative approach to caregiving and decision-making. Each party respects the knowledge, skills, and experience that the other brings to health care encounters. The family and health care team collaboratively assess the needs and development of the treatment plan.

3.2. In child welfare

The *Child Welfare Information Gateway* (2010) describes family engagement as “a family-centered and strengths-based approach to partnering with families in making decisions, setting goals, and achieving desired outcomes. . . . Engagement goes beyond simple involvement by ‘motivating and empowering families to recognize their own needs, strengths, and resources and to take an active role in working toward change.’”⁵

3.3. In juvenile justice

The *National Juvenile Justice Network* (2010) has recently published “An Advocate’s Guide to Meaningful Family Partnerships” highlighting the range of options for juvenile justice advocates and professionals in partnering with justice system-involved families. The *Campaign for Youth Justice’s Families in Power* (n.d.) outlines strategies for engaging families in advocacy and system reform efforts.

Within adolescent AOD treatment and recovery, the *National Federation of Families for Children’s Mental Health* (2010) has defined family-driven care as when “families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:

1. Choosing culturally and linguistically competent supports, services, and providers.
2. Setting goals.
3. Designing, implementing, and evaluating programs.

⁴ Note especially the leading health-related organizations that support these concepts (IPFCC, 2010a).

⁵ Note also the online toolkit, *Family Engagement* (NRCPPFC, 2009), promoted on the Child Welfare Information Gateway webpage.

4. Monitoring outcomes.
5. Partnering in funding decisions.

In researching the treatment and recovery of juvenile substance abuse, the Joint Meeting on Adolescent Treatment Effectiveness (JMATE) is the country’s leading research conference.⁶ The conference brings together people from diverse backgrounds who strive to improve the quality of treatment to youths and families who struggle with substance use problems. JMATE aims to provide a forum for a wide range of partners to come together to discuss the latest advances in adolescent drug treatment, with a particular emphasis on the unique perspectives of youth and their families.

In 2006, JMATE identified family involvement as a much needed focus and incorporated family and youth tracts for the conference, along with faculty guidelines on being family and youth friendly. For the 2010 JMATE conference, the planning committee adopted “Guidelines on Family and Youth and Culture and Linguistic Competence” (JMATE, 2010a) to ensure that all presentations acknowledged the value of the families involved, respected the level of involvement, used strengths-based language, and appreciate that youth and family members attending the conference come from all walks of life with varied life experiences, cultural diversities, educational backgrounds, vocations, and perspectives. Along with tracks aimed at Evidence-Based Practice, Integrated Services and Recovery, Juvenile Justice, Special Issue Topics, and Treatment System Frameworks, JMATE offers a Family/Youth track to encourage multiple presentations and perspectives.

4. Discussion

From numerous focus groups and open meetings with family members around the country, the authors believe the typical experience of parents who find out their adolescent is using drugs or alcohol is shock and surprise, followed by a realization that they lack knowledge about substance use and abuse and about information on community resources, then distress at the lack of available services and supports. If the family members have strength, determination, and resources, they find answers, but if not, they may give up for lack of direction or lose hope that things will get better.

The family can find out about their adolescent’s substance abuse from different community sources including the local school where he or she may have been intoxicated or in possession of drugs, law enforcement, or friends or other family members. Many times family members have had no indication that anything was wrong beforehand. Many symptoms of adolescent drug abuse look a lot like the typical adolescent behaviors—new interests, change in friends, withdrawing from family members. Furthermore, some parents may have their own AOD use and/or abuse histories, may have their own unmet AOD treatment and recovery needs, may not understand the potential adverse consequences, and may not even realize that what is happening to their adolescent is a problem.

After being notified, what happens next? Parents are not sure where to turn, whom to call, or what to do, and the fear is overwhelming that their child will end up with an addiction, in jail, hospitalized, or even worse, dead.

An example of the difficulty of accessing services is this father’s story. A successful businessman, he knew how to run a business, locate the needed resources, manage the bureaucracy, and so forth, in the large city where he and his family lived. However, upon being told by the school that his son needed AOD treatment, this father realized he was in unfamiliar territory. “After three unsuccessful hours of making calls to get help, I ended up crying in despair at the thought

⁶ JMATE is sponsored by SAMHSA, Executive Office of the White House, NIDA, NIAAA, Department of Education, and OJJDP, as well as numerous private agencies and foundations (<http://www.jmate.org/jmate2010>).

my son was going to die from drug use and I was unable to get any help.”⁷ Unfortunately, this situation is not the exception, but all too often the rule across this country. Because of the lack of access to available treatment, including insufficient adolescent programs, funding issues, and information about where to go and who to call, many parents feel the only option for their adolescent to receive any AOD treatment and recovery services and supports is to turn over custody to the child welfare or juvenile justice system.

Adolescent treatment and recovery should be more accessible, available, and appropriate. Turning over custody to a justice system should not be a parent's only option for help. This “alternative” to access treatment and recovery services and supports not only ignores but actually intensifies the pain, suffering, stigma, and shame families experience.

5. Lessons learned from the SAC Grants

In 2005, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) awarded three-year, \$1.2-million State Adolescent Substance Abuse Treatment Coordination (SAC) grants to 16 states and the District of Columbia.⁸ The SAC grant is a state infrastructure grant that seeks to build capacity in states to provide effective, accessible, and affordable substance abuse treatment for youth and their families. CSAT requires state grantees to address thirteen activities within five overarching topic areas: interagency collaboration, finance, workforce development, dissemination of evidence-based practices, and family involvement.

Each of the 16 SAC states differs in its adolescent substance abuse treatment infrastructure and family involvement experience. Such differences include the public and private leaders who champion this issue, the available resources, and the awareness, readiness, capacity, and past history of the various stakeholders involved for developing collaborative family professional partnerships.

Practice, program, and policy are three key target areas for expanding family involvement in the adolescent substance abuse treatment and recovery system. Families and professionals can partner to design, implement, and evaluate the delivery of treatment and recovery services and supports at each of these three levels. A number of lessons learned have emerged from the experience of the 16 SAC states for families and professionals. The following examples are not intended to be comprehensive, but rather brief examples to highlight some of these key lessons. This material is adapted from the CSAT Issue Brief, “Family Involvement in Adolescent Substance Abuse Treatment” (Smith et al., 2009).

5.1. Practice

5.1.1. Practice issues for families

- *What works:* Adolescent substance abuse treatment service providers who welcome, engage, support, and respect families “where they are.”
- *Benefits:* Family members gain awareness and understanding of addiction as a brain disease, develop realistic treatment and recovery expectations, and identify available family support services.
- *Challenges:* Professionals' inconsistent use of effective family engagement techniques, communication methods, and family support services.

5.1.2. Practice issues for professionals

- *What works:* Families who provide insight and experience into adolescent and family use history that can facilitate effective service planning and practice.
- *Benefits:* Adolescents and their families increase the engagement and retention in substance abuse treatment, recovery, and support services.
- *Challenges:* Families lack readiness to engage in treatment because of emotional crisis, culture, language, and/or logistical barriers.

5.2. Program

5.2.1. Program issues for families

- *What works:* Empowering families to provide valuable input for agency and program quality improvement planning.
- *Benefits:* Families provide crucial input into developing community-based family support services.
- *Challenges:* Family organizations lack the infrastructure support and resources necessary to increase the number and diversity of families involved.

5.2.2. Program issues for professionals

- *What works:* Professionals who encourage family-to-family outreach and promote awareness, peer education, and other support services.
- *Benefits:* Families with diverse experiences assist with efforts to improve the effectiveness, efficiency, and cultural competence of program staff and services.
- *Challenges:* Families lack leadership skills and a clear understanding of the impact of best practices and the high priority for family involvement in program operations.

5.3. Policy

5.3.1. Policy issues for families

- *What works:* Policy-makers who listen to family member experiences, welcome and respect family expertise, and seek family input as part of the policy-making process.
- *Benefits:* Family members experience opportunities to influence policy and develop relationships with policy makers and other family advocates.
- *Challenges:* Families do not receive adequate training and skill building in advocacy, education, and peer support, as well as the lack of infrastructure for families to connect and network with other advocates.

5.3.2. Policy issues for professionals

- *What works:* Professionals who hear personal experiences and input from credible family members to inform policy decisions, and who provide opportunities to foster relationships with constituents.
- *Benefits:* Policy makers have access to issue experts, convene stakeholder groups for hearings, and solicit consumer input to identify system issues, service gaps, and possible solutions.
- *Challenges:* Families lack a consistent, unified, and organized voice for policy agenda items.

6. A working definition of collaborative family–professional partnership

The goal of family involvement is not only to involve families in the treatment process, but also to develop collaborative partnerships that bring the expertise, resources, and experiences of families and professionals together. Such collaborative partnerships are necessary to help adolescents and their families not only understand the disease of addiction but engage in treatment, sustain recovery, and heal from the impact of substance abuse. In treatment, when families and

⁷ Personal communication with the authors.

⁸ SAMHSA awarded SAC grants to the following States: Arizona, Connecticut, District of Columbia, Florida, Georgia, Illinois, Kentucky, Massachusetts, North Carolina, Ohio, South Carolina, Tennessee, Virginia, Vermont, Washington, and Wisconsin (SAMHSA, 2005a,b).

professionals work together in the best interests of the adolescent and impacted family members, positive outcomes occur. When there is increased family involvement, family members have greater ownership of the treatment plan, which in turn increases their motivation and participation, and thereby improves outcomes.

Family involvement develops collaborative partnerships that bring the expertise, resources, and experiences of families and professionals together to improve treatment and expand recovery. Parents come with expertise the “experts” don't have—it can really enhance, support, and assist. That's real partnership.” — Family Partner

Currently, definitions concerning family involvement within adolescent substance abuse treatment and recovery systems are more aspirations than attributes. For example, in Pennsylvania the defined goal is:

Ensure a treatment system that is easily accessible, provides quality treatment in a timely fashion, utilizes the appropriate level of care, is family focused, supports recovery for the individual as well as their family, and ensures a level of accountability, in order that all these goals become a standardized practice in Pennsylvania. The impact for the field will be a substance use disorder treatment system that truly addresses the needs of individuals and gives the greatest possibility of recovery, not only for individuals but also for their families. (*Pennsylvania Drug and Alcohol Coalition, 2009, p. 14*)

Achieving such an ambitious goal will require leadership, coordinated reform efforts, and innovation. This true system change will improve not only the lives of those adolescents affected by the disease of addiction, but also their parents, siblings, caretakers, and/or extended family members impacted as well. It is the hope of the authors that the current efforts to increase family involvement will continue to expand the knowledge base, leadership, and resources necessary to support what works.

7. Promising examples

The following are promising examples of states applying the concept of collaborative family partnerships to adolescent substance abuse treatment and recovery. These examples are by no means exhaustive, but rather demonstrate how family members, professionals, and other allies, working together, can begin to expand family involvement within their states and local communities. These examples also demonstrate family-to-family learning and peer networking opportunities. Some – like those in Arizona, North Carolina, South Carolina, Ohio, Washington, Connecticut, Vermont, and Wisconsin – were initiated by the federal SAC grant, but others, such as Pennsylvania, have developed through state and local efforts to improve adolescent treatment and recovery systems.

7.1. Practice

7.1.1. Arizona

- Contracted with family organizations to provide family support and advocacy.
- Published a “Roadmap to the Substance Abuse System” in English and Spanish (*The Partnership, n.d.*).
- Tribal Family members actively engaged in Native American strategic planning meetings, and a Native American family partner was hired.

7.1.2. North Carolina

- Developed a training curriculum facilitated by family-professional teams called “How to Choose a Service Provider” (*NC-ASAP, 2008*).

7.2. Program

7.2.1. South Carolina

- Developed and implemented a statewide family “listening sessions” series, and established a Family Advocacy Board.

7.2.2. Ohio

- Created a Family Corner website with resources and tools for parents at www.ebasedtreatment.org.

7.2.3. Washington

- Contracted to fund a Family Navigator position. The Family Navigator will actively support and assist youth and families by connecting them with treatment, recovery, and post-treatment services. The program intends to close the gap from the time of a crisis to the time when treatment services are accessed (*SAMA, 2010*).

7.3. Policy

7.3.1. Connecticut

- Developed a policy paper entitled “Blue Print for Change: Bringing Families into Connecticut's Adolescent Substance Abuse Treatment System” (*CTASU, n.d.*).

7.3.2. Vermont

- The Vermont Family Advocacy Board (FAB) reviewed the GAIN-SS screening tool, the Behavioral Health Referral Protocol, the Core Competencies, the EBP proposal, the SIG/SAC Joint Strategic Plan, and the MOA, and played a key role in advocating for family and youth involvement and cultural appropriateness within all of the products being developed through the SAC grant.

7.3.3. Wisconsin

- The newly formed Child and Youth Substance Abuse Subcommittee will track and respond to legislative initiatives related to providing substance abuse treatment. This will ensure a family, youth, and treatment provider voice in the state's legislative process.
- A major priority is to increase the number of counties that utilize both early periodic screening, diagnosis, and treatment and rehabilitation options for adolescent substance abuse treatment.

7.3.4. Pennsylvania

- Created statewide drug and alcohol coalition in which subcommittees are chaired by parent-professional teams.
- *MOMSTELL Inc. (2009)*, a parent and family advocacy organization for substance abuse issues, conducted a statewide survey of substance abuse treatment accessibility in 2007–2008 and published the results in 2009. The results are being utilized and implemented into the statewide substance abuse treatment accessibility work plan.

8. Moving forward

In March 2009, SAMHSA sponsored a meeting “Families of Youth with Substance Use Addiction,” a National Family Dialogue (NFD) (*SAMHSA, 2010*). The NFD included 65 family members who had had youth impacted by the disease of substance abuse addiction from 34 states and six tribes from across the United States. The NFD goals were:

- Strengthen and shape the roles and responsibilities of families as valued substance use treatment/recovery system partners and advocates.
- Develop supports to empower families of youth with substance use disorders in order to create positive changes in the substance use disorders treatment and recovery system.

- Develop recommendations for CSAT/SAMHSA on strengthening and expanding family involvement in youth substance use disorder treatment and recovery at the practice, program, and policy levels. (p. i)

Efforts to raise awareness and coordinate family involvement to improve access, quality of care, and outcomes for adolescent substance abuse treatment and recovery have continued through a series of webinars, developed by NFD in partnership with *Faces and Voices of Recovery* (2010) to develop the following teleconferences, which are available as webinars:

- January 27, 2010: The Science of Addiction and Recovery
- March 24, 2010: Everything you need to know about the new Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
- May 26, 2010: Telling Your Story: Building Relationships, Partnerships and Collaborations
- June 23, 2010: Building and Honing your Public Education Skills.

In December 2010, the NFD held will hold its second next meeting during the JMATE conference in Baltimore. The family members reviewed will discuss the NFD 2009 report, which was released at JMATE, and began discussion to coordinate the next steps to achieve their goals. Specifically, the family members and allies agreed that with health care reform on the horizon, it is important to identify policy issues that need to be addressed (JMATE, 2010b):

- To use the National Family Dialogue report as an effective educational tool.
- Continue to develop the role the NFD can play in improving treatment and recovery services and supports.
- Create a fact sheet about youth substance use disorders.

9. Conclusions

Over the last twenty years, science has demonstrated that addiction is a disease with biologic, family, social, and environmental risk and protective factors. Furthermore, the availability of drugs, the drug of choice, its method of intake, age of initiation, community norms, the number of developmental assets, and the opportunities for positive activities, all affect the trajectory, intensity, and severity of need for treatment and recovery services and supports for adolescents and their families. Alcohol and other drug addiction affect the individual, their family, and the community.

Family involvement in the planning and delivery of services with practitioners at all levels – private, agency, community, county, state, tribal, and federal – is beginning to happen, and family and youth are urging the substance abuse treatment and recovery system to strengthen and support such efforts. Family involvement is necessary to improve the quality of care provided and to ensure that all adolescents and their families in need of substance abuse treatment and recovery receive accessible, appropriate, and quality treatment, as well as a menu of recovery services and supports.

Efforts to develop and enhance collaborative family–professional partnerships have been and will continue to be essential steps to sustaining, improving, and expanding access to and quality of adolescent substance abuse treatment and recovery services and supports. Ideally, state/tribal adolescent substance abuse treatment and recovery systems of the future will consist of collaborative partnerships between family members and professionals, as well as with other child- and family-serving systems. The goals should be (Smith et al., 2009):

- Integrate delivery of adolescent substance abuse and cooccurring disorder services into a seamless continuum of prevention, early intervention, treatment, and recovery support.
- Strengthen and build the leadership capacity of family members, professionals, and providers.

- Educate and train families on relevant issues (e.g., how the system works, advocacy skills, and peer support).
- Develop funding strategies to sustain family involvement (e.g., the Early Periodic Screening, Diagnosis, and Treatment Program; Medicaid).
- Provide resources for family involvement (e.g., transportation, program and policy stipends, funding for family advocates and advocacy groups).
- Include family choice of evidence-based, accessible, affordable, and culturally relevant service options.
- Support and build upon shared knowledge of what works.
- Identify and act on challenges and opportunities for success.
- Leverage political will for effective, efficient, and equitable allocation of resources and infrastructure development.
- Measure the outcomes of family involvement.

Given the current economic problems and budgetary shortfalls, funding levels and financing strategies have been and will remain a concern in the foreseeable future. However, although categorical funding streams may limit the amounts and the services and supports that are reimbursed by federal and state dollars, it is the elected and public officials along with policy makers and community leaders who make decisions on priorities, allocations of resources, and amounts to be spent. There are various strategies and policy approaches to increase and/or expand revenues,⁹ but it is ultimately relationships among key stakeholders and the affected families that drive decisions.

As family members, professionals and allies, we want to work with other community stakeholders and public officials to address the unmet needs of “the other 90%.” These are those individuals, ages 12 and over, who meet the criteria for alcohol and/or drug dependence, but do not receive any treatment and recovery support services. How will we reduce the unmet substance abuse treatment and recovery needs of adolescents, decrease the rate of first time users and address the impact of AOD problems on family members, including siblings? If substance abuse and addiction is a disease, then why are communities still relying on the criminal justice system to identify and refer 48% of the adolescents who receive substance abuse treatment and recovery services/supports?

As family members, professionals and allies, we must continue to educate and organize family members across the country, strengthen relationships with AOD treatment and recovery professionals, administrators and public officials and engage community leaders. Our goal is the elimination of adverse consequences of alcohol and other drug problems on children, youth and families in our communities, cities, counties, states, tribes and country. We need willing partners, as well as multiple funding sources to ensure family members are able to not only come to the policy table, but also enable them to participate at a level of true collaborative partnerships.

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⁹ Two examples are The Finance Project's *Thinking Broadly* (Hayes & Gilbert, 2002) and *Partners for Recovery* (2010).

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