

# Families of Youth with Substance Use Disorders: A National Dialogue

Report from the CSAT/SAMHSA  
National Family Dialogue March 27–28, 2009



**June 2010**

Prepared by

**Doreen Cavanaugh**  
*Georgetown University Health Policy Institute*

**Sharon Smith**  
*MOMSTELL*

**Shannon CrossBear**  
*National Federation of Families for Children's Mental Health*

**Steve Hornberger**  
*National Association for Children of Alcoholics*

**Catherine Kelley**  
*Georgetown University Health Policy Institute*

Sponsored by



# Families of Youth with Substance Use Addiction: A National Dialogue

**REPORT FROM CSAT/SAMHSA  
NATIONAL FAMILY DIALOGUE, MARCH 27–28, 2009**

**Prepared by**

Doreen Cavanaugh  
*Georgetown University Health Policy Institute*

Sharon Smith  
*MOMSTELL*

Shannon CrossBear  
*National Federation of Families for Children's Mental Health*

Steve Hornberger  
*National Association for Children of Alcoholics*

Catherine Kelley  
*Georgetown University Health Policy Institute*

**JUNE 2010**

**Sponsored by:**



Substance Abuse and Mental Health Services Administration  
Center for Substance Abuse Treatment and Center for Mental Health Service

### ***Acknowledgments***

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Health and Human Services (DHHS), by Doreen Cavanaugh, Sharon Smith, Shannon CrossBear, Steve Hornberger, and Catherine Kelley. It is based on the proceedings of the first national meeting of family members of youth with substance use disorders held on March 27–28, 2009. Leadership was provided by Randolph Muck, M.Ed., Chief, Targeted Populations Branch, Center for Substance Abuse Treatment and Jutta Butler, Team Leader, Targeted Populations Branch, Division of Services Improvement, Center for Substance Abuse Treatment.

### ***Disclaimer***

The views, opinions, and content of this publication do not necessarily reflect the views, opinions, or policies of SAMHSA, DHHS.

### ***Public Domain Notice***

All material appearing in this report is in the public domain and may be reproduced or copied without permission from SAMHSA. Citation of the source is appreciated. This publication may not be reproduced or distributed for a fee.

### ***Electronic Access and Copies of Publications***

This publication may be downloaded at:

<http://www.hpi.georgetown.edu>

<http://www.chestnut.org/LI/bookstore/index.html>

### ***Recommended Citation***

Substance Abuse and Mental Health Services Administration. (2010). *Families of Youth with Substance Use Addiction: A National Dialogue*. Rockville, MD: U.S. Department of Health and Human Services.

## Executive Summary

---

### Purpose and Approach

On March 27 and 28, 2009, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) convened the first national meeting of family members<sup>1</sup> of youth with substance use disorders<sup>2</sup> (SUD). The purpose of this historic meeting was to bring together representatives of families of youth who were receiving, or who had received, treatment for substance use disorders, to identify challenges and opportunities to improve the adolescent treatment/recovery system, and to strengthen family involvement in that system at Federal, State, and Tribal levels. Family members from 34 States, the District of Columbia, and 4 Tribal Nations attended the conference.

The goals of the CSAT/SAMHSA National Family Dialogue (NFD) included the following:

- 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 disorder 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.

### Organization of the National Family Dialogue (NFD) Report

This report includes a discussion of the meeting's purpose and approach; background information on family involvement in the adolescent substance use disorder treatment/recovery system; results of the discussion sessions;<sup>3</sup> challenges and opportunities for the development of a more family-focused treatment and recovery system for youth; priority recommendations for essential system elements; recommendations for action at the practice, program, and policy levels; and conclusions and next steps. The appendixes include (A) purpose and goals, (B) agenda, (C) participant list, (D) discussion questions, (E) Issue Brief: Family Involvement in Adolescent Substance Abuse Treatment, (F) family support materials list, and (G) 9 Key Elements of Effective Adolescent Drug Treatment (an excerpt from *Treating Teens: A Guide to Adolescent Drug Programs* (Drug Strategies, 2003)).

---

<sup>1</sup> In this meeting, family member was defined as an adult who plays or has played a primary role in the caretaking of a youth who is currently receiving or who has received treatment for a substance use/co-occurring mental health disorder.

<sup>2</sup> While the primary focus of the meeting was to improve treatment for youth with substance use disorders, meeting planners and participants acknowledged that many youth with substance use disorders have co-occurring mental health disorders as well. Thus, in this report, the term "youth with substance use disorders" also includes youth with accompanying mental health disorders.

<sup>3</sup> For the discussion sessions, participants were divided into five groups, each facilitated by teams consisting of a family member and a professional with expertise in the substance use disorder field. The five groups proceeded to address issues in small workgroups, and then reported their recommendations in plenary sessions. In a concluding session, attendees identified specific actions for CSAT's consideration.

## Background

In 2002, CSAT and the Robert Wood Johnson Foundation sponsored a national symposium on the state of treatment for youth with substance use disorders. At this meeting, participants concluded that the treatment system for adolescents with substance use disorders was inadequate and underdeveloped. They recommended immediate improvement in child-serving agency collaboration, system financing, workforce development, and the implementation of evidence-based treatment practices.

In 2004, in response to the recommendations of the 2002 meeting, SAMHSA's Center for Substance Abuse Treatment (CSAT) developed the Adolescent Substance Abuse Treatment Coordination (SAC) grants, a 3-year grant program to implement the 2002 meeting recommendations. In all, 48 States applied for the grants. In 2005, CSAT awarded 3-year \$1.2 million dollar SAC grants to each of 15 States and the District of Columbia.<sup>4</sup> The purpose of the SAC grants was to increase the capacity of the States to provide effective, accessible, and affordable treatment for youth with substance use disorders and their families. CSAT required SAC State grantees to address change within the five following overarching areas: (1) family involvement, (2) interagency collaboration, (3) finance, (4) workforce development, and (5) the dissemination of evidence-based practices.

For the SAC grants, family involvement was defined as "...any role or activity designed to provide youth and families direct, ongoing, and meaningful input into and influence on substance abuse system policies, programs, and practices that affect the health and well-being of youth and families served" (New York Council, 2007). Historically, the role of families has been underdeveloped within the treatment system for youth with substance use disorders. Family involvement experiences and activities vary widely across the SAC grant States as well as in all Tribal Nations and States.

Because of the SAC initiative, the grantees focused on developing family involvement and made substantial progress engaging families at the practice, program, and policy levels. The identification of the majority of participants in the NFD was a direct result of family member involvement in the SAC States. NFD planners also used a snowball nomination networking approach to identify family leader invitees from non-SAC States and Native American Tribes.

The inclusion of the family perspective is an essential component of SAMHSA's efforts to improve the access, quality of care, and outcomes of adolescent substance use disorder treatment across the country. The concept of family involvement has been defined in many different ways across SAMHSA programs. Terms such as family friendly, family focused, family supportive, family centered, and more recently, family driven, have characterized approaches that systems have used to engage families in participating, supporting, and evaluating treatment and recovery support services for their children.

---

<sup>4</sup> SAC States: AZ, CT, DC, FL, GA, IL, KY, MA, NC, OH, SC, TN, VA, VT, WA, WI

Family members have been active partners in other youth-serving systems, such as children's mental health and developmental disabilities for quite some time. These efforts have resulted in families being involved in treatment planning, service design and delivery, evaluation, and public policy efforts. However, to date, in the area of youth substance use disorders, family involvement has been minimal. The youth substance use disorder treatment and recovery field has lacked a common vision, specific expectations, and clearly defined roles and responsibilities for family members and professionals. By identifying family involvement as one of the five priority areas for the SAC grants, CSAT encouraged States to increase attention to this important area. The SAC State efforts created the foundation and the building blocks for this NFD meeting.

## **Presentations**

### **Day 1: Welcoming Remarks**

#### ***Jack B. Stein, Ph.D., Director, Division of Services Improvement***

*Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), Rockville, Maryland*

Dr. Stein:

- stressed the importance of family involvement in the substance use disorder treatment and recovery process; and
- stated that the NFD meeting was about listening to families to identify strategies, actions, and ideas.

#### ***Sharon Smith, President and CEO***

*MOMSTELL, Mechanicsburg, Pennsylvania*

Ms. Smith:

- welcomed participants and asked them to think about major issues, such as:
  - access to treatment,
  - implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and
  - the role of family involvement in the treatment system; and
- stressed that SAMHSA/CSAT brought family members together to share not only their experiences and challenges, but also their ideas on how to improve the treatment system.

**The Big Picture: Providing a Context for Our Work**  
***Treatment and Recovery System for Youth with Substance Use Disorders:***  
***National Public Policy Context***

***Doreen Cavanaugh, Ph.D., Research Associate Professor***  
*Health Policy Institute, Georgetown University, Washington, DC*

Dr. Cavanaugh:

- emphasized the importance of awareness of current national level public policy issues affecting the access to and quality of treatment and recovery services and supports for youth with substance use disorders;
- defined public policy as, "...a system of laws, regulatory measures, courses of action, and funding priorities concerning a given topic promulgated by a governmental entity or its representatives" (Kilpatrick, 2010);
- discussed Federal policy influences on what will happen at the State and local levels;
- stated that SAMHSA/CSAT, which sponsored the NFD, translates science to practice, works with States to strengthen the substance use disorder treatment/recovery system infrastructure, and assists States in providing quality treatment/recovery services;
- stressed the importance of both public and private sector financing of substance use disorder treatment/recovery services;
- highlighted current treatment system financing design and parity implementation issues;
- informed the group that although the administration's stimulus package provided most government agencies with significant additional funds, SAMHSA did not receive any funding from this source;
- outlined the elements of President Obama's health care reform plan and its potential to act as a catalyst for improving the youth substance use disorder treatment system; and
- asked attendees to think about the following questions during the 2-day meeting:
  - Is the youth substance use treatment/recovery system ready to meet the challenges of parity implementation and inclusion in health reform?
  - What is the system like now?
  - What would you want the system to look like?
  - How can the adolescent substance use disorder treatment/recovery system be a good partner with mental health and primary care?
  - What roles can family members play in developing the system you would like to see?
  - What supports do family member need?

***The Historical Perspective***

***Randy Muck, M.Ed., Chief, Targeted Populations Branch***

*Division of Services Improvement, CSAT, SAMHSA, Rockville, Maryland*

Mr. Muck:

- stated that the development of evidence-based practices, supported by CSAT, has resulted in better outcomes for youth but more progress is needed;
- reviewed the important elements of the SAC grant program, which included the following:
  - family involvement,
  - interagency coordination,
  - coordinated financing,
  - workforce development, and
  - implementation of evidence-based practices; and
- asserted that the family participation emphasis of the SAC program has enabled CSAT to identify and work with families interested in public education.

***Family Involvement in the Youth Substance Use Disorder Treatment and Recovery Systems***

***Cathy Finck, Resource Director***

*Cobb Community Parents in Action, Roswell, Georgia*

Ms. Finck:

- discussed the newly disseminated issue brief: “Family Involvement in Adolescent Substance Abuse Treatment,” which
  - was developed and supported by the CSAT State Adolescent Substance Abuse Coordination (SAC) infrastructure grant program;
  - was the result of a 4-year process involving families at the practice, program, and policy levels in the 15 SAC grant States and the District of Columbia; and
  - identified a number of challenges to family involvement in the youth substance use disorder treatment system, including:
    - absence of a common vision,
    - missing benchmarks,
    - a lack of strategies to incorporate family involvement at all levels,
    - inconsistent communication,
    - lack of referrals, and
    - cultural and language barriers.
- stated that one of the clear lessons learned from the SAC grants was that the experiences of families vary across the country, depending upon the champions within each State;
- asserted that it is essential that the energy and practical experience of families be harnessed to improve quality of care and clinical outcomes nationwide;

- highlighted the fact that the lessons learned through the SAC grants have identified the need for families to partner with professionals to develop meaningful and effective collaborations;
- advocated the position that families need to be invited and empowered to participate in all aspects of policy development, from planning through implementation; and
- encouraged family members to focus on three key areas at the NFD: practice or ground level view, program or view from the treetops, and policy or the high altitude view.

**Sharon Smith, President and CEO**

*MOMSTELL, Mechanicsburg, Pennsylvania*

Ms. Smith:

- provided examples of progress in the SAC States;
- encouraged CSAT to award a second round of SAC grants so all States might have the opportunity to develop the infrastructure necessary to improve substance use disorder treatment and to provide necessary support to families;
- argued that family involvement should address four key areas: validity, power, programs, and position; and
- encouraged family members to focus on being part of the solution.

**Day 2: Welcoming Remarks**

**Jutta Butler, Team Leader, Targeted Populations Branch**

*Division of Services Improvement, CSAT, SAMHSA, Rockville, Maryland*

Ms. Butler:

- welcomed the participants to the second day of the NFD and discussed the topic of the day;
- asked participants to focus on what roles family members could play in creating and implementing the future vision for the adolescent treatment and recovery system;
- acknowledged the attendees' resourcefulness in creating Web sites, developing education materials, opening centers, and providing networking opportunities;
- told the parents that the transition age youth group (18–25 years of age) is often neglected, and that it was important to hear from parents all over the country on issues related to this age group; and
- encouraged parents to search the SAMHSA Web site (<http://www.samhsa.org>) for specific grant opportunities and invited the attendees to contact her if they had any questions.

## **Family Involvement in Other Child-Serving Systems: What Can We Learn?**

***Shannon CrossBear, Training and Technical Assistance Specialist***

*National Federation of Families for Children's Mental Health, Hovland, Minnesota*

Ms. CrossBear:

- shared her family's experience of the youth substance use disorder treatment/recovery system;
- encouraged the parents to research the National Federation of Families and to study their model;
- shared the purpose of the NFD conference, which was to create a collective voice for families whose children have experienced substance use disorders;
- urged the group to think in political terms, to consider the political climate and the major issues they will confront; and
- encouraged the participants to engage others in this national conversation to promote family involvement, and to participate in developing policies that would directly affect access to and the quality of services and recovery support systems.

## **Discussion Session Results**

The work of the NFD sessions included extracting lessons learned from the presentations and sharing personal family member experiences with the youth substance use disorder treatment/recovery system in order to identify the current challenges and opportunities for improvement. Throughout the course of the 2-day meeting, attendees were assigned to one of five discussion groups. Each group was asked to address the following areas: challenges of the current system for youth with substance use disorders; important elements of the future vision for the treatment/recovery system; and, ideas for implementing this vision in order to create a new treatment/recovery system reality. Prioritized items are highlighted below.<sup>5</sup> This listing is not exhaustive, but the discussion session results do provide a clear picture of what participants deemed most critical for a family-focused youth substance use disorder treatment/recovery system.

### **Discussion Session 1. Challenges for the Youth Substance Use Disorder Treatment/Recovery System: Present Reality**

In Session 1, NFD participants identified the most significant challenges in the youth substance use disorder treatment/recovery system today. Challenges identified included the following:

- Lack of education and information on substance use disorders and treatment options,
- Insufficient family-focused care and support,
- Absence of a comprehensive substance use disorder treatment system,
- Stigma,

---

<sup>5</sup> This report prioritizes issues according to the number of groups that identified each issue.

- Lack of access to treatment,
- Insurance issues,
- Disparities in treatment,
- Need for public education on addiction,
- Financing treatment,
- Treatment quality,
- Lack of coordination with primary care providers,
- Inadequate workforce development,
- Insufficient use of evidence-based practices in program design,
- Legal and legislative challenges for parents, and
- Lack of integrated treatment for youth with co-occurring mental health disorders.

**Discussion Session 2. Youth Substance Use Disorder Treatment/Recovery System:  
Future Vision**

***Session 2A. Elements of a Quality Treatment System for Youth with Substance Use Disorders***

In Session 2A, NFD participants identified what they considered the necessary features of a quality youth substance use disorder treatment/recovery system. Features included the following:

- Seamless continuum of care,
- Recovery philosophy infused into the entire service continuum,
- Family involvement in the treatment and recovery system,
- Wraparound recovery services and supports for youth and family members,
- Fully financed system,
- Accurate and individually appropriate assessment and referral,
- Improved care coordination,
- Youth substance use disorder training for staff of youth and family service systems,
- Ongoing public awareness and anti-stigma campaign,
- Collaboration with other youth organizations, and
- Medication-assisted treatments for adolescents.

### ***Session 2B. Actions Needed to Realize the Vision***

In Session 2B, NFD participants identified actions needed to make their vision of an accessible, quality youth substance use disorder treatment/recovery system a reality. Essential elements included the following:

- Reduce stigma through a national public education campaign;
- Involve family members in informing policymakers about the need for youth substance use disorder treatment and recovery services;
- Increase financing for the youth substance use disorder treatment/recovery system;
- Increase family involvement at the practice level;
- Increase workforce development requirements;
- Develop comprehensive treatment models for youth with substance use disorders;
- Create national treatment standards for youth with substance use disorders; and
- Increase support for youth in the juvenile justice system with substance use disorders.

### **Discussion Session 3. Youth Substance Use Disorder Treatment/Recovery System: The New Reality**

#### ***Session 3A. Implementing the Future Vision: The Role of the Family***

In Session 3A, NFD participants described their understanding of the ideal role of family members in the youth substance use disorder treatment/recovery system. Essential elements included the following:

- Educate and support other families through the use of training tools and curricula;
- Increase family involvement in the treatment/recovery system;
- Provide public education about addiction and youth substance use; and
- Increase recovery support and continuing care for youth through reintegration and cultural inclusion.

#### ***Session 3B. Supports and Services Needed by Families***

In Session 3B, NFD participants identified what they considered the most essential supports families need to fulfill their roles in the youth substance use disorder treatment/recovery system. These supports include the following:

- Accessible data and standardized information,
- Improved infrastructure at the Federal, Tribal, and State levels to support sustainable family involvement,
- Better family support and continuing care services,
- Increased public education efforts,
- More support for family member input,

- Networking opportunities to move the NFD forward,
- Continuing SAC Infrastructure Grants,
- Creation of a national organization to promote a family-oriented adolescent treatment/recovery system,
- Development of a quality assurance review team,
- Increased legal supports for families, and
- Creation of family member/community-based research partnerships.

## **Next Steps**

In a plenary session, participants developed suggestions for increasing CSAT's support for family members of youth with substance use disorders. Ideas included the following:

- Develop and disseminate a press release about the establishment of the NFD and meeting;
- Develop a clearinghouse of information for parents;
- Provide funds to support planning and implementing opportunities for family involvement at the practice, program, and policy levels;
- Create communications vehicles for family members such as Listservs, conference calls, and Webinars;
- Help families to “make the case” for significant additional public resources to provide more treatment and recovery services and supports;
- Provide information on financing treatment and recovery services and supports;
- Require Tribes/States to support family organizations and to include family members in policy development;
- Assure that family members are on the planning committee for the annual CSAT Joint Meeting for Adolescent Treatment Effectiveness (JMATE); and
- Help family members measure the effectiveness of treatment.

## **Conclusions and Implications**

NFD provided an opportunity for family members of youth with substance use disorders to begin developing a unified voice within the treatment/recovery system. It enabled them to discuss strategies for implementing their vision of creating and sustaining a substance use disorder treatment/recovery system that effectively addresses the needs of youth and provides the greatest possibility of recovery, not only for youth, but for all family members, including siblings.

Each family's experience was unique, yet common elements quickly emerged that underscore the current treatment/recovery system's strengths and challenges and how they affect the whole family. They included the following:

- Lack of public knowledge on the impact of adolescent alcohol and drug use/dependence on the youth and their family members,
- Difficulty in accessing available, appropriate, affordable and comprehensive treatment,
- Lack of recovery services and supports,
- Lack of family peer education, advocacy, and supports,
- The continued existence of shame and stigma,
- The impact of trauma and loss,
- Determination to break the cycle of addiction within families,
- Commitment to get involved to improve the quality of care and the outcomes of treatment and recovery, and
- Hope to improve the health and well-being of families and communities across the United States.

NFD participants concluded that family involvement is necessary to improve the quality of care and to insure that all youth in need of substance use disorder treatment/recovery receive effective services that incorporate the entire family in order to promote holistic recovery for everyone.



# Table of Contents

---

<b>Introduction</b> .....	<b>1</b>
Organization of the National Family Dialogue (NFD) Report .....	1
<b>Approach</b> .....	<b>3</b>
<b>Background</b> .....	<b>4</b>
<b>Presentation Summaries</b> .....	<b>9</b>
Day 1 Welcoming Remarks .....	9
The Big Picture: Providing a Context for Our Work .....	10
The Historical Perspective .....	13
Family Involvement in the Youth Substance Use Disorder Treatment and Recovery Systems .....	14
Discussion Session Presentations .....	16
Family Involvement in Other Child-Serving Systems: What Can We Learn? .....	17
Charge to the Group: Discussion Session 3 .....	17
<b>Discussion Session Results</b> .....	<b>18</b>
Discussion Session 1. Challenges for the Youth Substance Use Disorder Treatment/Recovery System: Present Reality .....	18
Discussion Session 2. Youth Substance Use Treatment/Recovery System: Future Vision ...	21
Discussion Session 3. Youth Substance Use Disorder Treatment/Recovery System: The New Reality .....	26
<b>Next Steps</b> .....	<b>31</b>
<b>Conclusions and Implications</b> .....	<b>33</b>
<b>References</b> .....	<b>35</b>
<b>Appendixes</b> .....	<b>37</b>



## Introduction

---

On March 27 and 28, 2009, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) convened the first national meeting of family members<sup>6</sup> of youth with substance use disorders<sup>7</sup> (SUD). The purpose of this historic meeting was to bring together representatives of families of youth who were receiving, or had received, treatment for substance use disorders, to identify challenges and opportunities to improve the adolescent treatment/recovery system, and to strengthen family involvement in that system at Federal, State, and Tribal levels. Family members from 34 States, the District of Columbia, and 4 Tribal Nations attended the conference.

The goals of the CSAT/SAMHSA National Family Dialogue (NFD) included the following:

- 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 disorder treatment and recovery system; and
- 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.

### Organization of the National Family Dialogue (NFD) Report

This report includes a discussion of the meeting's purpose and approach; background information on family involvement in the adolescent substance use disorder treatment/recovery system; results of the discussion sessions;<sup>8</sup> challenges and opportunities for the development of a more family-focused treatment and recovery system for youth; priority recommendations for essential system elements; recommendations for action at the practice, program, and policy levels; and conclusions and next steps. The appendixes include (A) purpose and goals, (B) agenda, (C) participant list, (D) discussion questions, (E) Issue Brief: Family Involvement in Adolescent Substance Abuse Treatment, (F) family support materials list, and (G) 9 Key Elements of Effective Adolescent Drug Treatment (an excerpt from *Treating Teens: A Guide to Adolescent Drug Programs* (Drug Strategies, 2003)).

For the SAC grants, family involvement was defined as "...any role or activity designed to provide youth and families direct, ongoing and meaningful input into and influence on substance

---

<sup>6</sup> In this meeting, family member was defined as an adult who plays or has played a primary role in the caretaking of a youth who is currently receiving or who has received treatment for a substance use/co-occurring mental health disorder.

<sup>7</sup> While the primary focus of the meeting was to improve treatment for youth with substance use disorders, meeting planners and participants acknowledged that many youth with substance use disorders have co-occurring mental health disorders as well. Thus, in this report, the term "youth with substance use disorders" also includes youth with accompanying mental health disorders.

<sup>8</sup> For the discussion sessions, participants were divided into five groups, each facilitated by teams consisting of a family member and a professional with expertise in the substance use disorder field. The five groups proceeded to address issues in small workgroups, and then reported their recommendations in plenary sessions. In a concluding session, attendees identified specific actions for CSAT's consideration.

abuse system policies, programs and practices that affect the health and well-being of youth and families served” (New York Council, 2007).

Family involvement can be understood along a continuum ranging from parents actively participating in an adolescent’s treatment to family members advising the Executive and Legislative branches of State, Federal and/or Tribal leadership on policy issues. Working together, family members can become a strong voice advocating for practice, program, and policy changes in the treatment and recovery system for youth with substance use/co-occurring mental health disorders. Individually, or uniting with other family members, parents have begun communicating with agency administrators, elected officials, advocates, and other concerned stakeholders. The continued mobilization of family members will contribute to expanding, improving, and sustaining the treatment and recovery infrastructure for youth with substance use/co-occurring mental health disorders.

Facilitators charged participants with identifying what the treatment system for youth with substance use/co-occurring mental health disorders should look like at the practice and program levels and what needed to happen at the policy level to make this vision a reality. Family members were eager to come together in order to share their experiences and knowledge and to provide their input during this 2-day process.

During this meeting, family members learned about the status of substance use disorder treatment and recovery for youth, family involvement in the substance use disorder treatment/recovery system across the nation, and opportunities for building and sustaining family involvement initiatives.

The principles guiding the NFD included meeting families where they are, respecting each family’s culture and diversity, hearing and respecting each other’s voice, building consensus, and expecting results.

## Approach

---

During the 2-day meeting, participants heard presentations from family members, Federal government representatives, and national content experts. These presentations informed a series of small group discussion sessions. For those sessions, participants gathered in five groups, each facilitated by teams consisting of a family member and a professional with expertise in the substance use disorders field. The five groups addressed the following issues in small workgroups:

- Challenges for youth in the current substance use disorder treatment and recovery system,
- Ideal features of a youth treatment/recovery system and necessary actions to realize these features, and
- Definition of the roles of family members and the supports necessary to sustain family member involvement in the youth treatment/recovery system.

Participants then reported their recommendations in plenary sessions. In a concluding session, attendees identified specific actions for CSAT's consideration.

Discussion group participants identified a range of issues related to each topic, prioritized the most important issues through a group forced choice process, and reported those priorities in plenary sessions. The authors of this report employed qualitative methods to analyze the results. Discussion group content was reviewed and clustered; common themes were identified; and items were then reviewed, arrayed, and listed by themes. In this document, key concepts and supporting elements prioritized by one or more discussion groups are identified.

## Background

---

In 2002, the Center for Substance Abuse Treatment and the Robert Wood Johnson Foundation sponsored a national symposium on the state of treatment for youth with substance use disorders. At this meeting, participants concluded that the treatment system for adolescents with substance use disorders was inadequate and underdeveloped. They recommended immediate improvement in child-serving agency collaboration, system financing, workforce development and the implementation of evidence-based treatment practices.

In response to the recommendations of the 2002 meeting, in 2004, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) developed the Adolescent Substance Abuse Treatment Coordination (SAC) grants, a 3-year grant program to implement the 2002 meeting recommendations. In all, 48 States applied for the grants. In 2005, CSAT awarded 3-year \$1.2 million dollar SAC grants to each of 15 States and the District of Columbia (States).<sup>9</sup> The purpose of the SAC grants was to increase the capacity of the States to provide effective, accessible, and affordable treatment for youth with substance use disorders and their families. CSAT required SAC State grantees to address change within five overarching areas: family involvement, interagency collaboration, finance, workforce development, and the dissemination of evidence-based practices.

Historically, the role of families has been underdeveloped within the treatment system for youth with substance use disorders. Family involvement experiences and activities vary widely across the SAC grant States as well as in all States and Tribal Nations across the country. Because of the SAC initiative, the grantees focused on developing family involvement and made substantial progress engaging families at the practice, program, and policy levels. The identification of the majority of participants in the NFD is a direct result of family member involvement in the SAC States. NFD planners also used a snowball nomination networking approach to identify family leader invitees from non-SAC States and Native American Tribes.

The inclusion of the family perspective is an essential component of SAMHSA's efforts to improve the access, quality of care, and outcomes of adolescent substance use disorder treatment and recovery services across the country. The concept of family involvement has been defined in many different ways across SAMHSA programs. Terms such as family friendly, family focused, family supportive, family centered, and more recently, family driven, have characterized approaches that systems have used to engage families in participating, supporting, and evaluating treatment and recovery support services for their children.

Family members have been active partners in other youth-serving systems, such as children's mental health and developmental disabilities for quite some time. These efforts have resulted in families being involved in treatment planning, service design and delivery, evaluation, and public policy efforts. However, to date in the area of youth substance use disorders family involvement has been minimal. The youth substance use disorder treatment and recovery field has lacked a

---

<sup>9</sup> SAC States: AZ, CT, DC, FL, GA, IL, KY, MA, NC, OH, SC, TN, VA, VT, WA, WI

common vision, specific expectations, and clearly defined roles and responsibilities for family members and professionals. By identifying family involvement as one of the five priority areas for the SAC grants, CSAT encouraged States to increase attention to this important area. The SAC State efforts created the foundation for this NFD meeting.

Historically, a focus on negative family factors has often blocked a potentially powerful avenue of support and positive encouragement for families who are able and willing to aid in the treatment and recovery process of their youth. Since family factors have been known to be one of the strongest predictors of substance use initiation and problem use throughout adolescence, shortcomings in family life and the environment surrounding youth have received significant attention (Rowe et al., 2008). Research has demonstrated the potential for negative effects families may have in exacerbating substance use and co-occurring mental health conditions in youth. However, other studies identifying the potential protective influences of families against adolescent problems, the capacity of families to mediate individual and peer risk factors for substance use and the contribution of families to successful treatment outcomes have often been minimized. Therefore, rather than presuming that all family members are negative influences, families can also be seen as resources, active participants and supporters of the youth in treatment and recovery (Rowe and Liddle, 2006).

The American Academy of Child and Adolescent Psychiatry (AACAP) found that “Although there are many approaches to family intervention for substance abuse treatment, they have common goals: providing psycho-education about SUDs [substance use disorders], which decreases familial resistance to treatment and increases motivation and engagement; assisting parents and family members to initiate and maintain efforts to get the adolescent into appropriate treatment and achieve abstinence; assisting parents and family members to establish or reestablish structure with consistent limit-setting and careful monitoring of the adolescent’s activities and behavior; improving communication among family members; and getting other family members into treatment and/or support programs” (AACAP, 2005, p. 9).

“Studies consistently report that [active participation of family members in the adolescent treatment and recovery process] is critical to engaging and retaining adolescents in treatment, as well as to successful treatment as defined by reduction of drug use, decrease of behavior problems, and affiliation with the family and with prosocial peers” (Liddle and Dakof, 1995, p. 241). The family remains a primary support system and has the highest impact on youth. Family-oriented interventions “...rest upon two fundamental assumptions: the family plays an important role in the creation of conditions related to adolescent drug use, and certain family environments and parent-adolescent relationships can both protect adolescents against drug use and offer an antidote for drug use that has already begun” (Liddle and Dakof, 1995, p. 220).

Current research trials are incorporating critical contextual factors, including family, when designing targeted prevention and intervention models. “Integrated interventions that concurrently deal with coexisting psychiatric and behavioral problems, family functioning, peer and interpersonal relationships, and academic/vocational functioning not only will produce general improvements in psychosocial functioning, but most likely will yield improved outcomes

in the primary treatment goal of achieving and maintaining abstinence” (AACAP, 2005, p. 8). The premise of these models is that changes in family environment can prevent or reduce adolescent problem behaviors.

One therapeutic model, family-based therapy is a powerful tool for not only treating adolescent substance use disorders but associated behavior problems as well. These types of interventions are increasingly being used to treat adolescent substance use disorders. AACAP included family-based therapy in its recommended practice parameters for adolescent substance use disorder treatment (Ozechowski and Liddle, 2000).

Several studies have supported the premise that family involvement leads to better outcomes for adolescents with substance use disorders. For example, Multidimensional Family Therapy (MDFT) has helped youth develop better coping skills and decision-making while improving interpersonal functioning of the family as a protective factor (Henderson et al. 2009). A 1990 study by Lewis et al. found that family therapy participants had significantly lower post-treatment indexes of drug severity scores than family education recipients did. A 1992 study conducted by Henggler et al. found that individuals involved in multi-systemic therapy had “significantly lower rates of substance-related arrests” than those in individual counseling. Also in 1992, Joanning et al. found a “greater percentage of abstainers in family systems therapy (54 percent) than adolescent group therapy (28 percent) or family drug education (16 percent) groups. However, no differences in family functioning were found between the groups” (Deas and Thomas, 2001, p. 180). These findings support arguments for involving the family in the treatment process to maximize the benefits of treatment for youth.

Incorporating family member experiences and suggestions at the policy level is crucial to strengthening and expanding recovery-oriented care models. According to the National Federation of Families for Children’s Mental Health (NFFCMH), family leaders “...have a primary decision making role [at the Federal, State, and local levels] in designing, building, evaluating, and sustaining successful programs” (NFFCMH, 2009, p. 5). According to NFFCMH, family leaders are suited to this role for the following reasons:

- They have experienced raising children with mental, emotional, or behavioral challenges;
- They have long-term membership in the community, which has provided them with knowledge about the culture, socioeconomic strengths and weaknesses, and history of the community;
- They may have transferred into the new community from one with strategies that could inform this community; and
- They have intimate working knowledge of other child, youth and family services (National Federation of Families for Children’s Mental Health, 2009).

The World Health Organization has also found that “it is helpful to be supportive of [parent advocacy] groups as allies in the development of policy for the following reasons:

- i. Parents of children and adolescents with mental disorders tend to have considerable knowledge about the disorder which can be harnessed to achieve common goals
- ii. Parent advocacy groups can be helpful in gaining NGO [non-governmental organization] support for programme development
- iii. Parent advocates can be effective lobbyists specifically for child and adolescent mental health
- iv. These groups provide support for caregivers, who might otherwise not cope and thus cause the burden to shift to the State” (World Health Organization, 2005, p. 32).

From its inception, the SAC grant program emphasized that a family-focused treatment and recovery system for youth with substance use disorders results from mutually respectful and beneficial family-professional collaborative partnerships. Through these collaborative partnerships, families learn about current services, policies and procedures, emerging trends/challenges and research on the system from professionals and professionals learn to appreciate the unique experiences, perspectives, strengths and challenges from families.

“There are significant and important differences in how the disease of addiction affects families according to their cultural, racial, or ethnic backgrounds; their geographic location; their socioeconomic class; and their access to services, supports, or other resources” (Smith et al., 2009, p. 2). Thus, it is necessary to ensure that all families of youth receiving treatment and recovery services for substance use disorders are engaged, represented, valued, supported, and provided opportunities to be included in meaningful ways. Raising public awareness and educating families on adolescent substance use disorder treatment and recovery issues, and providing information on services and supports greatly benefit families who are trying to navigate the system. Given encouragement, information, tools, and resources, family members will not only participate in their own child’s recovery, but also expand family involvement in ongoing treatment and recovery system activities at Federal, Tribal, State, and community levels.

Initial efforts to promote, develop, and support family involvement within the youth substance use disorder treatment/recovery system have been very encouraging. Family members have been engaged, equipped, and mobilized to advocate for improving inadequate systems and sustaining effective treatment system practices, programs, and policies.

SAC States have worked successfully with children’s mental health, Medicaid, education, juvenile justice, child welfare, and family support organizations to address family involvement goals for the substance use disorder treatment/recovery system.

As an outgrowth of the family involvement efforts in these grantee States and in order to begin improving the role of the family in the treatment/recovery system for youth with substance use disorders, CSAT recognized the need for a national dialogue among family members, researchers, and Federal level policymakers in order to identify the lessons learned from the SAC grant, disseminate what works, and identify what still needs to be done. Thus, CSAT convened the NFD. This report contains a summary of the proceedings of that meeting and the recommendations of NFD participants.

## Presentation Summaries

---

### Day 1 Welcoming Remarks

***Jack B. Stein, Ph.D., Director, Division of Services Improvement***

*Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), Rockville, Maryland*

Dr. Stein welcomed attendees to the conference and thanked them for their participation personally and on behalf of Dr. H. Westley Clark, Director of the Center for Substance Abuse Treatment. Dr. Stein stressed the importance of family involvement in the treatment and recovery of youth with substance use disorders. He stated that his background as a social worker has been instrumental in his understanding of family and youth involvement. Initially, Dr. Stein noted that he worked with young people and saw a great deal of youth substance use. According to him, this experience illuminated the importance of family roles. He spoke about his experiences working with HIV/AIDS in Baltimore as well as how this experience shaped his belief that programs must include families. Dr. Stein said programs that included both families and young people simply made sense.

Dr. Stein remarked that this meeting was about CSAT listening to families over the next 2 days. He said that he saw the meeting as an opportunity to identify strategies, actions, and ideas. He expressed his hope that participants would share this experience by bringing their learning back to their communities.

***Sharon Smith, President and CEO***

*MOMSTELL, Mechanicsburg, Pennsylvania*

Ms. Smith thanked the Center for Substance Abuse Treatment for sponsoring the NFD. She expressed her enthusiasm for the realization of a 10-year dream to gather families who have been affected by substance use disorders together from across the country in order to initiate the dialogue on how family members can make a difference in the substance use disorder treatment system. Ms. Smith acknowledged that many of the NFD participants had experienced a great deal of adversity as a result of a child's addiction and saw this gathering as an opportunity to have a meaningful discussion around "...being willing to talk about what the adolescent treatment system looks like now, what it should look like, and how we are going to get there." She charged the participants to use the 2 days to identify obstacles to treatment for youth with substance use disorders and to identify the supports needed to overcome these obstacles. Ms. Smith urged the audience to think about access to treatment, issues in implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and most importantly, the role of family involvement in the treatment system.

Ms. Smith stated that the goal of this meeting was to identify challenges and solutions and she emphasized the value of family member feedback, stating that, "every single piece of your input is important to this dialogue and everything will be captured." The participants were charged with sharing information about their common experiences, suggesting improvements for the

system, and generating ideas for developing a national voice to share this information. Ms. Smith rallied the participants to "...unite their voices in hope." She stated that participants should take the opportunity to "...level the playing field." She stressed that everyone was on equal ground whether they led a statewide organization, a parent support group, or advocated for their own child, their individual voices mattered and that it was most important for each one of them to speak up and speak out during the sessions. She informed them that SAMHSA/CSAT brought them together to share not only their experiences and challenges, but also their ideas on how to improve the youth treatment/recovery system. In her closing remarks, Ms. Smith again emphasized the importance of every single voice in the room and the need for each voice not only to be expressed, but also heard by all.

## **The Big Picture: Providing a Context for Our Work**

### **The Treatment and Recovery System for Youth with Substance Use Disorders: National Public Policy Context**

***Doreen Cavanaugh, Ph.D., Research Associate Professor**  
Health Policy Institute, Georgetown University, Washington, DC*

Dr. Cavanaugh presented an overview of current national level public policy issues affecting the access to and quality of treatment and recovery services and supports for youth with substance use/co-occurring mental health disorders. She emphasized that awareness of these issues is important for strengthening the youth treatment/recovery system.

Dr. Cavanaugh set the stage for a policy discussion by defining public policy as, "...a system of laws, regulatory measures, courses of action, and funding priorities concerning a given topic promulgated by a governmental entity or its representatives" (Kilpatrick, 2010). She said it is important to recognize that decisions made at the Federal level may have a direct impact on Tribal, State, and local levels.

She emphasized the important research and policy development functions of the Federal agencies including the Office of National Drug Control Policy (ONDCP); the National Institute on Drug Abuse (NIDA); the National Institute on Alcohol Abuse and Alcoholism (NIAAA); the Substance Abuse and Mental Health Services Administration (SAMHSA) which includes the Center for Substance Abuse Prevention, the Center for Substance Abuse Treatment and the Center for Mental Health Services; the Centers for Medicare and Medicaid Services (CMS); and the Indian Health Services (IHS). She explained that the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) are responsible for conducting the research on substance use disorders including research in neuroscience, treatment efficacy and effectiveness, and health services research including the financing and organization of treatment. Of particular importance is the SAMHSA Center for Substance Abuse Treatment (CSAT), the sponsor of the NFD. SAMHSA/CSAT works to improve access to and the quality of treatment and recovery services and supports for youth with substance use/co-occurring disorders through working with Tribes/States and community-based providers. CSAT

translates science to practice, works with Tribes/States to strengthen the substance use disorder treatment/recovery system infrastructure and assists them in providing quality treatment/recovery services.

Dr. Cavanaugh stressed the importance of both public and private sector financing of substance use disorder treatment/recovery services. She stated while Medicaid is a primary funding source of treatment for many youth with substance use disorders, in 2001 Medicaid allocated only 1.5 percent of total expenditures for the treatment of substance use disorders, and 10 percent of total expenditures for mental health treatment. She noted that Medicaid regulations have significant influence on the provision of treatment for youth with substance use disorders. She informed the group that currently Medicaid law states:

*“No service (including counseling) shall be excluded from the definition of ‘medical assistance’ solely because it is provided as a treatment service for alcoholism or drug dependency.”*  
—Social Security Act

For youth covered by the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, State Medicaid programs must cover treatment for substance use disorders just as they cover treatment for mental health conditions; however, currently, this is not always the case. She stressed that upcoming changes such as the implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 will apply to Medicaid managed care plans as well as to group health plans with more than 50 employees. The Act, which addresses the inequity of health insurance benefits between mental health/substance use disorders and medical/surgical benefits, will be in effect as of January 1, 2010.

Dr. Cavanaugh explained that youth treatment for substance use disorders may be funded by other Federal funding sources such as two major programs administered by CSAT. CSAT’s Division of State and Community Assistance administers the Federal Substance Abuse Prevention and Treatment Performance Partnership Block Grant (SAPTPPBG) program. This grant program, funded at approximately \$1.8 billion in FY 2009, provides resources to the States to support substance abuse prevention and treatment. Although there are set asides in the SAPTPPBG for a number of purposes such as substance abuse prevention and treatment for pregnant women, there is no set aside for youth treatment. Thus, each State decides whether to use any of the Block Grant funds for youth. Only half of the 16 SAC States used Block Grant funds for youth treatment. The second CSAT program that supports youth treatment is the Children and Families line item administered by CSAT’s Division of Services Improvement (DSI). Dr. Cavanaugh illustrated the reduction in the CSAT Children and Families program funding levels, stating that the amount in this line item had been reduced from \$29.3 million in FY 2006 (SAMHSA 2008) to \$20.7 million in FY 2009 (Public Law No. 111-8, 2009). She informed the group that although the administration’s stimulus package provided most government agencies with significant additional funds SAMHSA did not receive any funding from this source.

Dr. Cavanaugh stated that funds supporting treatment/recovery services for youth with substance use disorders might be found in many other Federal departments/agencies. These agencies include, but are not limited to, Health and Human Services, Justice, Education, Labor, and Housing and Urban Development. In most cases, it is up to the Tribes/States to decide to use the money for youth treatment.

Dr. Cavanaugh stated that another major Federal initiative, the potential enactment of health reform legislation, could also affect the delivery of treatment services. Dr. Cavanaugh outlined President Obama's health care reform plan, which includes the following:

- Making health insurance affordable and accessible to all,
- Lowering health care costs,
- Promoting public health,
- Requiring that all children have health coverage,
- Allowing youth up to age 26 to be covered by parent's plan,
- Expanding eligibility for Medicaid and CHIP programs,
- Promoting state-of-the-art health information technology, and
- Ensuring electronic health records lead to better coordination (<http://www.barackobama.com>, 2009).

Dr. Cavanaugh expressed hope that the advent of health reform would provide a catalyst for the improvement of the youth substance use and mental health treatment systems. In her closing remarks, Dr. Cavanaugh asked attendees to think about the following questions as they participated in the 2-day meeting:

- Is the youth substance use treatment/recovery system ready to meet the challenges of parity implementation and inclusion in health reform?
- What is the system like now?
- What would you want the system to look like?
- How can the adolescent substance use disorder treatment/recovery system be a good partner with mental health and primary care?
- What roles can family members play in developing the system you would like to see?
- What supports do family members need?

## **The Historical Perspective**

***Randy Muck, M.Ed., Chief, Targeted Populations Branch***

*Division of Services Improvement, CSAT, SAMHSA, Rockville, Maryland*

Mr. Muck reflected on the changes in the treatment of adolescents with substance use disorders that he has seen since joining the Center for Substance Abuse Treatment. In 1997, he found that there were only 16 published papers addressing youth treatment. Today, he said there are at least 300 published studies documenting what works for treating adolescent substance use and co-occurring mental health disorders.

Mr. Muck emphasized that CSAT has supported the development of evidence-based practices for adolescent substance use disorder treatment and has encouraged their distribution across the country. While these evidence-based practices have resulted in better outcomes, he stressed that this progress was still insufficient.

Mr. Muck discussed the importance of the State Adolescent Substance Abuse Treatment Coordination grants (SAC) awarded to 15 States and the District of Columbia. These grants assisted the States in improving family involvement, interagency collaboration, coordinated financing, workforce development, and the implementation of evidence-based practices. Emphasizing family participation through SAC grants has enabled CSAT to identify and work with families interested in public education. Mr. Muck remarked that the NFD was proof that, through the SAC grants, treatment for adolescents with substance use disorders had reached a “tipping point” of families able to work for systemic change.

Mr. Muck advised the participants to weave their personal stories into a cogent, national message and expressed hope that the conference would assist CSAT in improving the substance use disorder treatment/recovery field. In closing, he thanked the participants and urged them to develop recommendations for CSAT.

## **Family Involvement in the Youth Substance Use Disorder Treatment and Recovery Systems**

***Cathy Finck, Resource Director***

*Cobb Community Parents in Action, Roswell, Georgia*

Ms. Finck discussed the newly disseminated issue brief, “Family Involvement in Adolescent Substance Abuse Treatment.” She stated that the issue brief was developed and supported by the CSAT State Adolescent Substance Abuse Coordination (SAC) infrastructure grant program. The issue brief was a result of a 4-year process involving families at the practice, program, and policy levels in the 15 SAC grant States and the District of Columbia. Ms. Finck stated that the NFD meeting is an effort to strengthen and sustain family involvement in grantee States and across the country. One of the clear lessons learned from the SAC grants was that the experiences of families vary across the country, depending upon the champions within each State. Ms. Finck stated that it was essential that the energy and practical experience of families be harnessed to improve the quality of care and outcomes nationwide.

The issue brief identified a number of challenges to family involvement in the youth substance use disorder treatment system including: absence of a common vision, missing benchmarks, absence of strategies to incorporate family involvement at all levels, the inconsistent use of communication, lack of referral sources for treatment, and cultural and language barriers. Ms. Finck expressed conviction that the lessons learned through the SAC grants have identified the need for families to collaborate with professionals to develop meaningful and effective relationships. She emphasized that partnerships work well when professionals are welcoming and engaging, which encourages the formation of relationships. At the practice level, Ms. Finck found that when families could be open and honest with professionals, treatment was more effective.

Ms. Finck stated that in the policy arena the focus is to identify improving the workforce through State regulations such as the credentialing requirements for treatment providers. She commented on how some professionals struggle with cultural competency, but she highlighted how families can help them overcome these challenges. She suggested that at this meeting family members focus on three key areas: practice or ground level view, program or view from the treetops, and policy or the high altitude view.

In closing, Ms. Finck highlighted the need to invite and empower families in all aspects of policy development from planning through implementation.

**Sharon Smith, President and CEO**

*MOMSTELL, Mechanicsburg, Pennsylvania*

Ms. Smith stated that policymakers do listen to families and recognize that families can have an impact on policy. She explained that although family members may lack training to discuss issues with policymakers, there are benefits to family input that can provide experts with useful information. Ms. Smith went on to explain how communication and collaboration are necessary to produce significant change and asserted that families need to be involved at the Federal, Tribal, State, and local levels.

Ms. Smith provided examples of progress in the SAC States. For example, Arizona, Vermont, and Washington used part of their SAC grants to hold annual events to increase awareness concerning the needs of youth with substance use disorders and their families. While Ms. Smith commended the significant advances in parent/professional partnerships in the SAC States, she pointed out that while 48 States had applied for SAC grants, only 15 States and the District of Columbia were awarded grants. She said that family members in the other 32 States were waiting for an equal opportunity to improve the substance use disorders system for their youth. She urged that CSAT award a second round of SAC grants so all Tribes/States might have the opportunity to develop the infrastructure necessary to improve substance use disorder treatment and to provide necessary support to families.

Ms. Smith emphasized that family involvement should address four key areas: validity, power, programs, and position. She explained that the ideas produced in the next 2 days would give CSAT a vision of not only what families affected by addiction across the nation need, but also what is necessary to improve the adolescent treatment system. She commented that while it is important to focus on eliminating the stigma, shame, and discrimination that family members face, they must not dwell on complaining about the treatment system, but rather focus on being a part of the solution. She reiterated her commitment to help develop a better treatment system and to foster the mission of building an equitable adolescent treatment/recovery system for all youth in every Tribe/State. She stressed that this meeting is just the beginning of identifying some of those solutions and closed with the rallying statement, "Are you all ready to work?"

## **Discussion Session Presentations**

### **Charge to the Group: Discussion Sessions 1 and 2**

#### ***Gina Wood, Deputy Director***

*Health Policy Institute, The Joint Center for Political and Economic Studies, Washington, DC*

Ms. Wood thanked the conference participants and stressed the importance of engaging in an open, meaningful dialogue in the discussion sessions. She emphasized that no one was gathering to judge, but to develop a safe learning community and she encouraged participants to voice their concerns openly. Ms. Wood introduced the format of the day and outlined the work assignments and expectations for Discussion Sessions 1 and 2. She explained that Discussion Session 1 would focus on the present reality of the youth substance use disorder treatment/recovery system. Ms. Wood asked participants to share their family experiences of the present system and to identify the most significant challenges with respect to access, quality, and family involvement.

She said that participants would share their priorities and have opportunities to react and respond to the findings following lunch. Then participants would proceed to Discussion Session 2 where they would discuss and envision an ideal youth substance use/co-occurring mental health disorder treatment and recovery system. Participants would have an opportunity to talk about what the youth substance use/co-occurring mental health disorder treatment and recovery system should look like at the practice and program levels.

### **Day 2: Welcoming Remarks**

#### ***Jutta Butler, Team Leader, Targeted Populations Branch***

*Division of Services Improvement, CSAT, SAMHSA, Rockville, Maryland*

Ms. Butler welcomed the participants to the second day of the NFD and discussed the topic of the day. She asked participants to focus on the roles family members might play in creating and implementing the future vision for the adolescent treatment and recovery system. She acknowledged the attendees' resourcefulness in creating Web sites, developing educational materials, opening centers, and providing networking opportunities. Ms. Butler asked the participants if they were familiar with the National Federation of Families for Children's Mental Health, and asked them to consider whether that model could be replicated for the treatment and recovery of adolescents with substance use disorders. Ms. Butler told the parents that the transition age youth group (18–25 years of age) is often neglected, and that it was important to hear from parents all over the country on issues related to this age group. She encouraged parents to search the SAMHSA Web site (<http://www.samhsa.org>) for specific grant opportunities and invited the attendees to contact her if they had any questions.

## **Family Involvement in Other Child-Serving Systems: What Can We Learn?**

***Shannon CrossBear, Training and Technical Assistance Specialist***

*National Federation of Families for Children's Mental Health, Hovland, Minnesota*

Ms. CrossBear welcomed the group and shared her family's experience of the youth substance use disorder treatment/recovery system with the participants. She encouraged the parents to research the National Federation of Families, and to study their model. Ms. CrossBear emphasized that the strength of the Federation is its ability to speak with one voice. The purpose of the NFD conference is to create a collective voice for families whose children have experienced substance use disorders. She urged the group to think in political terms, to consider the political climate, and the major issues they will confront. She suggested creating partnerships and engaging family members in the discussion. Ms. CrossBear encouraged the participants to engage others in this national conversation to promote family involvement, and to participate in developing policies that would directly affect access to and the quality of services and recovery support systems.

## **Charge to the Group: Discussion Session 3**

***Sherese Brewington-Carr, CSAT Consultant***

Ms. Brewington-Carr presented the goals of the day to participants. She stated that the first day had been about challenges and opportunities. For Day 2, Ms. Brewington-Carr urged participants to think about the role of family members in improving the youth substance use disorder treatment/recovery system. She charged the attendees with three tasks: to discuss the role of family involvement, to identify the role family members could play in creating and implementing the future vision, and to identify the supports family members need to fulfill these roles at the practice, program, and policy levels. Ms. Brewington-Carr encouraged participants to reconsider their roles in their Tribes/States and communities once they returned home.

## Discussion Session Results

---

The work of the NFD sessions included extracting lessons learned from the presentations and sharing personal family member experiences with the youth substance use disorder treatment/recovery system in order to identify the current challenges and opportunities for improvement. Throughout the course of the 2-day meeting, attendees were assigned to one of five discussion groups. Each group addressed the following areas: challenges of the current system for youth with substance use disorders, important elements of the future vision for the treatment/recovery system, and ideas for implementing this vision in order to create a new treatment/recovery system reality. Prioritized items<sup>10</sup> are highlighted below. This listing is not exhaustive, but the discussion session results do provide a clear picture of what participants deemed most critical for building and sustaining a family-focused youth substance use disorder treatment/recovery system.

### Discussion Session 1. Challenges for the Youth Substance Use Disorder Treatment/Recovery System: Present Reality

In Discussion Session 1, NFD participants identified the most significant current challenges in the youth substance use disorder treatment/recovery system. The specific challenges were developed from each family member's personal experience, dialogues with other family members, and the consensus of the group. Table 1 identifies, in priority order, the challenges prioritized by one or more of the five discussion groups.

**Table 1: Challenges**

<ul style="list-style-type: none"><li>• Lack of education and information on substance use disorders and treatment options</li><li>• Insufficient family-focused care and support</li><li>• Absence of a comprehensive substance use disorder treatment system</li><li>• Stigma</li><li>• Lack of access to treatment</li><li>• Insurance issues</li><li>• Disparities in treatment</li><li>• Need for public education on addiction</li><li>• Financing treatment</li><li>• Treatment quality</li><li>• Lack of coordination with primary care providers</li><li>• Inadequate workforce development</li><li>• Insufficient use of evidence-based practices in program design</li><li>• Legal and legislative challenges for parents</li><li>• Lack of integrated treatment for youth with co-occurring mental health disorders</li></ul>
---

---

<sup>10</sup> This report prioritizes issues according to the number of groups that identified each issue.

All five discussion groups cited a lack of education and information on substance use disorders and treatment options as a challenge. This applies to parents/family members, youth, and providers. According to participants, the lack of information and support exists across the continuum of care. Specific issues included difficulty in accessing information about topics such as understanding addiction, substance use disorder treatment availability, the navigation of the treatment system, and parenting a youth in recovery. Two groups identified that parents do not know where to go to get the information they need because the system lacks a central point of entry to access resources and get appropriate referrals. Participants expressed a need for improved parent education and peer-to-peer family training.

All five groups cited insufficient family-focused care and support as a challenge to the youth substance use disorder treatment/recovery system. Overall, the groups identified a deficiency in respect for family involvement and support for family members. Examples included the lack of appreciation for families, insufficient supports for siblings, lack of parent organizations, and the absence of families in comprehensive treatment and recovery plans. The lack of supports to help families cope with the stress and effects of substance use disorder treatment/recovery was also identified as a challenge. Participants encouraged greater alignment of the behavior of system professionals and the research on the value of family involvement.

Four of the five discussion groups identified as challenging the absence of a comprehensive treatment system that employs evidence-based practices and includes continuing care and recovery supports. Concerns highlighted disruptions in the continuum of care, disparities in quality treatment, the use of “one size fits all” treatment, insufficient or nonexistent youth-appropriate continuing care services, inadequate treatment capacity, and the lack of sustainable recovery plans for youth. Participants called for a wide array of available services across the continuum of care.

Four out of five groups cited the stigma associated with substance use as a challenge and the need to reduce stigma through education and awareness. Issues identified included the lack of understanding of addiction as a brain disease and the lack of policies to reduce stigma. Often, according to the group, family denial contributes to a silence which treatment professionals misconstrue as apathy or lack of family member cooperation. This misconception can increase stigma.

Four of the five discussion groups identified the lack of access to treatment as a challenge for youth in the substance use disorder treatment/recovery system. Barriers include the high cost of programs, treatment gaps, and lack of access to continuing care and recovery supports. These discussion groups further articulated logistical barriers to treatment and their concerns about ineffective treatment and recovery services. Participants stressed the extent of inadequate treatment for youth in the Tribes/States and the policy of terminating treatment because insurance coverage ends when youth turn 18.

Four out of five groups identified additional insurance issues as another dimension of inequitable quality treatment. Group members cited complications with the Health Insurance

Portability and Accountability Act (HIPAA), early discharges from treatment, inadequate private insurance coverage and insurance limitations, and poor financial support for low-income youth as examples. In some cases, family members were frustrated that insurance benefits would not cover services until a youth was already in crisis, rather than provide early intervention services to prevent the crisis.

Four out of five groups noted disparities in treatment, citing a deficiency in cultural competency, inequitable funding for minority and disadvantaged youth, and treatment availability that favors certain demographics and geographic locations rather than objective measures of unmet need. Family members said that services are not uniformly available to those who need them.

Three out of five groups expressed a desire that education on youth substance use disorder issues be made available to everyone. Ideas for educating the public included substance use disorder prevention programs, group awareness programs for children at earlier ages, more advocacy for larger systemic issues, increased publicity for success stories about recovering adolescents, and the elimination of the “parental blame” myth. Public education campaigns should incorporate ways to address stigma; explain disease models; and identify effective treatment, recovery, and family service models. Reducing the lag time in the dissemination and implementation of new research findings highlighting the value of family involvement was also a main concern.

Three of five groups identified finances as a major barrier to treatment. Examples included the high cost of treatment and recovery services, inadequate policies to provide funding for more and better treatment and recovery services, a lack of integrated financing for services, and insufficient designated funding for youth treatment.

Three of five groups identified treatment quality and a lack of coordination with primary care providers as challenges in the treatment/recovery system for youth with substance use disorders. These groups cited examples including a lack of comprehensive health information and a lack of uniformity in screening and assessment resulting in incorrect diagnoses. Participants expressed concern that these issues result in inappropriate treatment placements, particularly for youth with co-occurring disorders.

Three of the five discussion groups identified inadequate workforce development. Examples included a lack of understanding of the disease model, a lack of clinical practice guidelines for treating youth with substance use disorders, a shortage of staff experienced in youth development, addiction, and evidence-based treatment models, and insufficient provider knowledge of the service continuum including early intervention and treatment/recovery services and supports. These groups advocated for more consistent delivery of developmentally appropriate treatment services for youth and in-depth training and development for providers to improve the knowledge and application of science-based practices and thus improve access and quality.

Two of the five discussion groups stressed legal and legislative challenges for parents including the scope of parental rights, legal limitations, guardianship issues, and age of consent laws. Participants observed that the courts were overused as a point of access to treatment services. This often led to inappropriate referrals and the underutilization of services at the appropriate levels of care. Most participants felt that the courts stressed punishment rather than treatment.

Two of the five groups brought up the lack of integrated treatment for youth with co-occurring substance use and mental health disorders. Currently, families must choose which treatment system to approach. Group participants shared experiences and their observations of an apparent unwillingness of mental health and substance use disorders systems to work together. Participants urged that co-occurring conditions be treated together in one location with accompanying wraparound and recovery support services. Currently, families do not experience such a system.

## **Discussion Session 2. Youth Substance Use Treatment/Recovery System: Future Vision**

### **Session 2A. Elements of a Quality Treatment System for Youth with Substance Use Disorders**

In Session 2A, NFD participants identified what they considered the necessary features of a quality youth substance use disorder treatment/recovery system. Table 2A identifies, in priority order, the elements endorsed by one or more discussion group.

***Table 2A: Elements of an Ideal System***

- Seamless continuum of care
- Recovery philosophy infused into the entire service continuum
- Family involvement in the treatment and recovery system
- Wraparound recovery services and supports for youth and family members
- Fully financed system
- Accurate and individually appropriate assessment and referral
- Improved care coordination
- Youth substance use disorder training for staff of youth and family service systems
- Ongoing public awareness and anti-stigma campaign
- Collaboration with other youth organizations
- Medication-assisted treatments for adolescents

All five groups advocated a seamless continuum of care, which includes screening, assessment, treatment, continuing care, and recovery services and supports. Participants stressed that the system should allow for consumer choice and provide a system that supports a range of options from assessment to sustainable recovery services, including peer-to-peer

support. Each component of the treatment and recovery process should have specific steps. Well-trained substance use and mental health professionals should conduct assessments and use the information to refer youth to the appropriate service levels and modalities. The clinical treatment core should incorporate evidence-based models of treatment, and include service types such as day treatment programs and medication-assisted treatment when needed.

Participants recommended infusing the recovery philosophy throughout the service continuum and identified a need for more intensive recovery supports that include partial day programs, programs for family members, and youth-oriented programs. They also noted that families need information regarding the types of recovery services and supports available before a youth leaves treatment. These supports should include step-down services from treatment to recovery services and supports, including both 12-step and non-12-step models, youth peer-to-peer services, clean and sober support, recovery high schools, faith-based components, weekend and evening services, and educational and vocational opportunities for youth. For youth in the custody of the State (child welfare or juvenile justice system) providing weekend and evening recovery services is especially important. Transitional care and independent living supports were suggested for youth aging out of foster care and for homeless youth in the system.

Four out of five groups stressed the need for family involvement linkage activities in the substance use disorder treatment and recovery system. Strong partnerships between parents and professionals should be created to support youth recovery. Parent-to-parent groups should be created. The need for increased use of technology (e.g. internet Webinars and social media to support family involvement) was also discussed.

Three of the five discussion groups endorsed the need for recovery services and supports to wraparound youth and family members. Participants said this would entail creating an individualized recovery plan with help from members of a youth's family, interpersonal networks and community. An ideal wraparound program would center on youth in the context of the family and provide an individualized and coordinated care plan. Wraparound models should incorporate ancillary services and supports for youth and their families into a comprehensive treatment plan that is strengths-based, age-appropriate, and family-guided.

Three of the five groups noted that a fully financed system is essential. Group members expressed the sentiment that money should never be a barrier to accessing treatment. Adequate resources are necessary to support the treatment and recovery services for each youth and his/her family. For example, participants said that Medicaid should be available to youth through age 25, citing the difficulty of obtaining services especially for transition age youth from 18–25 years of age. Another group advocated that the budget allocation process be tied to the development of infrastructure support for family involvement. Other recommendations included using revenue from alcohol, tobacco, and pharmaceutical advertising taxes and confiscated drug money to provide youth treatment/recovery services.

Three of the five discussion groups emphasized the importance of accurate assessment and referral to treatment that is appropriate across age, gender, and developmental stages.

Identifying the optimal level of care requires individualized assessment and a thorough evaluation and referral to prevent assignment to inadequate or inappropriate levels of care. Some participants suggested using centralized intake to increase assessment quality and uniformity.

Three out of five groups also cited a need for better treatment/recovery planning to ensure that every child/family in need of addiction treatment or recovery services receives services that are strengths-based, effective, and appropriate across age, gender, developmental level, and culture. Another suggestion included adding spiritual or faith-based components to treatment planning. Participants recommended considering both therapeutic and 12-step models in treatment planning. Treatment planning should be individualized, youth-guided, and focused on the entire family, including siblings and all caregivers.

Three out of five groups expressed a need for better care coordination. The system should include a 24-hour point of contact for every parent in all jurisdictions. Participants stressed the need for expert care coordinators with youth-specific competencies to follow cases all the way through recovery. Participants also cited a need for a transparent data system to increase access to treatment, facilitate tracking individuals across public and private services, and maximize effectiveness of treatment.

Two of the five groups suggested that the staff of all related youth and family service systems should be required to participate in training in the adolescent substance use disorder treatment and recovery process. Law enforcement officials, principals, school counselors, child welfare, juvenile justice, and health care providers should work together to become educated about youth substance use treatment and the recovery system. The staff in systems that intersect with youth, including the education, legal, and medical systems, should have substance use disorders training.

Two out of five groups recommended an ongoing public awareness and anti-stigma campaign as a key feature of the youth substance use disorder treatment/recovery system. This public education effort should include information on substance use disorders as a brain disease, addiction signals, treatment model effectiveness research, the importance of recovery supports, the value of family involvement, and available support services for families and siblings of youth with substance use disorders. Participants suggested that a portion of marketing funding and attention should be focused on eliminating stigma and reducing isolation of youth with substance use disorders. Furthermore, the system should include public resources at the Tribal, State, and community levels, such as emergency numbers in the front of the phone book, interactive Web sites, and community resource sheets for schools.

Two groups determined that collaboration with other youth organizations should be an important feature of the treatment and recovery system. All youth-serving systems should use common language and protocols for substance use and mental health screening, assessment, and treatment strategies in order to ensure accurate diagnoses and appropriate referrals. Families

saw this possible collaboration across all youth-serving systems as a way to build a comprehensive recovery-oriented care model.

One group advocated further research into medication-assisted treatments that are appropriate for adolescents. Participants urged that medication-assisted treatments be accepted, reimbursed and available to youth when necessary.

### **Session 2B. Actions Needed to Realize the Vision**

In Session 2B, NFD participants identified actions needed to make their vision of an accessible, quality youth substance use disorder treatment/recovery system a reality. Table 2B identifies, in priority order, these essential steps.

**Table 2B: Actions Needed to Realize the Vision**

<ul style="list-style-type: none"><li>• Reduce stigma through a national public education campaign</li><li>• Involve family members in informing policymakers about the need for youth substance use disorder treatment and recovery services</li><li>• Increase financing for the youth substance use disorder treatment/recovery system</li><li>• Increase family involvement at the practice level</li><li>• Increase workforce development requirements</li><li>• Develop comprehensive treatment models for youth with substance use disorders</li><li>• Create national treatment standards for youth with substance use disorders</li><li>• Increase support for youth in the juvenile justice system with substance use disorders</li></ul>
---

Four of the five discussion groups suggested the need to reduce stigma about adolescent substance use disorders. Participants suggested the development and implementation of a national education campaign that would inform the public about addiction as a disease. The campaign would focus on substance use and co-occurring mental health disorders, the need for evidence-based treatment, and the de-stigmatization of substance use disorders. The role of the family and the need for ongoing recovery supports should also be focal points of public education efforts. Stories about problems with the treatment and recovery system and youth success stories should be shared. Financing should be available to create this public education campaign. CSAT should identify, promote, and disseminate knowledge at the individual, family, community, State, Tribal, and Federal levels.

On the policy level, four out of five groups suggested that family members could inform policymakers and decision makers about the need to eliminate the stigma of adolescent substance use. Participants emphasized the need to support families in their roles as advocates regarding substance use disorder issues. Ideas for advocacy included creating an advocacy toolkit, increasing activism, and educating family members on current legislative issues. Policymakers and decision-makers should receive a uniform clear, succinct, and focused message. Groups cited inadequate policies to hold alcohol, prescription drug, and the media

industries accountable. Policymakers should address continuing care and recovery needs, include these issues in Healthy People 2020, and develop policy that requires family involvement on Federal, Tribal, State, and local coordinating councils and resource allocation committees. Participants suggested Tribal and State level study groups on effective practices.

Three of the five groups cited financing as crucial to making their vision a reality. The groups offered ideas for creative funding sources such as using drug and alcohol advertising fines and confiscated drug monies to provide funding for substance use disorder programs. Family members urged tying a requirement to support family involvement to the allocation of public funds at both the Federal and State levels. Participants suggested the establishment of Federal level Substance Abuse Prevention and Treatment Performance Partnership Block Grant (SAPTPPBG) set aside to fund youth treatment, transitional services, and continuing care to support recovery. Participants identified the inclusion of support for families in each State's allocation of block grant dollars and funds for a national coordinating family oversight council as significant reforms in the Federal budget-allocation process.

Three of the five groups suggested increasing family involvement in the system. Participants recommended establishing family-support specialist positions to serve as coaches and guides and to provide peer support services to link families with recovery services. Family members could be trained to advocate at the case level through the development of tool kits and other educational materials and activities. Participants advocated the development of a national family involvement council that could ensure family input in financing issues and decision-making. Groups supported the development of youth involvement as a necessary piece of increasing family involvement. Participants felt that youth should be involved at the practice, program, and policy levels and youth voice should permeate all aspects of treatment and recovery systems. Youth should be allowed to speak for themselves and their peers and highlight success stories. Participants recommended providing more opportunities for families to join in the youth treatment process and suggested developing a system for organizing and mobilizing families.

Three of the five groups prioritized improving workforce development and increasing licensing and credentialing requirements as necessary steps toward realizing the ideal youth treatment and recovery system. Workforce development should include identifying and training treatment and recovery support providers and educators as well as staff in other child-serving agencies in adolescent substance use treatment and recovery. Licensing and credentialing standards should require competence in both adolescent and young adult development, generic counseling skills, and evidence-based practices for treatment and recovery of substance use/co-occurring mental health disorders.

Two of the five groups reiterated the need for comprehensive treatment models that move youth to recovery. These models need to be realistic, evidence-based models that include family-focused recovery supports. Peer-to-peer services should be included in the range of treatment options. Participants also stressed the need to expand the treatment and recovery workforce to ensure that quality services are located near the homes of all adolescents.

One group cited the need for national treatment standards. Specifically, this group recommended developing national standards for adolescent substance use disorder treatment that includes family and youth involvement and incorporates individualized treatment planning from diagnosis to sustained recovery and community reintegration that is appropriate across age, gender, cultural competence, and developmental levels.

One group said that all adolescents entering the juvenile justice system needed to receive automatic and thorough assessments, which would include tests for physical and mental health, substance use disorders, and trauma issues. Participants proposed giving a second chance to youth with criminal records who demonstrate successful substance use treatment and recovery. For this to be possible, incarcerated youth and youth in detention must receive comprehensive treatment for substance use and mental health disorders that would enable them to attain sustained recovery.

### **Discussion Session 3. Youth Substance Use Disorder Treatment/Recovery System: The New Reality**

#### **Session 3A. Implementing the Future Vision: The Role of the Family**

In Session 3A, NFD participants addressed the following question: What role can family members play in creating and implementing the future vision for the youth substance use disorder treatment/recovery system? Table 3A identifies, in priority order, the recommendations from one or more of the groups.

**Table 3A: Family Member Roles**

- Educate and support other families through the use of training tools and curricula
- Increase family involvement in the treatment/recovery system
- Provide public education about addiction and youth substance use
- Increase recovery support and continuing care for youth through reintegration and cultural inclusion

All the groups emphasized that family members can educate and support other families through the use of training tools and curricula. They stressed the need to develop family-to-family training tool kits, curricula, and feedback forms. Through family-to-family education, parents could identify the signs and symptoms of addiction, access existing information about substance use disorders and the treatment and recovery process, and identify the best ways to educate diverse groups on the issues. Some participants hoped that parents could educate other parents through sharing personal stories. Families could provide advocacy trainings, volunteer recruitment, standardized information, and outreach. Participants hoped to develop an educators'/speakers' bureau that provides relevant peer education for families on adolescent substance use issues including resources, access, and systems knowledge. Family-led education could help to inform other families on issues such as the implications of the Health Insurance Portability and Accountability Act and the need to be informed about treatment

options. Culturally competent videos and/or written materials outlining what to expect during the treatment and recovery process were also suggested. Participants also advocated for the development of a Web site for family members of youth with substance use disorders on treatment, prevention, recovery, resources, and opportunities for financial assistance.

All five groups emphasized the need for family members to increase their involvement in the treatment and recovery system. Participants recommended that family members develop a unified family voice to create a powerful substance use disorders family movement, decrease stigma, and provide spokespeople with accurate data. Examples include assuring parent representation on policymaking and budget advisory bodies and quality review committees and facilitating youth and adult groups to develop a movement to support family involvement. Other ideas included pursuing dialogues at the Tribal, State, and community levels, involving family members in Federal, Tribal, State, and foundation proposal processes, and holding policymakers and service providers accountable. Participants hoped that this would lead to a senior position created at the Tribal and State levels to focus on adolescent substance use treatment and recovery issues, similar to the coordinators CSAT funded through the SAC grants.

All five groups endorsed family members providing public education about addiction and youth substance use to providers, policymakers, and other family members through the use of personal stories, faces, and data. Groups stated that family members could play a vital part in reducing the stigma associated with youth substance use through their education efforts. Participants suggested that family members go into schools and participate in school committees and parent-teacher organizations. Family members could serve as advocates at the policy level by raising awareness, highlighting the need for early intervention, and championing effective treatment models. Family members could share their experiences with legislators and adopt multi-method approaches to develop networking strategies and use the media to promote their messages. Participants suggested that family members should pursue dialogue and establish a presence at Tribal, State, and community levels. Participants suggested that family members could enhance public awareness and the political will to increase resources for treatment and recovery services.

Three groups cited the need to increase families' roles in providing recovery support and continuing care for youth through re-integration and cultural inclusion. Families could ensure that treatment and recovery supports and services are culturally appropriate. Participants suggested that families could provide youth and family peer supports and coping strategies to families experiencing youth substance use disorders. Families could participate in child and family teams at intake and on recovery-oriented case level planning teams. Support groups or hotlines could also be established to move toward providing 24/7 youth and family support from other families who have had similar experiences.

### **Session 3B. Supports and Services Needed by Families**

In Session 3B, NFD participants identified what they considered the most essential supports families need to fulfill their roles in the youth substance use disorder treatment/recovery system. Table 3B identifies, in priority order, the supports and services endorsed by one or more discussion groups.

***Table 3B: Supports and Services Needed by Families***

- Accessible data and standardized information
- Improved infrastructure at the Federal, Tribal, and State levels to support sustainable family involvement
- Better family support and continuing care services
- Increased public education efforts
- More support for family member input
- Networking opportunities to move the National Family Dialogue forward
- Continuing SAC Infrastructure Grants
- Creation of a national organization to promote a family-oriented adolescent treatment system
- Development of a quality assurance review team
- Increased legal supports for families
- Creation of partnerships with community-based research

All five groups cited a need for accessible data and standardized information. Participants supported the creation of Web sites that would provide easy access to information on substance use disorder treatment, resources, and funding. Tribes/States would be required to have this information available to the public. The Web sites could inform the public of existing treatment resources and funding options. They could also serve as centralized resources or technical assistance centers for the development of social marketing campaigns. Participants noted that family members need the development of modules, curriculum, and fact sheets to distribute to stakeholders. Using these tools, family members could provide accessible working knowledge to students, family members, and parents about the youth treatment and recovery system. The format of such information would need to be culturally appropriate and multilingual for easy access. Group members emphasized the need for current, usable data or a report card on treatment and recovery at the Federal, Tribal, State, and local levels.

Four of the five discussion groups advocated building infrastructure at the Federal, Tribal, and State levels to support sustainable family involvement. Adequate infrastructure would require the creation of coordinated funding sources, including using Medicaid and the Children's Health Insurance Program, to support peer-to-peer or family to family programs. The groups suggested including funds for family member stipends and obtaining resources from a variety of sources

including government, business, and the community. The infrastructure would also need to provide training for family members that would prepare them for active participation in practice, program, and policy issues. Some participants suggested that CSAT require family member participation at the practice, program, and policy levels in the SAPTPPBG language.

Four out of five groups recommended developing better family support and continuing care services to help parents avoid exhausting themselves during the treatment and recovery process. Participants cited a need for increased funding for family-to-family programs, treatment navigators, parent support groups, and a more thorough and family-focused continuing care system.

Three out of five groups cited a need for increased public education efforts. Some participants wanted to develop a national campaign to support the need for long-term youth recovery services and supports. Such a campaign could highlight and promote the value of families' experiences of living with a youth with a substance use disorder, encounters with the treatment system, and ways to support long-term recovery. Raising awareness could reduce stigma and increase political will and public support for treatment and recovery services. Participants also recommended developing a speaker's bureau to play a leadership role in organizing public policy efforts, starting youth, and/or family councils, recruiting interested persons to participate in the system, and securing funding to sustain these activities.

Three out of five groups prioritized more support for family members to act as advocates. Ideas for advocacy included using a coaching model to assist families in expressing concerns to policymakers and generating political and public will to support youth substance use treatment and recovery. Family advocates could help encourage family involvement through holding town hall meetings, including family members on committees with providers, sponsoring dialogues with local and State legislators/Tribal leaders and policy makers, and maintaining contact with media outlets to promote youth treatment and recovery systems. They could also help secure information and tools to help with funding and writing grants. Participants suggested that professional training in public speaking should be provided for family members interested in advocacy. One group suggested developing a youth educator/outreach role for youth interested in advocacy.

Three out of five groups emphasized the need for networking opportunities to move the NFD forward. Identifying potential partners and key stakeholders would help build credibility for the treatment and recovery system and contribute to a foundation for a strong infrastructure. Participants stated that communication and marketing would be necessary to ensure effective networking efforts.

Participants also urged continuing the SAC infrastructure grants to assure that all Tribes/States have the opportunity to improve the system supporting youth substance use disorder treatment and recovery.

Two groups advocated for the creation of a national organization to promote family-oriented adolescent treatment and recovery for youth and families. The organization would have a clearly defined mission, values, and principles. The organization could recruit and identify a pool of diverse and culturally competent family members. Participants hoped that the organization could help to support efforts in the areas of public policy, the development of youth councils, and the organization of a speakers' bureau. This group should include a policy director, research analyst, program analyst, accountability/quality assurance professional, and event planner.

Two out of five groups stressed the need for developing a quality assurance review team to evaluate existing treatment and recovery services. Participants suggested that the team develop sensitive measures to evaluate important outcomes. Examples included creating a family-driven commission to recommend outcomes for examination and to develop standards to measure program effectiveness.

Two of the five groups cited legal support for families with examples including reforming privacy and age of consent laws and assistance in obtaining legal advice for civil rights issues. Participants noted that legal expertise would also be useful in supporting advocacy agenda development.

One group recommended proactive family member participation with all Federal and foundation-sponsored community-based research. Participants also suggested engaging university researchers to become partners with the treatment and recovery system community.

## Next Steps

---

**Randy Muck, M.Ed., Chief, Targeted Populations Branch,**  
*Division of Services Improvement, CSAT, SAMHSA, Rockville, Maryland*

For the concluding session, Mr. Muck solicited family members' ideas about how CSAT could be more supportive of family members. Participants identified the following suggestions for next steps:

- Develop and disseminate a press release about the establishment of the NFD and meeting.
- Develop a clearinghouse of information for parents.
- Provide funds to support planning and implementing opportunities for family involvement at the practice, program, and policy levels.
- Create communications vehicles for family members such as Listservs, conference calls, and Webinars.
- Help families to “make the case” for significant additional public resources to provide more treatment and recovery services and supports.
- Provide information on financing treatment and recovery services and supports.
- Require States to support family organizations and to include family members in policy development.
- Assure that family members are on the planning committee for the annual CSAT Joint Meeting for Adolescent Treatment Effectiveness (JMATE)
- Help family members measure the effectiveness of treatment.

In response, Mr. Muck thanked the family members for their very thoughtful hard work over the course of the 2-day meeting. He said that he would work with Linda Warden, a family member attendee, to assure that a press release about the NFD would be sent out. He said he would support ongoing communication among attendees and that he would look into the feasibility of some type of electronic clearinghouse to assist family members in gathering information on substance use disorder issues. He said that CSAT had very little funds for the entire youth treatment area but he suggested that if family members had specific requests for small amounts of money for start-up projects they should contact him directly.

Mr. Muck said that CSAT, through the State Adolescent Substance Abuse Treatment Coordination grant program (SAC) has been working closely with the grantee States to encourage them to improve family involvement at the practice, program, and policy levels. He pointed out that the NFD meeting was a direct result of the efforts made through the SAC grant program. He assured family members that some of the NFD participants would be included on the next JMATE planning committee. Mr. Muck stated that the information from the NFD meeting would be shared widely with CSAT grantees, with the staff of the CSAT Division of

State and Community Assistance, with State substance use disorder treatment directors and with the public.

He commented that he was very impressed with the enthusiasm and commitment of the attendees. He said that he had been hoping for a gathering such as this for over 8 years and that he and Jutta Butler would do everything that they could to support the efforts of family members across the country. He pointed out that people would need to be patient and take baby steps. In closing, Mr. Muck thanked Dr. Doreen Cavanaugh and Chris Bender from Georgetown University for their assistance in planning and implementing the meeting.

***Sharon Smith, President and CEO,***  
*MOMSTELL, Mechanicsburg, Pennsylvania*

Ms. Smith ended the meeting by thanking Mr. Muck and Dr. Cavanaugh for making the NFD a reality. She congratulated all of the NFD participants for their hard work during the 2 days of their intense meetings and thanked them for their participation. She told the family members that all of their crucial input would be captured and compiled into a report that would be sent to SAMHSA, and that they would be notified when it was released.

## Conclusions and Implications

---

This section summarizes and expands upon the themes that emerged from family member feedback shared in the discussion sessions. In small groups, family members told stories of their personal experiences with the adolescent substance use disorder treatment system and offered ideas for making the system more amenable to family involvement at the Federal, Tribal, and State levels. The NFD provided an opportunity for family members of youth with substance use disorders to begin developing a unified voice within the treatment/recovery system. It enabled them to discuss strategies for creating sustainable family involvement in the substance use disorder treatment/recovery system. Increased family member participation will help the system effectively, efficiently, and equitably address the needs of youth and provide the greatest possibility of recovery, not only for youth, but also for parents, caregivers, and siblings.

Each family's experience was unique, yet common elements quickly emerged that underscore the current youth substance use disorder treatment/recovery system's strengths and challenges and how they affect the whole family. They include the following:

- Lack of public knowledge on the impact of adolescent alcohol and drug use/dependence on the youth and their family members;
- Difficulty in accessing available, appropriate, affordable and comprehensive treatment;
- Lack of recovery services and supports;
- Lack of family peer education, advocacy, and supports;
- The continued existence of shame and stigma;
- The impact of trauma and loss;
- Determination to break the cycle of addiction within families;
- Commitment to get involved to improve the quality of care and the outcomes of treatment and recovery; and
- Hope to improve the health and well-being of families and communities across the United States.

Family involvement in the planning and delivery of substance use disorder treatment/recovery services is in the early stages, but it is beginning to happen at Federal, Tribal, State, and community levels. The adolescent substance use disorder treatment/recovery system must strengthen and support these efforts. Family involvement is necessary to improve the quality of care provided and to insure that all adolescents in need of substance use disorder treatment receive high-quality care that incorporates their family members and promotes holistic recovery for everyone involved.

Family members of youth with substance use disorders have a great deal of insight about the adolescent treatment system. They are learning how to support each other and advocate for improvements in the treatment of their sons, daughters, and families. In order for their input to

be heard, family member experiences and opinions must be respected, valued and supported. Uniting family members with professionals and advocates for substance use disorder treatment system improvements will not only create a substance use disorder treatment/recovery system that is relevant, responsive, and results-driven, but also one that will reduce and ultimately eliminate the shame, stigma, disparities, and discrimination associated with the disease of addiction.

The NFD brought stakeholders together to discuss the issues and to discover how the disease of addiction affects adolescents, families, and communities regardless of socio-economic status, gender, geography, race/ethnicity, language, or sexual orientation. They found common cause and left as allies, willing and able to collaborate with professionals, public officials, community leaders, the media, and the millions of youth and families affected by alcohol and drugs in the United States. These stakeholders believe in a future when families and communities will not struggle in isolation with this disease, and when the public will know the hope and reality of recovery. NFD participants concluded that family involvement is necessary to improve the quality of care and to insure that all youth in need of substance use disorder treatment/recovery receive effective services that incorporate the entire family in order to promote holistic recovery for everyone.

The recommendations in this report are a testament to the power of the family voice. Given the supports necessary to continue, family involvement in the treatment of adolescent substance use disorders will become a reality. In addition, these crucial supports will ensure that the voice of youth with substance use disorders will also be heard and respected at the practice, program, and policy levels of the substance use disorder treatment system.

New opportunities and resources to strengthen and support family engagement in all parts of the adolescent substance use disorder treatment system may become available as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 is implemented and the hope of health reform is realized.

## References

---

- American Academy of Child and Adolescent Psychiatry. (2005). Practice parameter for the assessment and treatment of children and adolescents with substance use disorders. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44(6), 609–621.
- Congressional Record Joint Explanatory Statement. Omnibus Appropriations Act of 2009, Public Law No. 111-8, pg. H2222, 2/23/09. United States Statutes at Large. <<http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf>>. Retrieved 03/27/09.
- Deas, D. & Thomas. S.E. (2001). An overview of controlled studies of adolescent substance abuse treatment. *The American Journal on Addictions* 10(2), 178–189.
- Drug Strategies. (2003). “9 key elements of effective adolescent drug treatment.” Excerpted from *Treating teens: a guide to adolescent drug programs*.
- Henderson, C. E., Rowe, C. L., Dakof, G. A., Hawes, S. W., & Liddle, H. A. (2009). Parenting practices as mediators of treatment effects in an early-intervention trial of Multidimensional Family Therapy. *American Journal of Drug and Alcohol Abuse*, 35, 220–226.
- Henggeler, S.W., Borduin, C.M., Melton, G.B., Mann, B.J., Smith, L., Hall, J.A., Cone, L., and Fucci, B.R. (1991). Effects of multisystemic therapy on drug use and abuse in serious juvenile offenders: a progress report from two outcome studies. *Family Dynamics of Addiction Quarterly*, 1, 40–51.
- Joanning, H., Quinn, W., Thomas, F., and Mullen, R. (1992). Treating adolescent drug abuse: a comparison of family systems therapy, group therapy, and family drug education. *Journal of Marital and Family Therapy*, 18(4), 345–356.
- Kilpatrick, D. G. Definitions of public policy and the law. National Violence Against Women Prevention Research Center, Medical University of South Carolina. Retrieved June 9, 2010 from <http://www.musc.edu/vawprevention/policy/definition.shtml/>.
- Lewis, R., Piercy, F., Sprenkle, D., and Trepper, T. (1990). Family-based interventions for helping drug abusing adolescents. *Journal of Adolescent Research*. 5(1), 82–95.
- Liddle, H. A. & Dakof, G. A. (1995). Family-based treatments for adolescent drug use: state of the science. In E. Rahdert & D. Czechowicz (Eds.), *Adolescent drug abuse: Clinical assessment and therapeutic interventions*. [NIDA Research Monograph 156, NIH Publication No. 95-3908], 218–254.
- National Federation of Families for Children’s Mental Health. (2009). A workbook on data-informed and family-driven decision making: evidence is co-pilot. 1–42.

New York Councils' Children and Families Coordinated Children's Services Initiative, Tier III Leadership Team. CCSI family involvement and strength based practices. Retrieved 8/3/07 from < <http://www.ccf.state.ny.us/Initiatives/CCSIRelate/CCSIFamInvolv.htm#definition>>.

Ozechowski, T. J. & Liddle, H. A. (2000). Family-based therapy for adolescent drug abuse: knowns and unknowns. *Clinical Child and Family Psychology Review*, 3(4), 269–298.

Rowe, C. L. & Liddle, H. A. (2006). Family-based treatment development for adolescent alcohol abuse. *International Journal of Adolescent Medicine and Health, Special Issue on Adolescence and Health*, 18(1), 43–51.

Rowe, C. L., Wang, W., Greenbaum, P., & Liddle, H. A. (2008). Predicting HIV/STD risk level and substance use disorders among incarcerated adolescents. *Journal of Psychoactive Drugs*, 40(4), 503–512.

Substance Abuse and Mental Health Services Administration (SAMHSA). FY 2008 Jurisdiction of Estimates for Appropriations Committee, pg. CSAT-2.

Smith, S. L., Hornberger S, Brewington-Carr, S., Finck, C., O'Neill, C., Cavanaugh, D., & Bender, C. Family involvement in adolescent substance abuse treatment. *Improving Access to and Quality of Treatment for Adolescents with Substance Use/Co-occurring Mental Health Disorders*, 1(1), 1–7.

Social Security Act, 42 U.S.C. § 1396 (d), Section 1905 (a). (1935).

World Health Organization. (2005). Mental health policy and service guidance package: child and adolescent mental health policies and plans. 1–67.

## Appendixes

---

<b>Appendix A. Families of Youth with Substance Abuse Addiction: A National Dialogue Purpose and Goals .....</b>	<b>38</b>
<b>Appendix B. Families of Youth with Substance Abuse Addiction: A National Dialogue Agenda .....</b>	<b>40</b>
<b>Appendix C. Families of Youth with Substance Abuse Addiction: A National Dialogue Participant List .....</b>	<b>43</b>
<b>Appendix D. Families of Youth with Substance Abuse Addiction: A National Dialogue Discussion Questions .....</b>	<b>51</b>
<b>Appendix E. Issue Brief: Family Involvement in Adolescent Substance Abuse Treatment.....</b>	<b>53</b>
<b>Appendix F. Selected Family Support Materials List .....</b>	<b>61</b>
<b>Appendix G. “9 Key Elements of Effective Adolescent Treatment” (an excerpt from <i>Treating Teens: A Guide to Adolescent Drug Programs</i> (Drug Strategies, 2003)).....</b>	<b>68</b>

# **Appendix A. Families of Youth with Substance Use Addiction: A National Dialogue**

## **Purpose and Goals**

---

### **Purpose**

- To bring together representatives of families of youth who have received treatment for substance use addiction to determine and plan for the steps necessary to strengthen family involvement at the Federal, State and Tribal levels.
- To mobilize family stakeholders to build and sustain treatment and recovery infrastructure for youth with substance use addiction.

### **Goals**

- To strengthen and shape the roles and responsibilities of families as valued substance use addiction treatment and recovery system partners and advocates.
- To develop supports to empower families of youth with substance use addiction in order to create positive change in the substance use addiction treatment and recovery system.
- To develop recommendations for Center for Substance Abuse Treatment (CSAT) and Substance Abuse and Mental Health Services Administration (SAMHSA) on strengthening and expanding family involvement in substance use addiction treatment and recovery at the practice, program, and policy levels.

### **Learning Objectives**

As a result of participation in this conference attendees will:

- Learn about the current state of substance use addiction treatment and recovery for youth across the nation.
- Learn about family involvement in the substance use addiction treatment and recovery systems as they currently exist.
- Explore opportunities for building and sustaining family involvement initiatives.

### **Guiding Principles**

- Meet families where they are.
- Respect families' culture and diversity.
- Hear and respect each other's voice.
- Build consensus.
- Expect results.

### **Conference Participant Eligibility Criteria**

- Meets the definition of family member:
  - A family member is an adult who plays or has played a primary role in the caretaking of a youth<sup>11</sup> receiving or who has received treatment for substance use addiction
- Is an individual who is currently active or interested in systems change efforts
- Is an individual who is willing and able to participate in future family involvement efforts

---

<sup>11</sup> A youth is an individual under 26 years of age.

# Appendix B. Families of Youth with Substance Use Addiction: A National Dialogue Agenda

---

## Families of Youth with Substance Use Disorders: A National Dialogue

### Agenda

Crowne Plaza Hotel  
3 Research Court  
Rockville, MD 20850

### Day One: Friday, March 27, 2009

- 7:15 a.m.–8 a.m. **Registration**  
(Remington 1)
- 7:30 a.m.–8:30 a.m. **Breakfast, Meet and Greet**
- 8:30 a.m.–9 a.m. **Welcome, Purpose and Goals of Meeting**  
*Jack Stein, Director*  
*Division of Services Improvement*  
*Center for Substance Abuse Treatment, SAMHSA*  
*Sharon Smith, President and CEO*  
*MOMSTELL*  
*Mechanicsburg, Pennsylvania*
- 9 a.m.–10:15 a.m. **The Big Picture: Providing a Context for Our Work**  
**Youth Substance Use Disorder Treatment and Recovery System:  
National Public Policy Context**  
*Doreen Cavanaugh, Research Associate Professor*  
*Health Policy Institute, Georgetown University*  
**Youth Substance Use Disorder Treatment and Recovery System:  
The Federal Government Perspective**  
*Randy Muck, Chief*  
*Targeted Populations Branch, Division of Services Improvement*  
*Center for Substance Abuse Treatment, CSAT*  
**Youth Substance Use Disorder Treatment and Recovery System:  
Developing Collaborative Family/Professional Partnerships  
Moving Forward**  
*Cathy Finck, Resource Director*  
*Cobb Community Parents in Action*  
*Roswell, Georgia*  
*Sharon Smith, President and CEO*  
*MOMSTELL*  
*Mechanicsburg, Pennsylvania*

- 10:15 a.m.–10:30 a.m. **Youth Substance Use Disorder Treatment and Recovery System: Charge to the Group**  
*Gina Wood, Deputy Director  
Health Policy Institute  
Joint Center for Political and Economic Studies*
- 10:30 a.m.–10:45 a.m. **Break**
- 10:45 a.m.–12:15 p.m. **Discussion Session 1. Challenges for the Youth Substance Use Disorder Treatment/Recovery System: Present Reality**  
*(Remington 1, Whistler, Pollack, O’Keefe and Albright)*
- What was your family’s experience with the youth substance use addiction treatment and recovery system?
  - What do you feel are the most significant challenges in the youth substance use addiction treatment and recovery system today?
  - Prioritize challenges
- 12:15 p.m.–1:30 p.m. **Lunch**  
*(Terrace Room)*
- 1:30 p.m.–2:15 p.m. **Report Out from Work Session 1**  
*(Remington 1)*  
Work session groups present prioritized priorities
- 2:15 p.m.–2:30 p.m. **Break**
- 2:30 p.m.–4 p.m. **Discussion Session 2. Youth Substance Use Disorder Treatment/Recovery System: Future Vision**  
*(Remington 1, Whistler, Pollack, O’Keefe and Albright)*
- What should the youth substance use addiction treatment and recovery system look like?
  - What needs to happen to make this vision a reality?
  - Prioritize suggestions
- 4 p.m.–4:45 p.m. **Report Out from Work Session 2**  
*(Remington 1)*
- Work session groups present priorities
- 4:45 p.m.–5 p.m. **Parking lot issues**

## Day 2: Saturday, March 28, 2009

- 8 a.m.–9 a.m. **Breakfast, Meet and Greet**  
*(Remington 1)*
- 9 a.m.–9:15 a.m. **Welcome**  
*Jutta Butler, Team Leader*  
*Targeted Populations Branch, Division of Services Improvement*  
*Center for Substance Abuse Treatment, CSAT*
- 9:15 a.m.–9:45 a.m. **Family Involvement in Other Child-Serving Systems: What Can We Learn?**  
*Shannon CrossBear, Training and Technical Assistance Specialist*  
*National Federation of Families for Children's Mental Health*
- 9:45 a.m.–10 a.m. **Youth Substance Use Addiction Treatment and Recovery System: Charge to the Group**  
*Sherese Carr, CSAT Consultant*  
*Wilmington, Delaware*
- 10 a.m.–10:15 a.m. **Break**
- 10:15 a.m.–11:45 a.m. **Discussion Session 3. Youth Substance Use Disorder Treatment/Recovery System: The New Reality**  
*(Remington 1, Whistler, Pollack, O'Keefe and Albright)*
- What roles can family members play?
  - What supports do families need to fulfill these roles?
  - Prioritize suggestions
- 11:45 p.m.–12:30 p.m. **Report Out from Work Session 3**  
*(Remington 1)*
- Work session groups present priorities
- 12:30 p.m.–1:45 p.m. **Lunch**  
*(Terrace Room)*
- 1:45 p.m.–3:15 p.m. **Youth Substance Use Addiction Treatment and Recovery System: Family Recommendations**  
*Shannon CrossBear*  
*Doreen Cavanaugh*
- Recommendations to improve the youth substance use addiction treatment and recovery system.
  - Recommendations to improve family involvement in the youth substance use addiction treatment and recovery system.
- 3:15 p.m.–4:15 p.m. **Next Steps**  
*Sharon Smith*  
*Randy Muck*
- What are you going to do?
  - What are we going to do?

## Appendix C. Families of Youth with Substance Abuse Addiction: A National Dialogue Participant List

---

### Participants Family Members

*Note: An asterisk indicates a member of the planning committee and a number sign indicates a group facilitator.*

**Donna Aligata**

135 West Road  
Marlborough, CT 06447  
Home: 860-295-9773  
[Donnaa@ctyouthandfamilies.org](mailto:Donnaa@ctyouthandfamilies.org)

**Eva Ayala**

P.O. Box 1776  
Sacaton, AZ 85247  
Home: 480-228-6934

**Alice Carter**

200 West 17th Street  
Suite 210  
Cheyenne, WY 82001  
Work: 307-635-9291  
[jackson6197@msn.com](mailto:jackson6197@msn.com)

**Shannon CrossBear\*\***

P.O. Box 214  
Hovland, MN 55606  
Home: 218-475-2728  
[scrossbear@centurytel.net](mailto:scrossbear@centurytel.net)

**Brenda DeJesus**

1818 Sunset Point Road  
Apartment A  
Clearwater, FL 33765  
Cell: 727-259-3954  
[bjdclearwater@aol.com](mailto:bjdclearwater@aol.com)

**Marie Allen**

172 Oldbury Drive  
Wilmington, DE 19808  
Home: 302-235-2634  
Cell: 302-395-8062  
Work: 302-395-8062  
[Mallen@nccde.org](mailto:Mallen@nccde.org)

**Janet Boughter**

207 Holmes Street, 1<sup>st</sup> Floor  
Frankfort, KY 40601  
Home: 502-875-1320  
[janet@kypartnership.net](mailto:janet@kypartnership.net)

**Valerie Coley**

2921 4<sup>th</sup> Avenue  
Apartment #4  
Richmond, VA 23222  
Home: 804-398-1678  
Cell: 804-398-1678  
[coleyvalerie@yahoo.com](mailto:coleyvalerie@yahoo.com)

**Robert Day**

1872 East Hamlin Street  
Seattle, WA 98112  
Work: 206-954-9922  
[rday@fhcrc.org](mailto:rday@fhcrc.org)

**Charles de-Krafft**

1808 Woodvalley Drive  
Columbia, SC 29212  
Home: 803-781-0844  
Cell: 803-238-0278  
Work: 803-781-0844  
[cdekrafft@sc.rr.com](mailto:cdekrafft@sc.rr.com)

**Participants  
Family Members**

*Note: An asterisk indicates a member of the planning committee and a number sign indicates a group facilitator.*

---

**Kathleen Dobbs**

133 West Gloucester Pike  
Barrington, NJ 08007  
Home: 856-547-5696  
Cell: 856-498-4231  
Work: 856-225-5071  
[dobbsk@aol.com](mailto:dobbsk@aol.com)

**Jacqueline Duda**

3908 Millstone Circle  
Monrovia, MD 21770  
Home: 301-865-4122  
Cell: 240-446-0960  
[jdudaeditor@aol.com](mailto:jdudaeditor@aol.com)

**Cathy Finck\*\***

4630 Gilhams Road, NE  
Roswell, GA 30075  
Home: 770-640-8862  
[cfinck@bellsouth.net](mailto:cfinck@bellsouth.net)

**Debbie Fowler**

110 Valley Lane  
Carrolltown, Pa 15722  
Home: 814-344-8026  
Work: 1-877-767-ADAM  
[debbie@rememberingadam.org](mailto:debbie@rememberingadam.org)

**Jackie Gabriel**

P.O. Box 665  
Rosebud, SD 57570  
Home: 605-574-5178

**Patricia Genereux**

5408 Abbott Place  
Minneapolis, MN 55410  
Home: 612-618-9754  
[patgenereux@comcast.net](mailto:patgenereux@comcast.net)

**Deirdre Drohan Forbes**

4 Ridgedell Avenue  
Hastings-on-Hudson, NY 10706  
Home: 914-478-5048  
Cell: 347-860-2277  
[dforbes@tforbes.com](mailto:dforbes@tforbes.com)

**Lorna Efford**

2270 Wyoming Boulevard, NE  
Suite 414  
Albuquerque, NM 87112  
Cell: 505-803-6770  
Work: 505-845-9430  
[inmemoryofseanpefford@yahoo.com](mailto:inmemoryofseanpefford@yahoo.com)

**Kathleen Foster**

541 Lincoln Avenue  
National Park, NJ 08063  
Home: 856-845-5614  
Cell: 856-983-3328  
Work: 856-983-3328  
[p2pkass@aol.com](mailto:p2pkass@aol.com)

**Maryanne Frangules**

30 Winter Street, 3<sup>rd</sup> Floor  
Boston, MA 02108  
Home: 517-423-6627  
[MOARfran@aol.com](mailto:MOARfran@aol.com)

**John Gahagan**

3810 Serene Way  
Lynnwood, WA 98087  
Home: 425-248-1795  
Cell: 425-743-9492  
[john.gahagan@verizon.net](mailto:john.gahagan@verizon.net)

**Patti Wilson-Herndon**

4817 Mistletoe Way  
Mesquite, TX 75150  
Home: 972-206-1993  
Cell: 214-883-1435  
[patti.herndon@gmail.com](mailto:patti.herndon@gmail.com)

**Participants  
Family Members**

*Note: An asterisk indicates a member of the planning committee and a number sign indicates a group facilitator.*

---

**Kathy Hughes**

4600 Kietzke Lane 0-269  
Reno, NV 89502  
Cell: 775-343-6180  
Work: 775-448-9950  
[khughes@nvpep.org](mailto:khughes@nvpep.org)

**Carolyn Jochens**

10205 Main Tree Drive  
Anchorage, AK 99507  
Home: 907-346-1318  
Work: 907-742-8100  
[jochens\\_carolyn@asdk12.org](mailto:jochens_carolyn@asdk12.org)

**Libby Jones**

2861 Morningdew Drive  
Sophia, NC 27350  
Home: 336-683-1356  
Cell: 336-988-7874  
[eyjones@uncg.edu](mailto:eyjones@uncg.edu)

**Candy Kennedy**

P.O. Box 113  
Upland, NE 68981  
Home: 308-830-0944  
[ckennedy@nefamilies4kids.org](mailto:ckennedy@nefamilies4kids.org)

**Judy Kirkwood**

5209 Nannyberry Drive  
Fitchburg, WI 53711  
Home: 608-230-6766  
Cell: 608-576-4718  
[judykirkwood@cs.com](mailto:judykirkwood@cs.com)

**Beryl Lewis**

P.O. Box 1641  
Sacaton, AZ 85247  
Home: 520-562-7362

**Alan Hyde**

13 Oakdale Road  
Southbury, CT 06488  
Home: 203-405-1840  
[Alanh@ctyouthandfamilies.org](mailto:Alanh@ctyouthandfamilies.org)

**Julie Johnson-Unwin**

7215 Ponderosa Pines Place  
Indianapolis, IN 46239  
Home: 317-862-0463  
Cell: 317-407-7528  
[unw22457@aol.com](mailto:unw22457@aol.com)

**Bettie Jordan**

7031 West Voltaire Avenue  
Peoria, AZ 85381  
Home: 623-979-5182  
Cell: 623-986-3892  
[Bettiejord@aol.com](mailto:Bettiejord@aol.com)

**Erica Kelso**

1700 Jefferson Avenue  
Anchorage, AK 99517  
Work: 907-339-0500  
Home: 907-770-0990  
Cell: 907-440-4720  
[eaglerl@msn.com](mailto:eaglerl@msn.com)

**Bernice Lefthand**

P.O. Box 417  
Montezuma, UT 84534  
Home: 435-651-3007  
Cell: 288-380-6268  
Work: 435-651-3425 x2610  
[blefthand@sanjuanschools.org](mailto:blefthand@sanjuanschools.org)

**Deborah Locke**

6001 Tattersall Court  
Brentwood, TN 37207  
Home: 615-377-0078  
Cell: 615-310-2111  
[dklocke@bellsouth.net](mailto:dklocke@bellsouth.net)

**Participants  
Family Members**

*Note: An asterisk indicates a member of the planning committee and a number sign indicates a group facilitator.*

---

**Kim Manlove**

11214 Echo Ridge Lane  
Indianapolis, IN 46236  
Cell: 317-331-5949  
[kim.m@the24group.org](mailto:kim.m@the24group.org)

**Mary Martin**

60 Bramley Street  
Saunemin, IL 61769  
Home: 815-832-4455  
[Mary4rkids@yahoo.com](mailto:Mary4rkids@yahoo.com)

**Dawn Mitchell**

1010 Drummond Drive  
Nashville, TN 37211  
Home: 615-333-1882  
Cell: 615-293-0676  
[dmitchell@tnvoices.org](mailto:dmitchell@tnvoices.org)

**Maureen Murphy**

1771 Northview Road  
Rocky River, OH 44116  
Cell: 440-724-4707  
[Maureen\\_Murphy@att.net](mailto:Maureen_Murphy@att.net)

**Sandra Parrent**

7201 Foxford Avenue, NW  
Albuquerque, NM 87120  
Work: 480-202-7152  
[sandra.parrent@gmail.com](mailto:sandra.parrent@gmail.com)

**Diane Pittman**

128 Sweetwater Drive  
Columbus, GA 31907  
Home: 706-617-3327  
[Pittmand84@yahoo.com](mailto:Pittmand84@yahoo.com)

**Alan Rabideau<sup>#</sup>**

112 Kincheloe Drive  
Kincheloe, MI 49788  
Home: 906-495-7158  
Cell: 906-440-1774  
[jawenodee\\_inini@yahoo.com](mailto:jawenodee_inini@yahoo.com)

**Veronica Marroquin**

5241 5<sup>th</sup> Street, NW  
Washington, DC 20011  
Cell: 202-731-2468  
Work: 240-497-6100  
[veronicamarisolmarroquin@rocketmail.com](mailto:veronicamarisolmarroquin@rocketmail.com)

**Tom Meyer**

6300 University Avenue  
Suite 300  
Middleton, WI 53562  
Cell: 608-332-8331  
Work: 608-824-7777  
[Tom@TomMeyer.com](mailto:Tom@TomMeyer.com)

**Theresa Mostiller<sup>#</sup>**

617 Cochran Road  
Donalds, SC 29638  
Home: 864-456-2664  
Cell: 864-554-2659  
Work: 864-227-7480

**Michaelene Paquette**

54 Suburban Square  
South Burlington, VT 05403  
Home: 802-860-6321  
Cell: 802-598-0376  
Work: 802-859-6977  
[mike.paquette@yahoo.com](mailto:mike.paquette@yahoo.com)

**Joanne Peterson**

PO Box 60  
Raynham, MA 02767  
Home: 508-801-3247  
[learntocope2001@yahoo.com](mailto:learntocope2001@yahoo.com)

**Nancy Porosky**

28 Chipmunk Lane  
Gilmanton, NH 03837  
Home: 603-267-6769  
[Nancy.Porosky@elavon.com](mailto:Nancy.Porosky@elavon.com)

**Will Rayford**

7 Kimberly Court  
Columbus, GA 31907  
Home: 706-682-3588  
Cell: 706-577-9303  
[bonemannn@yahoo.com](mailto:bonemannn@yahoo.com)

**Participants  
Family Members**

*Note: An asterisk indicates a member of the planning committee and a number sign indicates a group facilitator.*

---

**Angie Ritchie**

P.O. Box 956  
Midway, UT 84049  
Home: 801-310-8171  
[cleo84032@aol.com](mailto:cleo84032@aol.com)

**Cari Santibanes**

5480 Blossom Wood Drive  
San Jose, CA 95124  
Home: 408-356-2584  
Cell: 408-803-3110  
Work: 408-295-6033x120  
[santifamily@gmail.com](mailto:santifamily@gmail.com)

**Brenda Schellhorn**

8320 Olivia Drive  
Lincoln, NE 68512  
Home: 402-441-4386  
Cell: 402-525-6972  
[bschellhorn@region5systems.net](mailto:bschellhorn@region5systems.net)

**Fe Silva**

525 Parkway Street  
Santa Cruz, CA 95060  
Home: 831-234-4826  
Cell: 831-425-0338  
[fesilva@sbcglobal.net](mailto:fesilva@sbcglobal.net)

**Margarita Solis**

1635 Maple Avenue  
Corvallis, OR 97330  
Home: 541-231-7825  
Cell: 541-754-7489  
[margaritasolis@milestonesrecovery.com](mailto:margaritasolis@milestonesrecovery.com)

**Lisa Stalnaker**

125 Hibridge Circle  
Lewistown, Pa 17044  
Home: 717-242-8511  
Work: 717-242-8511  
[lstalnaker@msn.com](mailto:lstalnaker@msn.com)

**Donna Espinola-Rooney**

P.O. Box 782  
Atkinson, NH 03811  
Home: 603-887-5804  
Cell: 603-572-4232  
[WorkHerBee@comcast.net](mailto:WorkHerBee@comcast.net)

**RoseAnn Schek**

1515 Old Bainbridge Road  
Tallahassee, FL 32303  
Home: 850-606-8065  
Cell: 850-524-3412  
[roseann\\_scheck@doh.state.fl.us](mailto:roseann_scheck@doh.state.fl.us)

**Brooke Schewe**

209 Woodscape Drive  
Albany, NY 12203  
Home: 518-225-0387  
Cell: 518-225-0387  
Work: 518-432-0333 ext. 14  
[bschewe@ftnys.org](mailto:bschewe@ftnys.org)

**Sharon Smith<sup>\*#</sup>**

P.O. Box 450  
Mechanicsburg, PA 17055  
Home: 717-730-2020  
Cell: 717-512-3126  
[momstell@verizon.net](mailto:momstell@verizon.net)

**Laurie Spellmeyer**

1217 El Kay Court #36  
Highland, IL 62249  
Home: 618-975-3414

**Kathy Tribolet**

4025 East 3<sup>rd</sup> Street  
Tucson, AZ 85711  
Cell: 520-429-0359  
Work: 520-882-0142  
[Kathyt@mikid.org](mailto:Kathyt@mikid.org)

**Participants  
Family Members**

*Note: An asterisk indicates a member of the planning committee and a number sign indicates a group facilitator.*

---

**Lori Turner**  
565 McCall Way  
Philomath, OR 97370  
Home: 541-929-3702  
Cell: 541-231-7418  
[turnertribe4@peak.org](mailto:turnertribe4@peak.org)

**Cassie Undlin**  
14818 37<sup>th</sup> Avenue, NE  
Lake Forest, WA 98155  
Home: 206-365-9158  
[cassieundlin@gmail.com](mailto:cassieundlin@gmail.com)

**Joy Varney**  
P.O. Box 136  
Shelbyville, KY 40066  
Cell: 502-802-3565  
Work: 502-633-5683  
[jvarney@sevencounties.org](mailto:jvarney@sevencounties.org)

**Karen Ventrimiglia**  
51344 Nicolette Drive  
Chesterfield, MI 48047  
Home: 586-716-0306  
Cell: 586-292-4529  
[kvent@comcast.net](mailto:kvent@comcast.net)

**Linda Warden**  
3019 Hayden Drive  
Wilmington, NC 28411  
Home: 910-681-0835  
Cell: 910-524-2736  
[lcwarden@yahoo.com](mailto:lcwarden@yahoo.com)

**Lynne Windle**  
2355 Red Rock Street #106  
Las Vegas, NV 89146  
Cell: 702-408-2101  
Work: 702-388-8899  
[lwindle@nvpep.org](mailto:lwindle@nvpep.org)

**Kathy Winzig**  
31183 Roberta Drive  
Bay Village, OH 44140  
Home: 440-892-8704  
Cell: 440-382-2813  
[winzigohio@yahoo.com](mailto:winzigohio@yahoo.com)

**Sandi Yandow**  
3771 Lake Street  
Addison, VT 05491  
Cell: 802-759-9518  
[syandow@yahoo.com](mailto:syandow@yahoo.com)

---

**Substance Abuse and Mental Health Services Administration**

---

**Marsha Baker**  
Public Health Advisor, Division of Services  
Improvement  
Center for Substance Abuse Treatment  
1 Choke Cherry Road  
Rockville, MD 20857  
Work: 240-276-1566  
[marsha.baker@samhsa.hhs.gov](mailto:marsha.baker@samhsa.hhs.gov)

**Jutta Butler**  
Team Leader, Targeted Populations Branch  
Division of Services Improvement  
Center for Substance Abuse Treatment  
1 Choke Cherry Road  
Rockville, MD 20857  
Work: 240-276-1567  
[jutta.butler@samhsa.hhs.gov](mailto:jutta.butler@samhsa.hhs.gov)

**Randy Muck**  
Chief, Targeted Populations Branch  
Division of Services Improvement  
Center for Substance Abuse Treatment  
1 Choke Cherry Road  
Rockville, MD 20857  
Work: 240-276-1576  
[randy.muck@samhsa.hhs.gov](mailto:randy.muck@samhsa.hhs.gov)

**Jack Stein**  
Director, Division of Services Improvement  
Center for Substance Abuse Treatment  
1 Choke Cherry Road  
Rockville, MD 20857  
Work: 240-276-1660  
[Jack.stein@samhsa.hhs.gov](mailto:Jack.stein@samhsa.hhs.gov)

**Participants**  
**Georgetown University**

*Note: An asterisk indicates a member of the planning committee and a number sign indicates a group facilitator.*

---

**Chris Bender\***

Research Associate  
Health Policy Institute  
Georgetown University  
3300 Whitehaven Street, NW  
Suite 5000  
Washington, DC 20057  
Work: 202-687-1565  
[Chris.e.bender@gmail.com](mailto:Chris.e.bender@gmail.com)

**Doreen Cavanaugh\***

Research Associate Professor  
Health Policy Institute  
Georgetown University  
3300 Whitehaven Street, NW  
Suite 5000  
Washington, DC 20057  
Work: 202-687-0634  
[Dacemail2@aol.com](mailto:Dacemail2@aol.com)

**Marielle Kress**

Student  
Georgetown Public Policy Institute  
Georgetown University  
3520 Prospect Street, NW, 4<sup>th</sup> Floor  
Washington, DC 20057  
Cell: 917-453-1414  
[Mjk89@georgetown.edu](mailto:Mjk89@georgetown.edu)

**Georgina Lopez Cruz**

Intern  
Health Policy Institute  
Georgetown University  
3300 Whitehaven Street, NW  
Suite 5000  
Washington, DC 20057  
[Georgina.lopez.cruz@gmail.com](mailto:Georgina.lopez.cruz@gmail.com)

---

**State Adolescent Substance Use Treatment Coordination Grant Consultants**

---

**Sherese Carr<sup>#</sup>**

821 N. Jackson Street  
Wilmington, DE 19806  
Cell: 302-898-3098  
[reesecup13@comcast.net](mailto:reesecup13@comcast.net)

**Marian Daniel**

5619 Cadillac Avenue  
Baltimore, MD 21207  
Cell: 410-302-1304  
[divamar99@msn.com](mailto:divamar99@msn.com)

**Steve Hornberger<sup>\*\*</sup>**

Program Director  
National Association for Children of Alcoholics  
11426 Rockville Pike  
Suite 301  
Rockville, MD 20852  
Work: 301-468-0985  
[steve9603@comcast.net](mailto:steve9603@comcast.net)

**Kate Kraft<sup>#</sup>**

19 Andrews Lane  
Princeton, NJ 08540  
Cell: 609-203-7078  
[katekraft@comcast.net](mailto:katekraft@comcast.net)

**Dan Merrigan<sup>#</sup>**

Associate Professor  
Social & Behavioral Sciences  
Boston University School of Public Health  
801 Massachusetts Avenue  
Boston, MA 02118  
Work: 617-638-5159  
[merrigan@bu.edu](mailto:merrigan@bu.edu)

**Gina Wood<sup>#</sup>**

Deputy Director  
Health Policy Institute  
Joint Center for Political and  
Economic Studies  
1090 Vermont Avenue, NW, 11<sup>th</sup> Floor  
Washington, DC 20005  
Work: 202-789-3517  
[gwood@jointcenter.org](mailto:gwood@jointcenter.org)

**Participants**  
**Westat**

---

**Victoria Castleman**

1650 Research Boulevard

Rockville, MD 20850

Work: 240-314-5807

[VictoriaCastlemen@Westat.com](mailto:VictoriaCastlemen@Westat.com)

**Sylvia Jarrett-Coker**

1650 Research Boulevard

Rockville, MD 20850

Work: 240-314-5873

[Sylviajarrett-Coker@Westat.com](mailto:Sylviajarrett-Coker@Westat.com)

**Jeremy Rush**

1650 Research Boulevard

Rockville, MD 20850

Work: 301-610-5551

[JeremyRush@westat.com](mailto:JeremyRush@westat.com)

**June Crandall**

1650 Research Boulevard

Rockville, MD 20850

Work: 240-251-2252

[JuneCrandall@Westat.com](mailto:JuneCrandall@Westat.com)

**Ann Landy**

1650 Research Boulevard

Rockville, MD 20850

Work: 301-251-2219

[AnnLandy@Westat.com](mailto:AnnLandy@Westat.com)

**Lisa Stottlemyer**

1650 Research Boulevard

Rockville, MD 20850

Work: 301-251-1500

[STOTTLL1@Westat.com](mailto:STOTTLL1@Westat.com)

# **Appendix D. Families of Youth with Substance Use Addiction: A National Dialogue Discussion Questions**

---

## **Families of Youth with Substance Use Addiction: A National Dialogue**

**Discussion Questions  
Day 1: Friday, March 27, 2009**

### **Discussion Session 1. Youth Substance Use Addiction Treatment and Recovery System Present Reality**

- What was your family's experience with the youth substance use addiction treatment and recovery system?
- What do you feel are the most significant challenges in the youth substance use addiction treatment and recovery system today?
  - Regarding access?
  - Regarding quality?
  - Regarding family involvement?
- Prioritize challenges

### **Discussion Session 2. Youth Substance Use Addiction Treatment and Recovery System Future Vision**

- What should the youth substance use addiction treatment and recovery system look like?
  - At the practice level?
  - At the program level?
- Prioritize ideas
- What needs to happen to make this vision a reality?
  - At the policy level?
- Prioritize ideas

## **Families of Youth with Substance Use Addiction: A National Dialogue**

**Work Session Questions  
Day 2: Saturday, March 28, 2009**

### **Discussion Session 3. Youth Substance Use Addiction Treatment and Recovery System: The New Reality.**

#### **The Role of Family Involvement in Creating and Implementing the Future Vision**

- What roles can family members play in creating and implementing the future vision?
  - At the practice level?
  - At the program level?
  - At the policy level?
- Prioritize ideas
- What supports do families need to fulfill these roles?
  - At the practice level?
  - At the program level?
  - At the policy level?
- Prioritize ideas

## **Appendix E. Issue Brief: Family Involvement in Adolescent Substance Abuse Treatment**

---

# Improving Access to and Quality of Treatment for Adolescents with Substance Use/Co-occurring Mental Health Disorders

Volume 1, Number 1  
March 2009

## Family Involvement in Adolescent Substance Abuse Treatment

Sharon L. Smith, Steve Hornberger, M.S.W., Sherese Brewington-Carr, M.H.S., Cathy Finck, Cassandra O'Neill, M.A., Doreen Cavanaugh, Ph.D., Christopher Bender, M.P.P.

In 2005, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) awarded 3-year, \$1.2 million State Adolescent Substance Abuse Treatment Coordination (SAC) grants<sup>a</sup> to 15 States and the District of Columbia<sup>b</sup>. The SAC grant builds capacity in States to provide effective, accessible, and affordable substance abuse treatment for youth and their families. CSAT requires State grantees to address change within five overarching topic areas: family involvement, finance, workforce development, dissemination of evidence-based practices and interagency collaboration.

### Family Involvement

Written *by* families and professionals, *for* families and professionals, this initial family involvement issue brief is designed to inform, engage, and motivate a broad, national audience concerned about adolescents in need of treatment for substance use disorders. Benefits and challenges to developing family-focused, State-level adolescent substance abuse treatment systems in the SAC States are discussed. Each SAC State differs in its adolescent substance abuse treatment infrastructure and family involvement experience. This includes both the public and private leadership who champion this issue; the available resources; and the awareness, readiness, and capacity for developing collaborative family-professional partnerships.

Family involvement experiences and activities vary widely across the SAC grant States, as well as all States/Tribes across the country.

Too often, family involvement happens only because a charismatic leader champions the issue and makes things happen.

Family involvement should be an expectation for every State/Tribe and local adolescent substance abuse treatment system, and for the providers who deliver treatment and recovery services. This first issue brief will address the following:

- Defining family involvement and collaborative family-professional partnerships,
- Discussing specific benefits and challenges that exist for involving families,
- Identifying three key areas of focus for family involvement activity,
- Suggesting a working definition of collaborative family-professional partnerships,
- Highlighting lessons learned from family involvement in the SAC grant, and
- Envisioning the future of family involvement.

## Defining Family Involvement and Collaborative Family–Professional Partnerships

Family involvement has been defined in many different ways across adolescent and child serving systems. The type of involvement 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 the role of families in advocating,

participating, supporting, and evaluating treatment and recovery support services for their children. As a result of family involvement, family members have become a strong voice advocating for program, practice, and policy changes in the substance abuse treatment system. Individually, and in groups with other family members, parents have learned how to speak out and be heard by agency administrators, elected officials, advocates, and other concerned community stakeholders.

“Family involvement is any role or activity designed to provide youth and families with direct, ongoing, and meaningful input into and influence on substance abuse system policies, programs, and practices that affect the health and well being of youth and families served.”<sup>1</sup>

## Discussing Specific Benefits and Challenges That Exist for Involving Families

Family involvement in the adolescent substance abuse treatment system is still in its infancy, but families have participated as partners with professionals in other systems (e.g., children’s mental health, education, and developmental disabilities) for a longer time. Both family members and professionals have experienced benefits through creating such collaborative partnerships including:

- Families learning about current services, policies and procedures, emerging trends/challenges, and research on the system from professionals; and
- Professionals learning about unique experiences, perspectives, strengths, and weaknesses from families.

Initial efforts to promote, develop, and support family involvement within the adolescent substance abuse treatment system have been very encouraging. Family members have been engaged, equipped, and mobilized to advocate for improving inadequate systems and sustaining effective adolescent substance abuse treatment system practices, programs, and policies.

However, the adolescent substance abuse treatment field, in general, has lacked a common vision, specific expectations, and clearly defined roles and responsibilities for family members and professionals. Benchmarks to measure outcomes, as well as strategies and activities to increase family involvement at the practice, program, and policy levels still need to be discussed, defined, and disseminated.

Early efforts to increase involvement of family members within the adolescent substance abuse treatment system have identified critical lessons. There are significant and important differences in how the disease of addiction affects families according to their cultural, racial, or ethnic backgrounds; their geographic location; their socio-economic class; and their access to services, supports, or other resources.

Families are unique and their experiences vary. Every attempt must be made to build the capacity of each substance abuse family voice within every State/Tribe. While this fact may seem apparent, implementation may be difficult.

Some SAC States are working successfully with children’s mental health, education, and other family support organizations to meet substance abuse system family involvement goals. But it is necessary to ensure that all families of youth receiving substance abuse treatment services are recruited, represented, valued, supported, and included in meaningful ways. These are the families who are living with the impact of addiction. Their shared experiences, good and bad, offer real-life testimony to guide policymakers in efforts to improve adolescent substance abuse treatment system outcomes and the quality of care provided.

Once the need for treatment is established, knowing how to access treatment services is the next challenge that families face. Educating families about adolescent substance abuse treatment and providing information on how the system works will benefit families who need to navigate the system. Educating families on the disease of addiction and how substance abuse affects the entire family is important. Given the proper support, information, tools, and resources, parents and caretakers are able to not only advocate for their child’s recovery, but for their own recovery and that of other family members including siblings.

### **Identifying Three Key Areas of Focus for Family Involvement Activity**

Practice, program, and policy are three key target areas for expanding family involvement in the adolescent substance abuse treatment system. Families and professionals can partner collaboratively to design, implement, and evaluate the delivery of treatment and recovery services at each of the three levels.

- The practice area focuses on families and service providers as partners in the delivery of services and supports for individual adolescents and their families.
- The program area focuses on families and policymakers as partners to improve how programs are designed and

contracted as well as how providers need to collaborate with agencies in the community to sustain treatment gains and foster recovery for adolescents.

- The policy area focuses on families and policymakers as partners to improve the adolescent substance abuse treatment system. Family members may examine and comment on how the substance abuse treatment system works with other State/Tribal agencies, e.g., mental health, education, child welfare, juvenile justice; how providers are licensed; and how the system is funded and evaluated.

Focusing on these three levels of involvement provides direction for transitioning the current adolescent substance abuse treatment system into a fully collaborative partnership between family members and professionals. The first step is to inform family and community stakeholders and raise awareness of the importance of family involvement. The second step is to create an environment in which families and professionals can communicate honestly, respectfully, and openly about their expectations and respective roles in meeting an adolescent’s treatment needs and the recovery needs of the youth and other family members.

### **Suggesting a Working Definition of Collaborative Family/Professional Partnership**

One goal of family involvement is to develop collaborative partnerships between *family* expertise, resources, and experiences and *professional* expertise, resources, and experiences. Such collaborative partnerships are necessary to help adolescents and their families understand the disease of addiction, engage in treatment, heal, and then sustain recovery from the impact of substance abuse. In treatment, when families and professionals work together in the best interests of the adolescent and other family members, positive outcomes should occur.

Family involvement develops collaborative partnerships between *family* expertise, resources, and experiences and *professional* expertise, resources, and experiences to improve treatment and support recovery.

### **Highlighting Lessons Learned from Family Involvement in the SAC Grant**

A number of issues for families and professionals have emerged from the 15 SAC States and the District of Columbia. This section is not intended to be comprehensive, but rather highlight what has been learned in the first 2 years of the SAC grant period. The hope is that this will point the way for what is next in the development of collaborative partnerships between family members and professionals. Time, effort, and commitment are necessary to make sustainable changes across the adolescent substance abuse treatment field.

The SAC grant process has begun to find what works, and identify benefits and challenges for successfully involving families and professionals as collaborative partners in adolescent substance abuse treatment. This section identifies initial thoughts for consideration within the three key levels.

#### **Practice**

##### ***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, cultural competency, and family support services.

##### ***Practice issues for professionals:***

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

#### **Program**

##### ***Program issues for families:***

- What works: families are empowered to provide valuable input for agency/program quality improvement planning.
- Benefits: families provide crucial input into developing community-based family support services.
- Challenges: family organizations lack infrastructure support, resources, and cultural competency necessary to increase the number and diversity of families involved.

##### ***Program issues for professionals:***

- What works: professionals encourage family-to-family outreach; promote awareness, peer education, and other support services.
- Benefits: diverse family experiences assist efforts to improve the effectiveness, efficiency, and cultural competence of program staff and services.

- Challenges: families lack leadership and a clear understanding of the impact of best practices and the high priority for family involvement in program operations.

## Policy

### *Policy issues for families:*

- What works: policymakers 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 lack the infrastructure to connect and network with other advocates.

### *Policy issues for professionals:*

- *What works:* professionals hear personal experiences and input from family members to help inform policy decisions and provide opportunities to foster relationships with constituents.
- *Benefits:* policymakers have access to “issue experts”; convene stakeholder groups for hearings; and access consumer input to identify system issues, service gaps, and possible solutions.
- *Challenges:* the lack of a consistent, unified and organized family voice for policy agenda items.

Nationally, family involvement in adolescent substance abuse treatment is in the early stages of development. There are no documented successful models that address practice, programs, and policy. However, all SAC States are pioneering new ways to col-

laborate with family members. The following are examples from the first two years of the SAC grant period.

## Promising Practices

### Arizona

- Contracted with family organizations to provide family support and advocacy,
- Used teleconferencing to increase youth participation,
- Conducted outreach to Native American population, and
- Published a “Roadmap to the Substance Abuse System” in English and Spanish.

### North Carolina

Developed training curriculum facilitated by family-professional teams called “How to choose a service provider.”

## Promising Programs

### South Carolina

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

### Ohio

Created a “Family Corner” website with resources and tools for parents at [www.ebasedtreatment.org](http://www.ebasedtreatment.org).

## Promising Policies

### Connecticut

Developed a policy paper entitled “Blue Print for Change: Bringing Families into Connecticut’s Adolescent Substance Abuse Treatment System.”

### Vermont

Implemented ACT 264, legislation that requires human services and public education to work together to involve parents and coordinate services to achieve better outcomes for children and families.

## Envisioning the Future of Family Involvement

Efforts to develop and enhance collaborative family–professional partnerships have been and will continue to be essential steps to sustaining, improving, and expanding access and quality of the adolescent substance abuse treatment system. Ideally, State/Tribal adolescent substance abuse treatment systems of the future will consist of collaborative partnerships between family members and professionals, as well as with other child and family serving systems to:

- *Integrate delivery of adolescent substance abuse/co-occurring disorder services into a seamless continuum of prevention, early intervention, treatment, and recovery support;*
- *Strengthen and build leadership capacity of family members, professionals, and providers;*
- *Educate/train families on relevant issues (e.g., how the system works, advocacy skills, and peer support);*
- *Develop funding resources to sustain family involvement (e.g., Medicaid EPSDT and optional Medicaid coverage categories);*
- *Provide resources for family involvement (e.g., transportation, program and policy stipends, funding for family advocates/advocacy groups);*
- *Include family choice of evidence-based, accessible, affordable, and culturally relevant service options;*
- *Support and build on 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; and*

- *Measure the outcomes of family involvement.*

## Conclusion

This issue brief is based on what SAC States have learned in the first two grant years. It incorporates emerging knowledge on addiction, treatment, and recovery; and is a step toward building consensus for a vision of the future health and well being of our country's adolescents in need of substance abuse treatment and their families.

Family involvement in the planning and delivery of services with treatment providers and policymakers at all levels—individual, community, county, State/Tribal and Federal—is beginning to happen; and the adolescent substance abuse treatment system should strengthen and support such efforts. Family involvement is necessary to improve the quality of care provided and to ensure that all adolescents in need of substance abuse treatment and their families receive accessible, appropriate, and quality treatment.

Family members are learning how to speak out, support each other, and advocate for their sons and daughters who suffer from the disease of addiction. The family voice is becoming stronger. Collaborative partnerships of families, treatment professionals, researchers and public officials are developing. Learning from each other and working together will not only create an adolescent substance abuse treatment system that is relevant, responsive, and results-driven, but also one that will reduce and ultimately eliminate the shame, stigma, disparities, and discrimination associated with the impact of substance abuse.

“Coming together is beginning, keeping together is progress, and working together is success.”

Henry Ford

## References

<sup>1</sup> New York State Councils' Children and Families Coordinated Children's Services Initiative, Tier III Leadership Team. CCSI Family Involvement and Strength Based Practices. Retrieved 8/3/07 from <http://www.ccf.state.ny.us/resources/ccsi/family.htm#Definition>.

## Notes

<sup>a</sup> To learn more about the SAC grant, please read the NOFA on the World Wide Web at: [http://www.samhsa.gov/grants/2005/nofa/ti05006\\_adolescents.aspx](http://www.samhsa.gov/grants/2005/nofa/ti05006_adolescents.aspx).

<sup>b</sup> SAMHSA awarded SAC grants to the following States: Arizona, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, North Carolina, Ohio, South Carolina, Tennessee, Virginia, Vermont, Washington, Wisconsin, and the District of Columbia. In this document these grantees are referred to as States.

## Acknowledgements

Youth and families, advocates, public officials, administrators, and treatment providers in the field shared their experiences, wisdom, and insights in the preparation of this document. The authors are indebted to them for their candor, dedication, and contribution to the evolutionary work of collaborative family–professional partnerships.

This issue brief was supported by SAMHSA grant number TI 05-006, State Adolescent Substance Abuse Treatment Coordination Grant.

## Authors

Sharon L. Smith, Founder and President, MOMSTELL, Mechanicsburg, Pennsylvania.

Steve Hornberger, M.S.W., Program Director, National Association for Children of Alcoholics (NACOA), Rockville, Maryland.

Sherese Brewington-Carr, M.H.S., Consultant, former Juvenile Justice Director and Adult Corrections Warden, Wilmington, Delaware.

Cathy Finck, Georgia State Partner, Parent Corps, Roswell, Georgia.

Cassandra O'Neill, M.A, Consultant, Wholonomy Consulting, LLC., Tucson, Arizona.

Doreen Cavanaugh, Ph.D., Research Associate Professor, Georgetown University Health Policy Institute, Washington, DC.

Christopher Bender, M.P.P., Research Associate, Georgetown University Health Policy Institute, Washington, DC.

## **Appendix F. Selected Family Support Materials List**

---

### **Families of Youth with Substance Use Addiction: A National Dialogue Resource Materials List for Families**

The following list of resources is provided solely for additional information. The list is not comprehensive but rather examples of papers and materials addressing youth substance use addiction or related topics. Inclusion in the list below does not imply support or endorsement by either The Families of Youth with Substance Use Addiction: A National Dialogue Planning Committee or the Center for Substance Abuse Treatment. Some materials listed below are tailored for adults with substance use disorders or youth with mental health disorders; however, these materials have been included because some of the information can be applied to youth with substance use addiction.

#### **Family Involvement**

Catone, B. (2008). *Science helping parents confront youth drug use and abuse: New Web resource helps parents grasp teen behavior and connect with their kids*. Philadelphia, PA: Treatment Research Institute. Retrieved March 20, 2009, on the World Wide Web: [http://www.tresearch.org/headlines/2008Jun\\_TeenBrain.pdf](http://www.tresearch.org/headlines/2008Jun_TeenBrain.pdf)

Duchnowski, A. J. and Kutash, K. (2007). *Family driven care: Are we there yet?* Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies retrieved March 20, 2009, from the World Wide Web: [http://cfs.fmhi.usf.edu/resources/publications/fam\\_driven\\_care.pdf](http://cfs.fmhi.usf.edu/resources/publications/fam_driven_care.pdf)

Jennings, J. (2002). *Parent leadership: Successful strategies*. Chapel Hill, NC: FRIENDS National Resource Center for Community-Based Family Resource and Support Programs. Retrieved March 20, 2009, from the World Wide Web: [http://www.friendsnrc.org/download/parent\\_leader\\_strategies.pdf](http://www.friendsnrc.org/download/parent_leader_strategies.pdf)

National Federation of Families for Children's Mental Health (2008). *Working definition of family driven care*. Retrieved March 20, 2009, from the World Wide Web: <http://www.ffcmh.org/wordownloads/Family%20Driven%20Care%20Definition%20Jan%20%202008.doc>

The National Technical Assistance and Evaluation Center for Systems of Care. (2008). *Family involvement in public child welfare driven systems of care*. Retrieved March 20, 2009, from the World Wide Web: <http://www.childwelfare.gov/pubs/acloserlook/familyinvolvement/>

#### **Finance**

Cavanaugh, D. A. (2004). Maximizing potential: Federal financing for treatment of adolescents with substance use disorders. *Journal of Psychoactive Drugs*, 36(4), 415–427.

### **Policy Development/Public Education**

National Federation of Families for Children's Mental Health (n.d.). *Involving families in policy work*. Retrieved March 20, 2009, from the World Wide Web:  
<http://www.ffcmh.org/pdf/policycorner/involvingfamiliesTIPsheet-1.pdf>

The Afterschool Alliance. (n.d.). *Building relationships with policy makers—do's and don'ts*. Retrieved March 20, 2009, from the World Wide Web:  
<http://www.afterschoolalliance.org/reachPolicyDoDont.cfm>

### **Recovery**

Cavanaugh, D. A., Goldman, S., Friesen, B. and Bender, C. (2008). *Designing a recovery-oriented care model for adolescents and transition age youth with substance use or co-occurring mental health disorders*. Washington, DC: Resource materials developed for CSAT/CMHS/SAMHSA Consultative Session. For a copy of this document, contact Chris Bender ([chris.e.bender@gmail.com](mailto:chris.e.bender@gmail.com); 202-687-1565).

Flaherty, M. T. (2006). Special Report: Building resilience, wellness and recovery: A shift from acute care to a sustained care recovery management model. Pittsburgh, PA: Institute for Research, Education and Training in Addictions (IRETA). Retrieved on March 20, 2009, from the World Wide Web: <http://store.ireta.org/merchant2/> (Note: this link will take you to IRETA's publication store. You may download this document for no charge, but you will have to select it from the publications list first).

White, W. L. (2005). Recovery management: What if we really believed that addiction was a chronic disorder? *GLATTC Bulletin*. The Addiction Technology Transfer Center Network. <http://www.attcnetwork.org/learn/topics/rosc/docs/RecoveryManagement.pdf>

White, W. L. (2005). Recovery rising: Radical recovery in America. *Wellbriety: White Bison's Online Magazine*, 6(2). <http://www.whitebison.org/magazine/2005/volume6/no2.htm>

White, W. L. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, 33(3), 229–241.

White, W. L. and Chaney, R. A. (2008). *Generational patterns of resistance and recovery among families with histories of alcohol and other drug problems: What we need to know*. Washington, DC: Faces and Voices of Recovery. Retrieved March 20, 2009, from the World Wide Web:  
[http://www.facesandvoicesofrecovery.org/pdf/White/intergenerational\\_resilience\\_recovery.pdf](http://www.facesandvoicesofrecovery.org/pdf/White/intergenerational_resilience_recovery.pdf).

### **State Adolescent Substance Abuse Treatment Coordination (SAC) Grant Resources\***

Arizona. *Adolescent substance abuse services in Arizona: A roadmap to the system. Beginning your journey, family friendly version.*

Illinois Division of Alcoholism and Substance Abuse and Illinois Federation of Families. (2008). *A parent's journey: Navigating teen substance use.*

Ohio Department of Alcohol and Drug Addiction Services. (2009). *Parents corner.* Retrieved March 20, 2009, from the World Wide Web:  
<http://www.ebasedtreatment.org/treatment/toolbox/parents>

Wisconsin. Balousek, S. (2008). *Family guide to adolescent substance abuse information and services in Wisconsin.* Wisconsin Family Ties.

### **Sustainability**

Kraft, K. and O'Neill, C. (2007). *Evolutionary sustainability: Reconceptualizing sustainability of organizational and community change.* Tucson, AZ: Wholonomy Consulting, LLC. Retrieved March 20, 2009, from the World Wide Web:  
[http://www.wholonomyconsulting.com/docs/WhitePaper\\_April2007.pdf](http://www.wholonomyconsulting.com/docs/WhitePaper_April2007.pdf)

Hornberger, S., Martin, T. and Collins, J. (2006). *Resources: Relationships, not funding streams: Five key strategies for financing comprehensive child and family initiatives for state, local and collaborative decision makers.* As excerpted in *Integrating systems of care: Improving quality of care for the most vulnerable children and families.* Washington, DC: Child Welfare League of America. Retrieved on March 20, 2009, from the World Wide Web:  
<http://www.cwla.org/programs/bhd/1integrating.pdf>

Rosenbloom, D. L., Garson Leis, R., Shah, P. and Ambrogi, R. (2006). *Blueprint for the states: Policies to improve the ways states organize and deliver alcohol and drug prevention and treatment.* Boston, MA: Join Together. Retrieved March 20, 2009, from the World Wide Web: [http://www.jointogether.org/aboutus/policy-panels/blueprint/Blueprint\\_PDF.pdf](http://www.jointogether.org/aboutus/policy-panels/blueprint/Blueprint_PDF.pdf)

Substance Abuse and Mental Health Services Administration. (2009). *New reports highlight important substance abuse, mental health, treatment and grant information for each state and the District of Columbia.* Retrieved March 20, 2009, from the World Wide Web:  
<http://www.samhsa.gov/newsroom/advisories/0902053752.aspx>

### **Treatment**

Burney Nissen, L., Hunt, S. R., Bullman, S., and Marmo, J. (2004). Systems of care for treatment of adolescent substance use disorders: Background, principles and opportunities. *Journal of Psychoactive Drugs*, 36(4), 429–438.

---

\* These and other SAC Grant resources are available. Please contact Sharon Smith (ssmith@momstell.org).

- Cavanaugh, D. A. and Muck, R. D. (2004). Editors' introduction: Using research to improve treatment for adolescents: Findings from two CSAT demonstrations. *Journal of Psychoactive Drugs*, 36(1), 1–3.
- Cavanaugh, D. A. and Kraft, K. M. (2004). Editors' introduction: Exploring policy challenges and options: Improving treatment for adolescents with substance use disorders. *Journal of Psychoactive Drugs*, 36(4), 411–413.
- Cavanaugh, D. A., and Doucette, A. (2004). Using administrative data to assess the process of treatment services for adolescents with substance use disorders. *Journal of Psychoactive Drugs*, 36(4), 473–481.
- Chan, Y. F., Godley, M. D., Godley, S., Dennis, M. L. (2007). Utilization of mental health services among adolescents in community-based substance abuse outpatient clinics. *The Journal of Behavioral Health Services & Research*. (Electronic Publication).
- Clemmey, P., Payne, L., and Fishman, M. (2004). Clinical characteristics and treatment outcomes of adolescent heroin users. *Journal of Psychoactive Drugs*, 36(1), 85–94.
- Cook, J. A., Burke-Miller, J., Fitzgibbon, G., Grey, D. D., Heflinger, C. A., Paulson, R. I., Stein-Seroussi, A., Kelleher, K. J., Hoven, C. W., and Mulkern, V. (2004). Effects of alcohol and drug use on inpatient and residential treatment among youth with severe emotional disturbance in Medicaid-funded behavioral health plans. *Journal of Psychoactive Drugs*, 36(4), 463–471.
- Dasinger, L. K., Shane, P. A., and Martinovich, Z. (2004). Assessing the effectiveness of community-based substance abuse treatment for adolescents. *Journal of Psychoactive Drugs*, 40(1), 27–33.
- Dennis, M. L., Godley, S. H., Diamond, G. S., Tims, F. M., Babor, T., Donaldson, J., Liddle, H., Titus, J. C., Kaminer, Y., Webb, C., Hamilton, N., and Funk, R. R. (2004). The Cannabis Youth Treatment (CYT) study: Main findings from two randomized trials. *Journal of Substance Abuse Treatment*, 27(3), 197–213.
- Dennis, M. L., and Kaminer, Y. (2006). Introduction to special issue on advances in the assessment and treatment of adolescent substance use disorders. *American Journal on Addictions*, 15(Suppl.1), 1–3.
- Dennis, M. L., Scott, C. K., Godley, M. D., and Funk, R. R. (2000). Predicting outcomes in adult and adolescent treatment with case mix vs. level of care: Findings from the Drug Outcome Monitoring Study. *Drug and Alcohol Dependence*, 60(Suppl.1), p. s51.
- Dennis, M. L., Titus, J. C., Diamond, G. S., Donaldson, J., Godley, S. H., Tims, F. M., Webb, C., Kaminer, Y., Babor, T., Roebuck, M. C., Godley, M. D., Hamilton, N., Liddle, H., Scott, C. K.,

- and CYT Steering Committee. (2002). The Cannabis Youth Treatment (CYT) experiment: Rationale, study design, and analysis plans. *Addiction*, 97(Suppl.1), s16–s34.
- Diamond, G. S., Godley, S. H., Liddle, H. A., Sampl, S., Webb, C., Tims, F. M., and Meyers, R. (2002). Five outpatient treatment models for adolescent marijuana use: A description of the Cannabis Youth Treatment interventions. *Addiction*, 97(Suppl. 1), s70–s83.
- French, M. T., Roebuck, M. C., Dennis, M. L., Diamond, G. S., Godley, S. H., Tims, F. M., Webb, C., and Herrell, J. M. (2002). The economic cost of outpatient marijuana treatment for adolescents: Findings from a multisite experiment. *Addiction*, 97(Suppl. 1), s84–s97.
- French, M. T., Roebuck, M. C., Dennis, M. L., Diamond, G. S., Godley, S. H., Liddle, H. A., and Tims, F. M. (2003). Outpatient marijuana treatment for adolescents: Economic evaluation of a multisite field experiment. *Evaluation Review*, 27(4), 421–459.
- Garner, B. R., Godley, M. D., Funk, R. R., Dennis, M. L., and Godley, S. H. (in press). The impact of continuing care adherence on environmental risks, substance use and substance-related problems following adolescent residential treatment. *Psychology of Addictive Behaviors*.
- Garner, B. R., Godley, S. H., and Funk, R. R. (2002). Evaluating admission alternatives in an outpatient substance abuse treatment program for adolescents. *Evaluation and Program Planning*, 25(3), 287–294.
- Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R., and Passetti, L. L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment*, 23(1), 21–32.
- Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R. R., and Passetti, L. L. (in press). The effect of assertive continuing care on continuing care linkage, adherence, and abstinence following residential treatment for adolescents. *Addiction*.
- Godley, S. H., Dennis, M. L., Godley, M. D., and Funk, R. R. (2002). What does adolescent relapse look like? *Drug and Alcohol Dependence*, 66(Suppl. 1), p. S65.
- Godley, S. H., Dennis, M. L., Godley, M. D., and Funk, R.R. (2004). Thirty-month relapse trajectory cluster groups among adolescents discharged from outpatient treatment. *Addiction*, 99(Suppl. 2), 129–139.
- Godley, S. H., Jones, N., Funk, R., Ives, M., and Passetti, L. L. (2004). Comparing outcomes of best-practice and research-based outpatient treatment protocols for adolescents. *Journal of Psychoactive Drugs*, 36(1), 35–48.
- Godley, S. H., Funk, R. R., and Godley, M. D. (2000). Changes in coping skills following adolescent outpatient treatment (abstract). *Drug and Alcohol Dependence*, 60(Suppl.1), s72.

- Godley, S. H., Godley, M. D., Pratt, A., and Wallace, J. L. (1994). Case management services for adolescent substance abusers: A program description. *Journal of Substance Abuse Treatment*, 11(4), 309–317.
- Godley, S. H., White, M. K., and Passeti, L.L. (2006). Employment and adolescent alcohol and drug treatment and recovery: An exploratory study. *American Journal on Addictions*, 15(Suppl.1), 137–143.
- Godley, S. H. and White, W. A. (2006). Student assistance programs: A valuable resource for substance-involved adolescents. *The Counselor*, 7(2), 66–70.
- Grella, C. E., Scot, C. K., Foss, M. A., and Dennis, M. L. (2008). Gender similarities and differences in the treatment, relapse and recovery cycle. *Evaluation Review*, 32(1), 113–137.
- Hall, J. A., Smith, D. C., Easton, S. D., Hyoggin, A., Williams, J. K., Godley, S. H., and Jang, M. (2008). Substance abuse treatment with rural adolescents: Issues and outcomes. *Journal of Psychoactive Drugs*, 36(1), 109–120.
- Kinlock, T. W., Gordon, M. S., and Battjes, R. J. (2004). Pretreatment illegal activities of a nationwide sample of adolescent substance abuse clients. *Journal of Psychoactive Drugs*, 36(1), 5–12.
- Knudsen, H. K. (2008). Adolescent-only substance abuse treatment: Availability and adoption of components of quality. *Journal of Substance Abuse Treatment*, 36(2), 295–304.
- Libretto, S. V., Weil, J., Nemes, S., Copeland Linder, N., and Johansson, A. (2004). Snapshot of the substance abuse treatment workforce in 2002: A synthesis of current literature. *Journal of Psychoactive Drugs*, 36(4), 489–497.
- Liddle, H. A., Rowe, C. L., Dakof, G. A., Ungaro, R. A., and Henderson, C. E. (2004). Early intervention for adolescent substance abuse: Pretreatment to posttreatment outcomes of a randomized clinical trial comparing Multidimensional Family Therapy and peer group treatment. *Journal of Psychoactive Drugs*, 36(1), 49–63.
- Muck, R., Zempolich, K. A., Titus, J. C., Fishman, M., Godley, M. D., and Schwebel, R. (2001). An overview of the effectiveness of adolescent substance abuse treatment models. *Youth and Society*, 33(2), 143–168.
- Perry, P. D., and Hedges, T. L. (2004). Adolescent and young adult heroin and non heroin users: A quantitative and qualitative study of experiences in a therapeutic community. *Journal of Psychoactive Drugs*, 36(1), 75–84.
- Pollio, D. E., McClendon, J., and Reid, D. L. (2004). Certification and program regulations for inpatient services to youth with addiction: A state-level analysis. *Journal of Psychoactive Drugs*, 36(4), 499–509.

- Roebuck, M. C., French, M. T., and Dennis, M. L. (2004). Adolescent marijuana use and school attendance. *Economics of Education Review*, 23(2), 145–153.
- Ruiz, B. S., Stevens, S. J., McKnight, K., Godley, S. H., and Shane, P. (2005). Treatment issues and outcomes for criminally involved youth from rural and non-rural geographic areas. *The Prison Journal*, 85(1), 97–121.
- Schubert, K., Pond, A. S., Kraft, K. M., and Aguirre-Molina, M. (2004). The adolescent addiction treatment workforce: Status, challenges, and strategies to address their particular needs. *Journal of Psychoactive Drugs*, 36(4), 483–488.
- Sterling, S., Kohn, C., Lu, Y., and Weisner, C. (2004). Pathways to chemical dependency treatment for adolescents in an HMO. *Journal of Psychoactive Drugs*, 36(4), 439–453.
- Stevens, S. J., Estrada, B., Murphy, B. S., McKinight, K. M., and Tims, F. (2004). Gender differences in substance use, mental health, and criminal justice involvement of adolescents at treatment entry and at three, six, twelve and thirty month follow-up. *Journal of Psychoactive Drugs*, 36(1), 13–25.
- Tims, F. M., Dennis, M. L., Hamilton, N., Buchan, B. J., Diamond, G. S., Funk, R., and Brantley, L. B. (2002). Characteristics and problems of 600 adolescent cannabis abusers in outpatient treatment. *Addiction*, 97(Suppl. 1), s46–s57.
- Titus, J. C., Dennis, M. L., White, M. K., Godley, S. H., Tims, F., and Diamond, G. (2002). An examination of adolescents' reasons for starting, quitting, and continuing to use drugs and alcohol following treatment (abstract). *Drug and Alcohol Dependence*, 66(Suppl. 1), p. s183.
- Titus, J. C., Godley, S. H., and White, M. K. (in press). A post-treatment examination of adolescents' reasons for starting, quitting, and continuing the use of drugs and alcohol treatment. *Journal of Child and Adolescent Substance Use*.
- Titus, J. C., White, W. L., Dennis, M. L., and Scott, C. K. (2000). Gender differences in the severity and patterns of victimization among adolescents treated for substance abuse: Intake status and outcomes (abstract). *Drug and Alcohol Dependence*, 60(Suppl. 1), p. S221.
- Turner, W. C., Muck, R. D., Muck, R. J., Stephens, R. L., and Sukumar, B. (2004). Co-occurring disorders in the adolescent mental health and substance abuse treatment systems. *Journal of Psychoactive Drugs*, 36(4), 455–462.
- White, M. K., Godley, S. H., and Passetti, L. L. (2004). Adolescent and parent perceptions of outpatient substance abuse treatment: A qualitative study. *Journal of Psychoactive Drugs*, 36(1), 65–74.

## Appendix F. Drug Strategies

---



### 9 Key Elements of Effective Adolescent Drug Treatment

Excerpted from *Treating Teens: A Guide to Adolescent Drug Programs, Drug Strategies*, 2003

1. **Assessment and Treatment Matching:** Use standard, nationally recognized screening and assessment instruments for youth; address medical (including an exam), psychiatric, family functioning, school performance, peer relationships and socioeconomic issues; review periodically and revise as needed.
2. **Comprehensive, Integrated Treatment Approach:** Youth substance abuse frequently accompanied by other problems. Treatment plan, developed by counselor with adolescent and his/her family, should address problems comprehensively. Services should include psychiatric, health (and sexual health), family counseling, home visits, parent education, recreational/alternative activities, remedial or regular education classes, mentoring, case management/care coordination, and continuing care. Maintain linkages with family, school, primary care, juvenile justice (as needed).
3. **Family Involvement in Treatment:** Engaging parents—or responsible caregiver—increases likelihood that youth will stay in treatment and that treatment gains will be sustained after treatment ends; the more the family is involved, the better the outcomes. Ranges from telephone conversations with counselor to group meetings, to observation of family dynamics with techniques to improve relationships.
4. **Developmentally Appropriate Program:** Programs can't just be adult programs modified for youth. Adolescence is a period of rapid developmental change involving major biological, behavioral and cognitive transitions. The key is to find creative ways to make treatment relevant to the everyday concerns of the adolescent so he or she will be motivated to make the necessary effort to change fundamental behavior patterns.
5. **Engage and Retain Teens in Treatment:** Over half of teens leave treatment early, spending 50 days (7 weeks) in treatment, rather than the recommended length of 90 days. By 90 days, over 75 percent have left treatment. Engaging and motivating youth to make their own internal commitment to change requires creative program content and experienced counselors. Treatment for teens has to have tangible, concrete aspects and outcomes if the teen is to remain engaged.
6. **Qualified Staff:** The strength of the therapeutic alliance—a climate of trust, confidence and acceptance between the teen and his or her counselor—greatly influences the extent to which the program will be able to motivate change. Staff must have experience



or be trained to recognize problems in multiple domains (psychiatric, trauma, learning etc.), understand adolescent development and be responsive to how young people think, and be able to work effectively with families. Clinical supervision and team meetings are productive.

7. **Gender and Cultural Competence:** This is essential in developing a successful therapeutic alliance between the teen and the counselor, particularly for gay and lesbian youth, and adolescents and families with mixed racial and cultural identities. Special issues in designing treatment for adolescent males include learning how to change disruptive behaviors, understanding responsibilities of becoming an adult, HIV risks, date rape and experiencing rites of passage from adolescence to manhood. Abandonment, abuse and depression are key issues adolescent females must address in treatment.
8. **Continuing Care:** Continuing care, or continuing care, for adolescents has been repeatedly shown to reduce the risk of relapse and enhance the maintenance of treatment gains. Yet three in four relapse in the first 3 months following treatment. Continuing care services include relapse prevention training, follow-up plans, and referrals to community resources as well as periodic check-ups 1 month, 3 months, and 1 year after completing treatment.
9. **Treatment Outcomes:** Despite its limitations, adolescent treatment research does offer strong evidence that treatment completion is closely linked to positive outcomes. While few programs can point to results from rigorous evaluations, every program should be able to provide accurate, intelligible data on client retention and completion. Further, a program should be able to document changes in the trajectory of their clients' lives, both while they are in treatment and at periodic intervals in the year following treatment.