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Focus Group Study to Examine Content of Family Meetings in Short-term Substance Use Disorder Treatment

JUDITH FABERMAN, M.S.W.,

Clinical Director, Sunspire Health Spring Hill, Ashby, MA, USA

SCOTT E. PROVOST, M.M., M.S.W.,

Sr. Clinical Project Manager, Division of Alcohol and Drug Abuse, McLean Hospital, Belmont, MA, USA

ROGER D. WEISS, M.D., and

Professor of Psychiatry, Harvard Medical School, Chief, Division of Alcohol and Drug Abuse, McLean Hospital, Belmont, MA, USA

Shelly F. Greenfield, M.D., M.P.H.

Professor of Psychiatry, Harvard Medical School, Chief Academic Officer, Chief, Division of Women's Health, Director, Alcohol and Drug Abuse Clinical and Health Services Research Program, McLean Hospital, Belmont, MA, USA

Abstract

This study explores the content family members find helpful in family meetings that occur while patients are in short-term treatment for substance use disorders. Three focus groups were conducted; two with 23 family members and one with 10 patients who were asked to identify those topics that are helpful or unhelpful for families with and without prior treatment experiences. Families identified education about substance use disorders and an overview of treatment options as useful for family members new to treatment, and an emphasis on response to relapse and family supports as important for those with prior treatment experiences.

Keywords

Family meetings; short-term; treatment; focus groups; substance use disorders

Family involvement is considered an important component of treatment for mental health (Dixon et al., 2001; Glynn, Cohen, Dixon, & Niv, 2006) and substance use disorders (SUDs) (Klostermann & O'Farrell, 2013). In the context of SUD treatment, family members can help motivate individuals with substance use disorders enter and remain in treatment, helping to build upon treatment gains (Daley, 2013; National Institute on Drug Abuse, Revised December 2012). Research has shown that involving family members in the treatment process is effective in facilitating recovery from substance use disorders (Carise, 2000; Johnson, 1986; Meyers, Smith, & Lash, 2003; Meyers & Wolfe, 2004; O'Farrell,

Murphy, Alter, & Fals-Stewart, 2007, 2008a, 2008b). Although beyond the scope of this paper, there is also some evidence to suggest that brief interventions (Copello, Orford, Velleman, Templeton, & Krishnan, 2000; Copello, Velleman, & Templeton, 2005; Templeton, 2009) and community-based educational and support groups (Platter & Kelley, 2012) for family members of individuals with substance use disorders can lead to improved outcomes for the family members themselves, including improved coping and health, reduction of symptoms of stress and decreased enabling.

Most empirically-evaluated family treatment interventions for substance use disorders, such as behavioral couples counseling, either involve multiple sessions or are limited in focus to helping family members intervene to get their addicted loved ones into treatment. Illustrative examples of approaches to helping Concerned Significant Others (family members) intervene in getting their loved ones to recognize a substance use problem and into treatment include the Johnson Intervention (Johnson, 1986) and Community Reinforcement and Family Training (CRAFT) approaches (Brigham et al., 2014; Meyers et al., 2003; Meyers & Wolfe, 2004). The Johnson Intervention approach consists of a confrontational style of intervention whereby family members are coached by a therapist in how to confront an individual with a substance use disorder about their use and the effects on concerned, participating family members. In contrast, the CRAFT approach is an intervention to support and help concerned significant others, including family members, in engaging treatment-refusing substance users into treatment. Research evidence has shown CRAFT to be efficacious and effective in engaging treatment-resistant individuals with substance use disorders compared to confrontational style approaches (Bischof, Iwen, Freyer-Adam, & Rumpf, 2016; Roozen, de Waart, & van der Kroft, 2010). Examples of other interventions are reviewed elsewhere (Copello et al., 2005; Klostermann & O'Farrell, 2013).

The limited research on family treatment interventions in acute-care settings suggests that family-involved treatments may lead to better outcomes by bolstering the likelihood of patients' participating in aftercare treatments and increasing length of abstinence following discharge (O'Farrell et al., 2007, 2008a, 2008b). Research by O'Farrell et al. occurred within an inpatient detoxification setting, where the focus of the brief family treatment (BFT) was to enhance family involvement in the aftercare planning process. The research showed that patients receiving brief family treatment ($n = 24$) were significantly more likely than patients assigned to treatment-as-usual ($n = 21$) to enter a continuing care program post-detoxification. In another study of patients with cocaine use disorders ($n = 99$) and alcohol use disorders ($n = 105$) in an intensive outpatient treatment setting, family involvement in treatment significantly increased the likelihood that the patients would complete the full course of treatment (Carise, 2000).

Families of patients receiving SUD treatment in acute care settings have multiple needs in addition to those related to discharge dispositions and coordination of aftercare planning. Families often need psychoeducational information about SUDs, resources about available family support services, and guidance in recognizing and responding to relapses. In addition, clinicians and case managers working with families in acute care settings often do much more than provide aftercare and resources and arrange and facilitate aftercare appointments.

Little is known about what family members want or find helpful from a family meeting during a brief, acute-care SUD treatment episode.

Conducted with family members of patients with SUDs admitted to a short-term acute care SUD program, the goal of this qualitative focus group study was to understand the views of family members, recruited from a hospital support group offered to family members, regarding what might be helpful or unhelpful in family meetings as part of a short-term SUD program where only one or two meetings might be possible. Particularly, the aim was to investigate what information or topics family members rated as important and recommend to be included in family meetings based on their experiences and perceptions. One focus group of patients was also conducted to assess the degree to which the perceptions of patients were concordant with the perceptions of family members. The study was developed as part of a hospital-wide professional development initiative to engage social workers in practice-based research activities. The study was approved by the Institutional Review Board of McLean Hospital, a New England psychiatric teaching hospital.

METHOD

Sample and Participant Selection

Qualitative focus group methods (Krueger & Casey, 2009) were used to explore family member and patient experiences and perceptions of family meetings in short-term treatment for substance use disorders, defined as 30 days or less. For the family focus groups, family members were recruited from a hospital-based family support group comprised of family members of patients who participated in one of the short-term acute SUD treatment programs at the hospital. We conducted 3 focus groups, consisting of 6–8 family members each, between October 2012 and March 2014. A total of 23 family members participated in the focus groups. The focus groups were facilitated by two members of the research team (J.F. and S.P.). Focus group participants were not required to have prior experiences with family meetings to be eligible for study participation. Researchers recruited participants by attending the family support group and asking for volunteers for participation in a one-hour focus group and completion of two surveys. Eligible participants provided written informed consent for participation and for focus group audio recording at the time of recruitment. Researchers contacted participants one week prior to the focus group as a reminder and to confirm attendance.

For the patient focus group, patients were recruited from an inpatient detoxification unit (average length of stay 4 days) and the hospital's partial hospital and residential treatment programs (average length of stay 10 days). The one focus group was held in April 2014 and consisted of 10 patients. It was facilitated by two members of the research team (J.F. and S.P.). The sampling criteria included interest in participation in the study and treatment team approval based on psychiatric stability and medical safety. To recruit, researchers predetermined the date and time for the focus group, attended the tail end of treatment groups to elicit potential eligible participants, confirmed treatment team approval for participants, obtained informed consent, and ran the focus group on the same day.

Surveys

Family members and patient participants completed two surveys prior to the scheduled focus group. The first was a 13-item demographic survey capturing age, gender, ethnicity, and race. The survey also included questions about the relationship to the patient (for the family members), patient's substance(s) of abuse, family member's or patient's prior experiences with family meetings or support groups, and the length of time since the patient last received SUD treatment at the hospital. The second survey asked participants to rate the importance of addressing each of 17 possible family meeting topics on a 4-item Likert scale from 1 to 4, with one indicating very unhelpful, and four indicating very helpful (see Figure 1).

Focus Group Interview Guide

A 7-item open-ended, semi-structured interview guide was used to facilitate the focus group discussion. Before facilitating the focus group, researchers completed a self-directed training by reviewing the focus group questions and rehearsing the format. The following questions were included in the guide:

- What topic would you recommend be addressed in every family meeting?
- What would the top 1 or 2 topic recommendation(s) be for family meetings with families without prior treatment experiences? Is there information/ advice you heard or wish you had heard from the beginning?
- What would the top 1 or 2 topic recommendation(s) be for family meetings with families who have had prior treatment experiences?
- Are there topics that you recommend NOT be addressed in family meetings?

On average, the focus group discussions took approximately one hour to complete. All focus groups were audiotaped and transcribed. Audiotaped transcripts were prepared for two of the three family focus groups and the patient focus group. One family focus group was not audiotaped due to a tape recorder malfunction; however, notes were taken during the focus group session. The facilitator notes for this one unrecorded focus group session were examined and incorporated into the analysis

Data Analysis

Two members of the research team (J.F. and S.P.) conducted a thematic analysis of the focus group transcripts separately using a deductive approach (Braun & Clarke, 2006). Through this approach, focus group questions were developed in advance in anticipation of a hypothesized difference between family members' needs from a first family meeting compared to subsequent meetings. Themes were compared for reliability and consistency. Any disagreements in coding themes were discussed with feedback and input from a third researcher involved in the project (S.F.G.) until agreement was reached. The authors coded the transcripts with respect to the types of social work processes that occur in treatment, resulting in 6 categories: assessment, agenda setting (organizing the meeting, selecting topics for discussion), counseling style, psychoeducation, advice, aftercare planning, and referral (see Table 2). Each unit of analysis that was identified as part of the same concept

was given a common label. Authors merged similar statements under each category to create a cohesive model.

RESULTS

Family Focus Groups

Twenty-three family members participated in 3 focus groups (See Table 1). The mean age of the family member focus group participants was 61. Ninety-six percent of the focus group participants were white, and 77% of the participants were a parent of a patient with a substance use disorder. Alcohol and opioids were the most commonly used substances according to the responses of the focus group participants. Most of the participants had previous experience with family meetings (68%) and family support groups (86%).

Family focus group participants ranked almost all of the 17 topics as somewhat helpful to very helpful. However, participants ranked aftercare planning and relapse planning as the most important topics to address in a family meeting (See Figure 1). Conversely, they considered strategies to reduce family criticism and information about co-occurring disorders as least important.

Both first-time family members and those with prior treatment experience agreed that helpful interventions needed to focus on assessment, agenda setting, and counseling style (see Table 3). Family member participants reported that assessment and agenda setting to prepare for the meeting are best completed in advance of the family meeting during telephone calls with the social worker. A participant in the focus group stated, “Send an email to me saying like, in the next forty-eight hours she was going to schedule a family meeting and that it was going to address A,B,C,D, and E.”

Analyses of focus group data found that the desired content of family meetings and the degree to which meetings focused on four of the six social work intervention categories differed according to whether or not it was the first treatment experience for families. For instance, family members with *no* prior experience with the treatment system expressed interest in receiving concrete psycho-education and advice. A family member asks:

What is the correct next step? What do we do in the short-term? What do we do when they get out of here? What is their treatment plan? What medicines are they going to come out with? Should they be going home?

In addition, there was a desire for detailed information about the course of substance use disorders, prognostic factors affecting treatment outcome and treatment options. One focus group member asked:

What has been successful to the majority of folks who’ve gone through this, I mean there are obviously lots of ups and downs in the process following the release from a program, but I’d like to know what are those key success factors...that have worked for people?

First-time treatment families stressed the importance of receiving education on the signs of potential relapse and the chronic disease model. In contrast, family members *with* prior

experiences felt that additional information about treatment options and strategies for managing relapses were important. One family member stated:

I know when my wife went through...the 3rd or 4th detox in a very short amount of time... (I realized) she's not going to be able to come home. The people need to understand that there are other treatment options that probably necessitate time away from family.

Experienced family members stressed the importance of understanding that relapse is a learning opportunity and that family members may need to make adjustments in their approach. One family focus group participant asked, "What could we do the second time that we either neglected to do the first time, or did the first time and we shouldn't have done?" Family members with *prior* treatment experiences stressed the importance of addressing the difference between enabling and support, the fact that remaining sober is up to the patient, and the helpfulness of family support in learning to cope (See Table 5).

Patient Focus Group

Ninety-percent of patient focus group participants were white, and 90% identified their primary substance use problem as alcohol. The mean age of the patient focus group participants was 43. Seventy percent of the participants were hospitalized on the inpatient detoxification unit at the time of the study. Forty-percent of the participants had prior experiences with family meetings.

Patient focus group participant ratings of the 17 topics ranged from neutral to very helpful. They rated discussion of aftercare plans, what family can do to help, education about SUDs, and discussing what they should do in case of relapse as the most critical topics to address in family meetings. They rated discussion of co-occurring disorders and recommendation of support groups and other referrals for family members as less helpful for family meetings (see Figure 1).

Like the families, the patients also viewed basic education about SUDs as important topics for family meetings with families new to treatment. Similarly, they agreed with family members that addressing why people relapse would be helpful for families with prior treatment experiences. The patient participants concurred with families in suggesting that the therapist needs to have a clear agenda and create an environment that promotes honesty and open communication in family meetings. The patient participants also stressed the importance of avoiding discussion of the past and issues that would induce guilt and shame, such as negative behaviors they exhibited while using drugs and alcohol. One patient stated her fear "that they're going to make me feel guilty or ashamed, and you know, bring up things that I've done while I was drinking."

The patients in the focus group recommended some concrete intervention strategies to which the family members made general reference in their focus groups, such as educating family members on the importance of removing alcohol and drugs from their homes. A patient suggested the following:

One thing's not keeping alcohol in the house, or you know, trying to avoid certain situations where they don't try to kind of pressure you into going to certain places that, you know, there's a lot of drinking or whatever else.

Like the family member participants, the patients also stressed the importance of sharing an array of options for aftercare and educating the family on what the patient needs to do to recover. The patients stressed the importance of informing families of the fact that relapse happens as well as teaching families that fixing the problem is the responsibility of the patient, not the family. One patient stated:

in the event that you come back for treatment again... (it) might be (helpful) to provide them (with) some statistics about the fact that people do relapse, this isn't uncommon, and people do get better, that it's not uncommon, that this is part of the disease.

Another patient in the focus group shared that:

they can't fix it. We have to fix it. Like if they can give us support and understanding and love, but it's really our responsibility. I know personally, my husband is, he's going to fix everything. But he can fix anything, and he can't fix this. So I see the horrible frustration, and it's not healthy, and he needs to remove, know when to remove himself from my situation.

The patient participants suggested additional content that the family member participants had not addressed, including providing tips for managing tension at home. Many patient participants suggested that educating children about SUDs and ways to cope with the disorder is important to them, for example, "Obviously, talking about the dangers of drinking (and) of drugs would be important, especially if you (have) younger kids." Focus group participants stressed the importance of giving messages of hope. One patient stated "There's gotta be hope that's balanced in reality."

DISCUSSION

The focus group method is an accepted method of qualitative research (Rubin & Babbie, 2013) and focus groups have been used in other areas of research in substance use disorder treatment to examine the experiences of patients (Bell-Tolliver, Kramer, Lynch, & Small, 2012; Connors & Franklin, 2000; Heinz et al., 2010; Matusow et al., 2013). The aim of this research was to investigate what information or topics family members rated as important and recommend be included in family meetings.

Family involvement in substance use treatment settings typically consists of a social worker or counselor providing families with psychoeducation and advice as well as acknowledging family members' feelings and offering support and encouragement (Center for Substance Abuse Treatment, 2004). Psychoeducation and advice for family members can play a role in relapse prevention and/or lengthen the recovery time from relapse to subsequent treatment. Studies of family involvement in substance use disorder treatment, however, have examined multi-session treatment approaches, intervention-based strategies (Johnson, 1986; Meyers et al., 2003; Meyers & Wolfe, 2004), or limited the scope to the facilitation of family

involvement in the aftercare planning process in detoxification treatment programs (O'Farrell et al., 2007, 2008a, 2008b). While a few studies have specifically examined the impact of brief interventions (Copello et al., 2000; Copello et al., 2005; Templeton, 2009) and educational and support groups (Platter & Kelley, 2012) on family outcomes, to our knowledge, this is the first focus group study examining the perceptions and experiences of family members and patients in family meetings in acute care, short-term substance use disorder treatment settings where psychoeducation, advice, and family support are integral components of treatment service .

The results of this study have implications for social work practice and education. Findings from this study suggest that social workers may wish to provide somewhat different, individualized approaches to working with family members of patients with substance use disorders based on whether or not they are new to treatment or have had prior exposure and experience with treatment. Findings from this study also underscore the importance of listening to and learning from family members about their concerns, needs, and preferences from SUD treatment providers. Listening to and learning from family members is crucial for discerning how ready, willing, and equipped they are to support their loved one's course of recovery. This is especially important in short-term, acute-care treatment settings, where social workers are charged with assessing the degree of social support available from family members while patients prepare for the transition along the continuum of care. Additionally, this study reinforces the need for incorporating psychoeducational literature, evidence-based resources (e.g., NIDA and SAMHSA websites), and community resources, including support groups, in preparation for family meetings and as guidance to families for information and support beyond the short-term SUD treatment experience. Ongoing continuing education in communicating information to families about substance use disorders and their treatment as well as skills in agenda setting and family assessment would be useful for social workers to enhance their work with families of patients with SUDs.

The focus group research had some positive, unexpected benefits for the resources available to families in the acute care substance use disorder treatment program, similar to participatory action research in which study participants and researchers work together in pursuit of practical forms of knowledge and change (Lawson, Caringi, Pyles, Jurkowski, & Bozlak, 2015). As a result of the research, the hospital developed a Patient and Family Guide for Substance Abuse Treatment based on feedback from the focus group family members.

Study Limitations

The study has several limitations. The focus groups were conducted in one hospital setting and the results could be an artifact of the composition of the focus group participants. A majority of the participants were white. In addition, a majority of the participants in the focus group had previous exposure to substance use disorder treatment services, and all were recruited from a support group for family members in which they were informed about SUDs and recovery. While we did find some distinctions between the families with and without previous exposure to treatment, it is unknown if these groups differ substantially from one another in their needs from family meetings due to the fact that this was a small-

scale focus group study. Additionally, the majority of family focus group participants were parents; it is possible that spouses, siblings, and significant others may have responded differently.

Conclusion

Further research is needed to explore whether the experiences and needs of family members and patients are similar in other acute care settings with more diverse participants and to develop a menu of clinical strategies and techniques to engage families and patients in the recovery process depending on whether or not they have had prior exposure and experience with the treatment system. Future focus group research may call for separate focus groups for family members who have had any experience with family meetings compared to those without prior experience with family meetings to determine if responses would be different without the group effect (Carey, 1994).

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Figure 1.

Average ratings of family meeting topics by family members (n = 23) and patients (n = 10)

Table 1.

Demographic Data of Family Focus Group Participants

Characteristic (% or M)	Family member (n=22 [*])
Gender (% female)	45%
Age (mean in years)	61
Race (% white)	96%
Relationship to patient:	
Parent	77%
Spouse	9%
Other	5%
Unspecified	9%
Financially supporting patient	36%
Living with patient	32%
Prior experiences with family meetings	68%
Prior experiences with family support groups	86%
Patient has a co-occurring disorder	
Yes	50%
No	16%
Unspecified	14%
Patient's Drug of Choice	
Opiates	32%
Alcohol	64%
Dextromethorphan	4%

^{*} Note: One focus group participant did not complete the Demographic Survey

Table 2.

Demographic data of Patient Focus Group Participants

Characteristic (% or M)	Patient (n=10)
Gender (% female)	40%
Age (mean in years)	43
Race (% white)	90%
Include in a family meeting:	
Parent	77%
Spouse	30%
Child	50%
Sibling	30%
Financially supported by a family member	40%
Living with a family member	40%
Prior experiences with family meetings	40%
Has a co-occurring disorder	50%
Inpatient detoxification	70%
Partial hospital program	30%
Primary substance use problem	
Opiates	10%
Alcohol	90%
Cocaine	10%
Amphetamine	10%
Marijuana	10%
Benzodiazepines	20%
Hallucinogens	10%

Table 3.

Themes from Any Family Meeting

Themes	Examples
1. Assessment and Structuring a. Decisions regarding who belongs in the meeting and how to engage those family members. Decision to include the patient in the meeting.	"...this foundation (is) missing for some people and there needs to be a family meeting, and where that family should be, and who is the family that should be coming to meetings"
b. Stress the importance of the family meeting and schedule <u>early</u> in the admission	"I think the importance is to relate to the family how important that family meeting is. I think it should be discussed almost immediately at the time of admission" "If that family meeting is occurring the day before discharge it's kind of almost too late at that point"
c. Defining goals of the meeting; List of possible topics to address- what are the family and patient priorities	"I just remember going into a family meeting and not having any idea of what it was going to accomplish, or what its intent, outcome was expected to be" "Send an email to me saying like, in the next forty-eight hours she was going to schedule a family meeting and that it was going to address A,B,C,D, and E" "...I've gone to a lot of meetings, and usually the meeting that I go to where I get some material beforehand, not a lot of material but a little bit that kind of prepares me for the meeting- those meetings go better usually, because people are much better prepared to participate in them"
d. Family members' current understanding of addiction, first time or prior experiences and knowledge base	"In terms of family meetings and things, it seems that very different things have to happen at first, second, or third, whatever and where they're coming from and where they're going to... But it does have to focus on education of the family member at that point where they are in the understanding of addiction of their loved one"
e. Define realistic expectations of the current admission/treatment episode f. Begin aftercare planning	"And (define) what our expectation should be from detox, versus a thirty-day program, and start that aftercare treatment discussion immediately"
2. Counseling Style a. Honest and direct b. Candor and Sophistication c. Empathic and appreciative	"...you need to be brutally honest" "Because it's (addiction) definitely a long-term, possibly chronic situation. It seems like candor and knowledge, it's really important in a very sophisticated way, in an encouraging way, present it in an encouraging way as opposed to maybe being harsh about it."
d. Avoid discussion of the following: i. Money ii. The past	"I don't want to talk about who carries the freight, I don't want to talk about what this is costing... I don't want to talk about insurance..." "I wouldn't want to talk about the past; I would want to talk about what to do this afternoon, tonight, tomorrow, the next week, and forget what happened... with the health care professional, you don't want to waste time with that"
iii. Blame or disappointment	"Don't get into the blame game because that is counterproductive"
e. Avoid stigmatizing language- like 'addict'	"Avoid the use of terms like addict, treatment, recovery, whatever, which are stigmatizing in their nature"
f. Avoid family therapy issues- stick	"....Know your boundaries when you're in that"

Themes	Examples
to the agenda	family meeting. Sometimes our patients can be going through a lot of whatever and want to turn it on (the family) (it's important) to have that clinician keep directing it back to the patient and that's why we're here"

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Table 4.**Themes From Those Attending First Time Family Meeting**

Themes	Examples
1. Psychoeducation a. Education about what is addiction, what are realistic recovery expectations- offer statistics	“(I’d like to know) Here are the numbers. And it amazed me it’s not something right up front, it’s just, you just got to know.... If you’re here, what we’re seeing is, if the family does this, this, and this, the chances of relapse are far less.... But to use the statistics”
i. Chronic illness orientation, ‘long haul of it’, ‘there is no long-term quick fix’ with recognition of relapse as a possibility	“We didn’t have enough information on what could possibly happen. We thought, gee, this is great, he’s done now, and he’s going to be fine. And that was so naïve on our part... I think some of these things have to be addressed about what we can expect, what might happen”
ii. Signs that the patient is about to relapse or relapsing	“... what the signs are that we were falling off course; things that would give us some indication that plan might not be working or that plan needed to be adjusted”
b. Overview of key success factors that work for people trying to maintain abstinence (AA/NA, medication-assisted recovery, therapy)	“... What has been successful to the majority of folks who’ve gone through this, I mean there are obviously lots of ups and downs in the process following the release from a program, but I’d like to know what are those key success factors... that have worked for people”
c. Overview of treatment options for addiction recovery- levels of care	“It’d be really helpful to have a real presentation about the AA programs, NA programs, and the value of those programs” “(It would’ve been helpful) if I was given more resources to research on my own”
2. Advice- specific and concrete action items for the family a. How can the family support the patient with maintaining recovery?	“...What is the correct next step? What do we do in the short-term? What do we do when they get out of here? What is their treatment plan? What medicines are they going to come out with? Should they be going home?”
b. Stress the importance of aftercare, consistent care, and coordination with all treatment providers	“I think the importance of aftercare and consistent care and the communication of the plan to the other health care providers, I think is important.”
c. Self-care and support/ counseling for the family- recommend attending multiple times for full benefit	“...going to a family meeting for the first time, what would have been the best thing for me to hear on my first family meeting is to get myself support and start to educate myself how to deal with something that’s not going to be cured in three days”
3. Aftercare Planning- Short-term a. What follows the current level of care? –recommendations for next treatment program and the rationale b. Include multiple program options c. DO NOT create the discharge plan without consulting the family	“I don’t get the flow. I still don’t get the flow. I’ve been listening to it for seven months. I’d like to see it spelled out.... How come PHP is the choice for my daughter?... I’m not a clinician... but I do want to know why somebody is saying that this is going to be the treatment of choice.”
4. Referral a. Family support groups, self-help, family counseling or case management services, individual therapy- depending on assessment of family situation	“By going to family support meeting...it’s almost prepared me for when the relapse did happen and how should I react to it... I think that (it) is important to learn those buzzwords to get you and your loved one through the situation and perhaps that loved one back into recovery and to stop using” “I would have liked it early on if there was a professional (recommending) go to a lot of meetings. Here’s a pile of different types of

Themes	Examples
	meetings”
b. Reading list, resource guide, website information	“I think there should be a resource, a written guide or book or some kind of pamphlet that comes right at admission about what to expect, about what is treatment, what has been tried” “Information in handouts, a website, videos; so (much) information to grasp...”

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Table 5.**Themes From Those Attending Meeting for Families with Prior Treatment Experiences**

Themes	Examples
1. Psychoeducation <ul style="list-style-type: none"> a. Relapse is a learning opportunity for the patient and family-time sober is not time lost, despite relapse b. Effects of substance use disorders on family members' mental health and coping-common reactions 	<p>"My own therapist, when I told her that X had relapsed, she said you know, you can learn a lot from a relapse... this is an opportunity, maybe not that one would seek, but having happened, you can learn from it"</p> <p>"I think you need to stress that it (relapse) wasn't a failure. You know, this is just part of the process"</p>
c. Review of "where the family may have contributed to the current relapse"	<p>"... to look where we went wrong in supporting the first time. That, did we contribute to this relapse, if we did something different, would it not have happened?"</p> <p>"What could we do the second time that we either neglected to do the first time, or did the first time and we shouldn't have done"</p>
d. Healthy limits and boundaries for family involvement- reminder that family has little control over whether or not the addict is successful; it's up to the patient	<p>"The difference between enabling and support, which is a very difficult line for us as family members to adhere to, and a lot of issues were just brought up with the conversation with my daughter"</p> <p>"One thing that I realized in these communications and support groups that we've been going to for many years now it seems, is we as parents... we have very little control. I mean we can write the checks, we can do a number of things, (but) we have very little control over this"</p>
2. Aftercare Planning <ul style="list-style-type: none"> a. What is the patient's recovery plan? Specific living situation, treatments, meetings, etc.- b. DO NOT create the discharge plan without consulting the family c. What is the family plan if the patient relapses? Specific response and recommendations d. Develop a clear set of agreements between the patient and the family- contingency planning 	<p>"Many more things were covered, not just where she would be going, but also because of her relapse history, what choices she should make differently this time"</p> <p>"...Finding empties in the barrel. What do you do when they are all of a sudden back doing the same thing again"</p> <p>"It seems to me it would be helpful for there to be a defined set of agreements between a person who's been using and the family that's been at the effect of that, so that there's real clear communication about what the ground rules are, and whatever the point is of going forward"</p>
3. Referral <ul style="list-style-type: none"> a. Long-term treatment options for current or future referral (in the event of relapse) 	<p>"I know when my wife went through...the 3rd or 4th detox in a very short amount of time... (I realized) she's not going to be able to come home. The people need to understand that there are other treatment options that probably necessitate time away from family"</p>
b. Family support groups, self-help, family counseling or case management services, individual therapy- depending on assessment of family situation	<p>"...make sure the family is getting support it needs as far as the family support programs that are here because a relapse can be really discouraging"</p>