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Marriage and Family Therapy 6 Hrs/Units

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1. Family Therapy Terms and Definitions

Family therapy is a collection of family-based interventions that reflect family-level assessment, involvement, and approaches. A systems model underlies family counseling. The model views families as systems, and in any system, each part is related to all other parts. A change in any part of the system will bring about changes in all other parts (Becvar & Becvar). Family therapy uses family dynamics and strengths to bring about change in a range of diverse problem areas, including substance use disorders (SUDs).

A family is a complex system that attempts to keep equilibrium (or "homeostasis," in family therapy terms). A family may go through a range of responses to keep the family functioning. Some may view these responses as unhealthy, enabling, compensatory, or counterproductive, but they serve a purpose— to keep the system operating. This operating system directly influences treatment engagement, treatment outcomes, use of support systems, and sustained recovery for each family member.

Key Points

✤ Mental health and substance use disorders (SUDs) affect not just those with the disorders, but also their families and other individuals who play significant roles in their lives.
✤ Integration of family-based therapy interventions into treatment honors the important role families can play in the change process.
✤ Families can greatly influence the treatment of any illness, including mental illness and SUDs. Family involvement on any level can:
  ✓ Motivate individuals facing mental illness and/or addiction to receive or continue treatment.
  ✓ Improve overall family functioning.
  ✓ Foster healing for family members affected.
  ✓ Reduce risk in children and adolescents of being exposed to violence and of developing SUDs/mental disorders.
✤ Family counseling in mental health and SUD treatment is positively associated with increased treatment engagement and retention rates, treatment cost effectiveness, and improved outcomes for individual clients and their families.

Rather than focusing solely on individuals who have a presenting problem, mental disorder, or SUD, family counseling widens the focus by shifting attention to clients and their whole families. This shift in focus supports identification of goals as a family group and as individuals within that group. It also creates a transparent atmosphere that helps individuals with a presenting problem, mental disorder, or SUD see that their families are not blaming them or ganging up on them to seek treatment.

Key Terms

Addiction: The most severe form of SUD, associated with compulsive or uncontrolled use of one or more substances. Addiction is a chronic brain disease that has the potential for both recurrence (relapse) and recovery. (This term is not used for diagnostic purposes in the American Psychiatric Association's [APA's] *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* [DSM-5]. This TIP uses "addiction" interchangeably with SUDs for brevity and refers only to addictions related to alcohol or drugs.)

Continuing care: Care that supports a client's progress, monitors his or her condition, and can respond to a return to substance use or a return of symptoms of a mental disorder. Continuing care is both a process of post-treatment monitoring and a form of treatment itself. It is sometimes referred to as **aftercare.**

Family-based interventions: Family-based interventions include those that provide psychoeducation and other assistance to family members and those that involve family therapy. This course uses **family-based interventions** interchangeably with **family counseling.**

Family therapy: Family therapy views the whole family as the primary client and intervenes specifically on a systems level with the family unit. Family therapy may occur across all behavioral health service settings and within behavioral health subspecialties (e.g., mental health services, addiction treatment, prevention). To identify as a marriage and family therapist, a provider must receive specific training and licensing; requirements vary across states. In addition, many family therapists seek specialized training to meet the needs of their clients and the requirements for their profession to treat families.

Family therapy is based on the idea that a family is a system of different parts. A change in any part of the system will trigger changes in all the other parts. This means that when one member of a family is affected by a behavioral health disorder such as mental illness or addiction, everyone is affected. As a result, family dynamics can change in unhealthy ways. Lies and secrets can build up in the family. Some family members may take on too much responsibility, other family members may act out, and some may just shut down. Sometimes conditions at home are already unhappy before a family member's mental illness or addiction emerges. That person's changing behaviors can throw the family into even greater turmoil. Often a family remains stuck in unhealthy patterns even after the family member with the behavioral health disorder moves into recovery. Even in the best circumstances, families can find it hard to adjust to the person in their midst who is recovering, who is behaving differently than before, and who needs support. Family therapy can help the family as a whole recover and heal. It can help all members of the family make specific, positive changes as the person in recovery changes. These changes can help all family members heal from the trauma of mental illness or addiction.

Who attends family therapy?

"Family" means a group of two or more people with close and enduring emotional ties. Using this definition, each person in treatment for a behavioral health disorder has a unique set of family members. Therapists don't decide who should be in family therapy. Instead they ask, "Who is most important to you?" Sometimes members of a family live together, but sometimes they live apart. Either way, if they are considered family by the person in treatment, they can be included in family therapy. Examples include:

➡ Parents
➡ Spouses or partners
➡ In-laws
➡ Siblings
➡ Children
➡ Elected, chosen, or honorary family members
➡ Other relatives
➡ Stepparents
➡ Stepchildren

➡ Foster parents
➡ Foster children
➡ Godparents
➡ Godchildren
➡ Blended family members
➡ Extended family members
➡ Friends
➡ Fellow veterans
➡ Colleagues who care
➡ Mentors
➡ Mutual-help group members
➡ Sponsors

Family therapy goals

There are two main goals in family therapy. One goal is to help everyone give the right kind of support to the family member in behavioral health treatment. The other goal is to strengthen the whole family's emotional health, so that everyone can thrive. Specific objectives for family therapy are unique to each family, and these objectives may change over time. The family decides for itself what to focus on, and when.

Family therapy vs. family education

Family therapy is more than family education. Many behavioral health programs conduct education sessions for families on such topics as a particular mental illness, drug and alcohol addiction, treatment, relapse, and recovery. Families can use this information to better understand what is happening, how it might affect them, and what to do to help the family member in treatment. Education is important, but many families also need help applying the information they have learned. Family therapy provides a safe and neutral space in which everyone learns how to adjust to life with a member recovering from mental illness or addiction. The therapist helps the family make changes so that members support each other and treat each other with respect, stop enabling unhealthy behaviors, and learn to trust each other. Working with a specially trained therapist, family members take a close look at how they act with one another. They look at whether they are conducting themselves in ways that are hurtful or helpful. Family members learn how to modify their behaviors so that they support the needs of the person in recovery as well as the needs of the whole family, including themselves. They also learn how to better communicate with each other, and they practice new ways of talking, relating, and behaving. Sometimes, a family has problems that have been hidden behind the drama of mental illness or addiction. These problems rise to the

surface once the person with a behavioral health disorder goes into treatment. The family therapist can help the family talk together to resolve concerns and mend relationships. The family therapist can refer members of the family to individual counseling if they need or request it.

Who conducts family therapy sessions?

The leader of a family therapy session may be a licensed family therapist, social worker, psychiatrist, psychologist, counselor, or some other type of professional. Whatever the title, the leader must meet the legal and professional requirements for working in family therapy. Special training and skills are required, because family therapy is quite different from one on-one counseling. The professional who conducts family therapy sessions may be associated with a center that specializes in this work. Sometimes the professional is on the staff of the behavioral health treatment program where the family member is a client. It's important that the professional who conducts the sessions be sensitive to the family's unique characteristics. This person does not have to have the same background as the family in terms of culture, race, ethnic group, or any other factor. However, he or she must be respectful and understanding without being judgmental. Typically, the family is provided with a 24-hour crisis phone number. If there is a family emergency between sessions, counseling professionals who staff the crisis line can provide support.

How is family therapy organized?

Family therapy involves the entire family meeting together. Sometimes part of the family meets. The family therapist may work one-on-one with a particular family member, in addition to the family sessions, although this is not typical. Sessions usually last about an hour and take place at a clinic, at the therapist's office, or— less often—in a family member's home. The focus of the session may be on the person in treatment, on another family member, or on the family as a whole. Sessions can be low-key or intense, depending on the purpose of the particular session. Before starting the first session, the therapist may ask family members to sign a contract. This is a way to show that family members agree to certain behaviors, such as to continue individual treatment or to not interrupt each other. Family members also may be asked to sign a consent form to show that they understand the ground rules for privacy and confidentiality. Usually, everyone including the therapist is expected to respect the privacy of what is said during each session and not share it with anyone outside the group. There are some exceptions to this rule, which will be explained on the consent form and by the therapist. In the session, the family therapist may ask questions or listen and observe while the others talk. The therapist does this to learn such things as how

family members behave and communicate with each other and what the family's strengths and needs are. The particular techniques used by the therapist will depend on the phase of treatment for the member in treatment and the family's readiness for change. The family therapist may refer the whole family or individual members to extra sources of help. For example, the therapist may encourage family members to go for individual counseling, to join a mutual-help group, or to take classes on topics such as parenting or anger management.

What happens in a particular session?

There are many things that can happen in family therapy. A session can be devoted to talking about family concerns and how people are feeling. Family members might use the session to talk about a particular crisis or problem that needs solving. Or, they might want to focus on the changes that have been happening. Another possible topic for a family therapy session is coping skills, such as how to deal with anger, regret, or sadness. Sometimes just letting out feelings and talking about them in therapy sessions can bring relief, understanding, and healing. The focus of a session might be on learning how to communicate more effectively with each other. For example, the therapist might coach a family member to speak up, to practice saying "no" to unreasonable demands, or to give a compliment. Family members might be asked to rephrase a statement in a more positive way. The therapist also might help family members improve their listening and observing skills to reduce misunderstanding. Sometimes the therapist asks family members to do homework before the next session. For example, the therapist might ask family members to watch for nice things that other family members say during the week. The therapist might ask family members to eat a meal together or to do something fun together, like play board games or go bowling. The homework is designed to help family members practice new and healthier ways of behaving with each other.

What if family members are unwilling to participate?

Sometimes family members are unwilling to join family therapy. There are many possible reasons for this:

➡ **Fear**. They may prefer to have the family unit stay as it is, even if that is painful, rather than take chances with the unknown.
➡ **Fatigue**. They may be tired of dealing with the issues. Concerns about power. They may feel that they have an advantage the way things are—or that they don't, but family therapy won't fix it.
➡ **Distrust**. They may be unwilling to risk speaking frankly with other family members or in front of a therapist.
➡ **Skepticism.** They may not be convinced that family therapy will be useful, or they may have tried it before and not liked it. It may help to have the family

therapist talk one-on-one with unwilling family members. Together they can identify the reasons for resistance, figure out how to resolve concerns, and discuss the benefits of family therapy. Sometimes what's needed is simply time. Willing members of the family can choose to get started. Unwilling members can join when they are ready.

Effectiveness
Research suggests that behavioral health treatment that includes family therapy works better than treatment that does not. For people with mental illness, family therapy in conjunction with individual treatment can increase medication adherence, reduce rates of relapse and re-hospitalization, reduce psychiatric symptoms, and relieve stress. For people with addiction, family therapy can help them decide to enter or stay in treatment. It can reduce their risk of dropping out of treatment. It also can reduce their continued use of alcohol or drugs, discourage relapse, and promote long-term recovery. Family therapy benefits other family members besides the person in treatment. By making positive changes in family dynamics, the therapy can reduce the burden of stress that other family members feel. It can prevent additional family members from moving into drug or alcohol use. Research also shows that family therapy can improve how couples treat each other, how children behave, how the whole family gets along, and how the family connects with its neighbors. Family therapy isn't always easy. There will be struggles for everyone involved, but the outcome is worth it. Family therapy is an effective way to help the person in treatment, while also helping the family as a whole.

2. Family Therapy Objectives

When someone is affected by mental illness or addiction, it can affect the entire family. When that person enters treatment, the family's pain and confusion don't just go away. How does any family member move past the damage that has occurred? How does the family as a whole strengthen the ties that hold it together? Family therapy is one answer. It works together with individual therapy for the benefit of all family members. This section summarizes some of the core objectives of family-based interventions.

Core objective: Leverage the family to influence change. From the outset, family-focused interventions encourage family members to motivate each other to make important lifestyle changes, including shifts away from toxic symptoms and behaviors. Family therapy also helps families develop effective coping and

communication skills that will promote improvement for each member. Family therapy takes advantage of the strength of family relationships to support all family members in their initiation of and engagement in treatment, continuing care services, mutual aid, and peer support services.

Core objective: Use a strengths-based approach to involve families in treatment. Family involvement can have a positive influence on treatment engagement—and lack of family involvement can derail treatment. Families can have negative effects on treatment in other ways, too. Certain aspects of family relationships and parenting practices can worsen alcohol and drug misuse, relapse risk, stress, and behavioral problems. Using a strengths-based approach, family therapy addresses such problematic family dynamics (e.g., parent–child role reversals), as well as inconsistent or ineffective parenting practices. Family therapy can encourage parenting practices that help prevent mental disorders, mental health problems, and SUDs in children as well as improve treatment outcomes in adolescents, and enhance the family recovery process.

Core objective: Change family behaviors and responses that may support continued toxic symptoms and behaviors. Another core objective is assessing and reorganizing families' behavioral, cognitive, and emotional responses that may unintentionally support significant stress and responsibility on family members. Most families experience stress, loss, and trauma as a direct or indirect consequence of addiction in the family; family therapy focuses on addressing these consequences to improve family functioning and to potentially prevent further stress-related symptoms, substance misuse of spouse or children, and other biopsychosocial effects. Family therapy should adopt a trauma-informed stance. It should also identify and addresses safety concerns (e.g., domestic or sexual violence), the unique needs of the family, and the potential obstacles a family may face in accessing and using family services.

Core objective: Prevent SUDs from occurring across family relationships and generations. Family counseling aims to keep SUDs from moving from one generation or relationship to another. If a parent misuses alcohol or drugs, the remaining family members are at increased risk of developing SUDs and mental disorders or establishing relationships with someone who misuses alcohol or drugs. If the person misusing substances is an adolescent, successful treatment reduces the likelihood that siblings will misuse substances or commit related offenses (Whiteman, Jensen, Mustillo, & Maggs).

FAMILY THERAPY OBJECTIVES

Distrust	➡	**Reconciliation**
Guilt	➡	**Forgiveness**
Stress	➡	**Strength**
Frustration	➡	**Understanding**
Despair	➡	**Hope**
Sadness	➡	**Support**
Anger	➡	**Peace**
Conflict	➡	**Agreement**
Crisis	➡	**Resolution**

Understanding Families

Although many people view "family" as the group of people with whom they share close emotional connections or kinship, there is no single definition of family. Diverse cultures and belief systems influence definitions, and because cultures and beliefs change over time, concepts of family are not static. In some cultures, the definition of family is narrow and determined by birth, marriage, or adoption. In other cultures, more expansive definitions include in the concept of family those individuals who share a household, values, emotional connections, and

commitments. The level of commitment people have to each other and the duration of that commitment also vary across definitions of family.

Family Types

Just as there is no single definition of family, there is also no typical family type. Families are quite diverse in organizational patterns and living arrangements. Some families consist of single parents, two parents, or grandparents serving as parents. Many families are blended, including children from previous relationships. Many others are intergenerational within the household and include extended family members, such as grandparents, uncles, aunts, cousins, other relatives, and close friends. Still other types are adoptive or foster and other families whose members are not biologically related and instead come together by choice. Different family constellations often present specific and predictable challenges. For instance, in newly formed blended families, conflicts are typical between parents on how to parent and between a parent and stepchild on the rights of who can discipline, who holds authority, and so forth. Common challenges for single parents include the stress of balancing many responsibilities while parenting. Understanding family types can help clinicians anticipate expected and normative family issues.

Common Characteristics of All Families

A systems view of families assumes that some core characteristics influence functioning across all family types. In systems theory, the family is a system of parts that is itself embedded in multiple systems—a community, a culture, a nation. Families strive for balance and self-regulate accordingly (Nichols & Davis). The next sections summarize key characteristics of families from a systems perspective.

Subsystems

Subsystems are groupings in the family that form according to roles, needs, interests, and so forth. Subsystems appear in most families among parents, siblings, and couples (Gehart). A subsystem can be one person or several family members. Subsystems have their own roles and rules in the family. For example, in a healthy family, a parental subsystem (including one or more members) maintains some privacy, takes responsibility for providing for the family, and has power to make family decisions. Subsystems can significantly affect individuals' behavior in the family. They can motivate and positively influence a family member. But some subsystems are unhealthy, even if they serve a necessary function in the family—as with a parentified child assuming adult roles that are not age-appropriate.

Homeostasis

Subsystems can significantly affect individuals' behavior in the family. They can motivate and positively influence a family member. But some subsystems are unhealthy, even if they serve a necessary function in the family—as with a parentified child assuming adult roles that are not age-appropriate. Family members work to keep the family stable via emotional, cognitive, and behavioral responses. The idea of stability and balance, or "homeostasis," in the family emerged in the early 1950s, with the development of Bowen's natural systems theory (Rambo & Hibel). This theory suggests that systems try to maintain balance in the interest of preservation. Following is an example of homeostasis in a family affected by SUDs.

Within this two-parent household, the father developed alcohol use disorder and stimulant use disorder. Prior to having three children, he indicated that his primary use was cocaine. After the birth of their first child 12 years ago, he began drinking more alcohol and using stimulants more sporadically. As the father's drinking progressed, the mother focused on controlling his alcohol consumption. She started by monitoring how much he drank and checking on him when he was out (e.g., calling him, going to the bar to fnd him). She also took on increasing responsibilities, like driving their children to all activities, working additional hours out of fear that the father would lose his job, and assuming all household and parenting tasks.

The oldest daughter, age 12, often worried about her father when he went drinking but showed irritation toward him when he was home. She ignored his directives and stopped communicating with him. Meanwhile, she aligned with her mother. Preoccupied with the idea that her father treated her mother unfairly, she began trying to pick up his slack. In so doing, the daughter took on more parenting duties for her younger sister (age 9) and brother (age 6) while she herself had less supervision and more freedom in and outside the home.

After the father entered treatment and accepted continuing care services, both parents felt as if they were having more family difficulties than before, despite working hard to communicate with each other and deal with the effects of addiction on their relationship. They found their oldest daughter hostile and hard to talk to. "She wasn't like this before—but now, if there is a rule to break, she does," the father stated. Neither parent realized the significant challenges their daughter had faced since her father's treatment. She had held a powerful role in the family by serving as a confidant for her mother and surrogate parent for her siblings. That role granted her authority and certain privileges. Her parents were unable to see through their daughter's anger to her pain. They did not yet realize that, in essence, their relied more and more on her daughter for emotional support as her spouse's SUD progressed. daughter had been demoted back to a child's role without enough support. Thus, she was fighting to regain the more powerful role.

In hindsight, the mother stated that her daughter became a "parent replacement, a little adult." She had relied more and more on her daughter for emotional support as her spouse's SUD progressed.

Rules

Families operate with rules. Rules provide guidance on acceptable behaviors and exchanges, and they reflect family values. Most rules are unspoken, but some are more prescriptive, such as not allowing a child to date until he or she is 16 (Goldenberg, Stanton, & Goldenberg). The structure of rules creates a sense of safety—as long as those rules are not too rigid.

Some families hold rules rigidly even when circumstances call for reevaluation. Other families experiencing duress or operating chaotically may not have enough rules. In families with SUDs, unspoken rules develop in response to the effects of drinking or drug use. For example, children may come to understand that they don't ask permission from their mother when she is drinking.

Shared Values, History, and Narratives

Each family holds certain beliefs and values (e.g., specific moral beliefs). Children may move away from these values and beliefs as adolescents or adults, but they are nonetheless influenced by them.

Families have shared histories and often develop defining narratives around past familial events. Individual family members can adopt these narratives even when they were not personally present for key events within that narrative, such as by hearing stories of past events about ancestors. Events in each family member's life can be incorporated into the defining family narrative over time as well.
Based on their values, histories, and significant life events, families assume certain characteristics and identities, such as always having been risk-takers. These translate across generations and influence the selection of partners, hobbies, and occupations (e.g., intergenerational vocations as first responders, military personnel, or healthcare professionals).

Roles

Family members assume certain roles, which often relate to generation (e.g., parent, grandparent), cultural attitudes, family beliefs, gender, and overall family functioning. Some roles develop in response to stress or the underfunctioning of a family member Historically, the addiction field has used role and birth order theory to help families explore how they have adjusted or reacted to SUDs in the family. Roles help families maintain homeostasis, yet certain roles affect the individuals in that role negatively or distract from underlying issues. For example, a family may see a child as the root of their problems, although one or both parents have significant SUDs.

Boundaries

Family boundaries regulate the flow of information in and outside the family. There are individual and generational boundaries within families, as well as boundaries between families and other systems. Appropriate boundaries vary from culture to culture. Families may present with boundaries that initially appear unhealthy but turn out to be a function of culture. Boundary types range from rigid or fixed to diffused. Ideally, boundaries are clear, flexible, and permeable, allowing movement and communication in and outside the family as needed.

However, some families have very strict boundaries that keep people outside the family from engaging with or providing support to family members. Similarly, rigid boundaries can restrict communication or discussions across generations. For example, a father may state, "This is just the way it is in this house," without allowing discussion of the rule or boundary in question.

Other families' boundaries are too loose or too enmeshed. They may reduce privacy and allow inappropriate access to information. For instance, a sister may have a private conversation with her sibling, which the sibling then shares with everyone in the family without the sister's permission. Another example is a child privy to too much adult information about a sibling, parent, or other person.

Power Structures

Some family members have more power or influence than others. Power differences are expected across generations (e.g., between parent and child) but can also occur between parents. There can also be differences in which parent makes which types of decisions for the family.Sometimes, families give decision-making power to children or to a specific child, allowing the child to control relationships between the two parents, between parents and other siblings, and so forth. This occurs often when a family is under stress, or when a parent who had more influence disengages with the family because of an illness, divorce, or SUD.

Clinicians can harness family power structures to foster change. To do so, counselors should realize that power is not always obvious. A family member who seems uninfuential may have more power than one assumes. For example, a family member who appears more subservient may have learned to use somatic complaints to curtail an activity or to communicate disregard for a course of action nonverbally.

Communication Patterns

Each family has patterns of communication. These can be verbal or nonverbal, overt or subtle, and they may reflect cultural influences. They are families' unique means of expressing emotion, conflict, and affection. Communication patterns may not be obvious to one outside the family but can significantly influence how family members act toward each other and toward people outside the family.

> Family therapy is a collection of treatment approaches and techniques founded on the understanding that if change occurs with one person, it affects everyone else in the family and creates a "change" reaction.
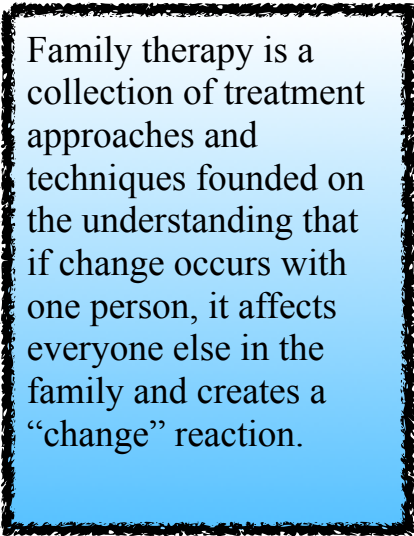
Communication patterns reflect relationship dynamics, including alliances. They can indicate support and respect, or lack thereof, between family members. For example, a teenager in family counseling may look to a parent before answering a question; a husband may roll his eyes when his wife speaks.

Directionality is important in family communication patterns. One directional pattern that frequently occurs is called triangulation (Bowen). Triangulation happens when, instead of communicating directly with a family member who has an SUD, families who are under stress or lack coping skills instead talk around the person or with a third party in the family system. An example would be a mother who calls her daughter to talk about her son's drinking rather than talking to the son himself about his problem with alcohol.

The daughter, in turn, does not redirect or set a boundary with her mother. Triangulation often includes a third person as a go-between, an object of concern, or a scapegoat. Triangulation can involve someone who is not considered a family member.

Durability and Loyalty

Families are durable; membership in a family never expires. Even family members who have moved far away, disengaged emotionally, or become estranged from the family are still a part of it. Some family theorists would go so far as to say, "once in the family, always in the family." Even divorced or deceased family members remain a part of their families' shared histories. Families also tend to be loyal. It can be difficult for family members to divulge secrets or express differences outside the family. Family members can and will oppose certain family beliefs or

report certain family incidents, but when they do so, they normally experience shame, fear, or feelings of disloyalty. Loyalty can be a strength or a limitation for counselors in addressing family problems.

Developmental Stage

All families are engaged in one or more family developmental stages. Families are not static across the life span. Marked by transitions, aging, births, and deaths, extended families undergo developmental stages that predicate the normative stresses, tasks, and conflicts they may face. Understanding these normative stages will help counselors better perceive a family's presenting problems, including SUDs. Clinicians can tailor SUD treatment to meet family needs through developmental tasks. Following is an example of a couple who could benefit from treatment that aligns with their family development stage.

A couple met 25 years ago through a shared interest in the club scene, and they married after 2 years of dating. They have three children who are now in college or living independently. Before having their children, the couple's relationship centered around their use of alcohol and drugs.

Their substance misuse was curtailed throughout the parenting years but escalated after the last child left the home. In recent months, the husband stopped drinking and began receiving treatment at an intensive outpatient counseling program. The husband's abstinence has amplified the couple's sense of being strangers in the same house, which initially became apparent when their children moved out. They feel as if they no longer know what to do with each other or how to be together. The couple frst connected through substance use. Now, they must reconnect with each other through different interests and activities and rework their relationship to center on emotional connection. They would likely benefit from the therapeutic tasks suited to new relationships. Such tasks may include prescribed activities, such as formal dates, and spending time without others to get reacquainted.

Context and Culture

Many systems significantly influence family members and the functioning of the family unit. These include educational, community, employment, legal, and government systems. Families operate as parts of these sociocultural systems, which themselves exist in diverse environments. A family-informed, systems-based approach to SUD treatment will take into consideration questions such as:

➡ What are the current community or geographic stressors?
➡ What are the effects of acculturation?

➡ What economic and supportive resources are available to the family?
➡ Does the family have access to services?

Treatment Issues According to Family Type

Certain treatment issues are more likely to arise in some family types than others when addressing substance misuse in a family member:

➡ **Client who lives with a spouse (or partner) and minor children.** Most data on the effects of parental substance misuse on children demonstrate that a parent's substance misuse often has lasting, negative effects (Calhoun et al.). The spouse of a person who misuses substances is likely to protect the children and assume parenting duties not fulfilled by the parent misusing substances. If both parents misuse alcohol and drugs, the effects on children are likely to worsen.

➡ **Client who lives in a blended family.** Blended families may face unique challenges even when no one in the family misuses substances. Substance misuse can intensify these challenges, making it harder for the family to integrate and find stability.

➡ **Older client who lives with an intergenerational family, including their own children and grandchildren.** An older adult with an SUD can affect everyone in the household. Some family members may try to work around the older person, ignoring SUD-related issues or writing off substance misuse as part of "old age." Many family members are committed to being caregivers, yet they are often left out of treatment decisions and recovery planning (National Academies of Sciences, Engineering, and Medicine). Counselors may need to mobilize additional family resources to treat the older adult's SUD and other comorbid physical conditions.

➡ **Adolescent client who lives with family of origin.** When an adolescent misuses alcohol or drugs, the needs and concerns of siblings in the family may be ignored or minimized while the parents address continual issues and crises related to the adolescent's substance misuse. In many families with adolescents who misuse substances, parental substance misuse is evident (Ali, Dean, & Hedden).

➡ How do culture, race, and ethnicity influence the family (e.g., how are issues of power or oppression at play for the family)?

Sociocultural interventions often stress the strengths of clients and families in specific contexts; such interventions include job training, education and language

services, social skills training, and supports to improve clients' socioeconomic circumstances. Other interventions may involve community- and faith-based activities or participation in mutual-help groups to alleviate stress and provide support.

History of Family-Based Interventions

Family Theory—Initial Research

After War World II, research started to explore the role of families in the development and maintenance of mental disorders. In part, family therapy was an outgrowth of research on communication patterns within families who had a family member with schizophrenia (Bregman & White). Interest in the role of families, family dynamics, and family theoretical approaches appeared to emerge simultaneously in the 1950s among practitioners and researchers in the United States and other countries.

Incorporating the Concept of Systems Into Family Models

Thereafter, family models started to incorporate the concept of systems, which was grounded primarily in psychoanalytic theory (Gladding). This systems-informed theory of the family evolved into several new schools of thought, each of which began to inform specific treatment strategies and training centers. At first, it was typical for practitioners to subscribe to just one model of family therapy. Yet, as more therapists began endorsing an eclectic approach that synthesized several family treatment models, the field witnessed a burgeoning of family therapy applications. Treatment for SUDs, eating disorders, and adolescent behavioral problems increasingly reflected aspects of family therapy.

At the same time, treatment of SUDs as a primary condition was taking hold. As with family therapy's view of SUDs as a symptom of family issues, SUD treatment often viewed substance misuse as a symptom of underlying pathology. As the SUD treatment field evolved, it started to recognize the influence of biological, familial, cultural, and other psychosocial factors on substance use.

3. Different Pathways in Working With Families

Parallel, Integrated, and Sequential Approaches

Parallel
Family therapy and family-based interventions can be an addition to SUD treatment. Parallel approaches deliver family counseling and SUD treatment independently, but at the same time. Some concurrent treatment approaches involve the person with SUD; others treat families separately from the family member with SUD. This depends on providers' philosophy and program logistics. When family counseling and SUD treatment occur at the same time, communication between providers is vital. To prevent treatment goals from conflicting, both providers should have competency in family processes and SUDs. In keeping with the principles of recovery-oriented systems of care (ROSCs), they should work together, in collaboration with the client and family, to improve family functioning, address the dynamics and effects of addiction in the family, and build a family environment that supports recovery for all. Case conferencing is an efficient way for family clinicians and SUD treatment providers to address conflicting service objectives and other concerns constructively in a forum that fosters identification of mutually agreeable priorities and coordination of treatment.

Integrated
Integrated interventions embed family counseling within SUD treatment. The individual with the SUD participates in family approaches as part of the SUD treatment program. Integrated family counseling for SUDs can effectively address multiple problems by taking into account each family member's issues as they relate to the substance misuse, as well as the effects of each member's issues on the family system. The integrated framework assumes that, although SUDs occur in individuals, solutions to substance misuse exist within the family system that will support recovery among all family members. Exhibit 1.7 explores integrated family SUD counseling for individuals who may not initially wish to include family members in their treatment process.

Levels of Family Involvement
Family-based interventions have different functions and require specific clinical and programmatic competencies. For example, in continuing care services, parenting skills training may be implemented after discussing how symptoms, behaviors and related family dynamics have affected parenting.

Understanding Client Reluctance Toward Family Involvement

Most clients are willing to invite a substance-free family member or friend to support their recovery (e.g., when recovering from opioid misuse; Kidorf, Latkin, & Brooner). However, some people with SUDs do not wish to contact their families, and they may not sign a Release of Information that would allow their providers to initiate such contact. This limits the possibilities of family-based interventions, but family involvement in SUD treatment can still be a goal. Family members generally have additional information about clients' behavioral patterns and the effects and consequences of their substance misuse. Even if solicited, this information may feel overwhelming for the person in treatment—yet it can also motivate the person to recover.

As clinicians build therapeutic alliances with clients, they gain insight into clients' hesitancy toward inviting family members into the treatment process. Before promoting family involvement, counselors should understand clients' rationale for preventing it. Their reasons may be well-founded (e.g., a history of abuse or estrangement). Younger clients may try to separate themselves out of a desire to find an identity outside the family. Others may fear what family members will say or feel ashamed of their behavior while using.

Once clinicians understand the reasons behind clients' reluctance to include their families in treatment, it becomes easier to develop respectful strategies to integrate family counseling into SUD treatment. Counselors can make informed decisions with their clients about whether, and how, to involve the family if appropriate and if the client grants permission.

Different programs endorse different strategies to promote family involvement. In programs that promote family services during the intake process and reinforce an ongoing expectation of family inclusion, family participation is typically more accepted.

In residential treatment, family sessions may explore the relational patterns and behavioral consequences of substance misuse or identify specific behaviors

associated with drinking or drug use to establish ways for interrupting those patterns and behaviors. In intensive outpatient treatment, a family component can help individual family members define specific goals to help with family functioning.

4. Family Therapy Approaches

Many family therapy approaches reflect the principles of systems theory. Systems theory views the client as an embedded part of multiple systems—family, community, culture, and society. This chapter will discuss both family therapy that also includes substance use disorder (SUD) treatment principles as well as general family therapy treatment principles. Family therapy approaches specific to SUD treatment require SUD treatment providers to understand and manage complex family dynamics and communication patterns. They must also be familiar with the ways family systems organize themselves around the "identified patient." For example, substance misuse is often linked with other difficult life problems— for example, co-occurring mental disorders, criminal justice involvement, health concerns including sexually transmitted diseases, cognitive impairment, and socioeconomic constraints (e.g., lack of a job or home). The addiction treatment field has adapted family systems approaches to address the unique circumstances of families in which substance misuse and SUDs occur.

It is beyond the scope of this course to cover all family therapy theories and counseling approaches. This chapter reviews the most relevant and research-based family counseling approaches specifically developed for treating couples and families. It describes the underlying concepts, goals, and techniques for each approach. This chapter covers the following family-based treatment methods.

Overview of SUD Family-Based Treatment Methods

Family counseling had its origins in the 1950s, adding a systemic focus to previous understandings of the family's influence on an individual's physical health, behavioral health, and well-being. The models of family counseling that have developed over the years are diverse. They generally focus on either long-term treatment emphasizing intergenerational family dynamics and the family's growth and well-being over time or brief counseling emphasizing current family issues and

cognitive– behavioral changes of family members that influence the way the family system operates.

Family-based counseling in SUD treatment reflects the latter family systems model. For example, in SUD treatment, family counseling focuses on how the family influences one member's substance use behaviors and how the family can learn to respond differently to that person's substance misuse.

When family members change their thinking about and responses to mental illness, symptoms, behaviors, and substance misuse, the entire family system changes. These systems-level changes lead to positive outcomes for the family member who is struggling and improved health and well-being for the entire family.

Family counseling in SUD treatment also differs from more general family systems approaches because it shifts the primary focus from being on the *process* **of family interactions to planning the** *content* **of family sessions.** The clinician primarily emphasizes substance use behaviors and their effects on family functioning. For example, in a couples session in which the couple discusses the husband's return to drinking after a period of abstinence, the counselor would note the interactions between the husband and wife but zero in on the return to use. In doing so, the counselor can develop strategies the couple can use as a team to learn from the experience and prevent another return to use.

Family-based methods this chapter describes reflect core principles of working with family systems. These core principles include (Corless, Mirza, & Steinglass):

➡ Recognizing the therapeutic value of working with family members, not just the individual with the presenting problem, as they deal with the presenting problem.
➡ Incorporating a non-blaming, collaborative approach instead of an authoritative, confrontational approach in which the clinician is the expert.
➡ Having harm reduction goals other than abstinence, which can bring positive physical and behavioral health benefits to the individual and entire family.
➡ **Expanding outcome measures of "successful" treatment** to include the health and well-being of the entire family.
➡ Acknowledging the value of relationships within the family and extrafamilial social networks as critical sources of support and positive reinforcement.
➡ **Appreciating the importance of adapting family counseling methods** to fit family values and the cultural beliefs and practices of the family's larger community.

APPROACH	PHILOSOPHY AND KEY PRINCIPLES	CORE METHODS/GOALS	POPULATIONS/ ISSUES
FOR SUD TREATMENT			
Functional Family Therapy	Behaviorally based family counseling approach based on an ecological model of risk and protective factors	Changes the dysfunctional family behavioral and interactional patterns that maintain the adolescent's substance misuse and reinforces positive problem-solving responses to adolescent risk behaviors; has three treatment phases and associated counseling strategies: engagement and motivation, behavior change, and generalization	Suitable for all families dealing with SUDs; widely disseminated in the United States and other countries
Solution-Focused Brief Therapy	Pinpointing the cause of problematic family functioning is unnecessary; counseling focused on solutions to specific problems is enough to help families change	Helps family members find solutions to their problems instead of emphasizing the problem-solving techniques of structural and strategic counseling approaches; counselors emphasize exceptions to the problem (e.g., substance use) when it does not happen and help identify achievable solutions that enhance motivation and hope for behavioral change	Adults with SUDs or mental disorders; families with a member who has a mental disorder; parents with SUDs and trauma-related symptoms in the child welfare system
Community Reinforcement and Family Training (CRAFT)	Structured, family-focused approach that assumes environmental contingencies are important in promoting treatment entry	Teaches family members and CSOs strategies for encouraging the family member who is misusing substances to change his or her substance use behaviors through positive reinforcement and enter SUD treatment	Suitable for all families dealing with SUDs

Continued on next page

EXHIBIT 3.1. Overview of Family-Based Treatment Approaches Addressed in Chapter 3 *(continued)*

APPROACH	PHILOSOPHY AND KEY PRINCIPLES	CORE METHODS/GOALS	POPULATIONS/ ISSUES
FOR SUD TREATMENT			
Behavioral Couples Therapy (BCT)	Structured approach that focuses on an intimate partner's ability to reward abstinence and other efforts to change and to promote continuing recovery for the person with an SUD	Lessens relationship distress, improves partners' patterns of interaction, builds more cohesive relationships to reduce risk of returns to use for the partner with an SUD, supports abstinence, improves relationship functioning	Appropriate participants are generally couples in which: • Partners are married or living together. • Neither partner has a significant co-occurring mental disorder. • Only one member has substance misuse. • There is no indication of risk of severe intimate partner violence.
Behavioral Family Therapy (BFT)	Based on social learning and positive and negative reinforcements to change behavior; emphasizes the client's substance use behaviors within the family context; counselors view substance misuse as a learned behavior that peers, parents, and role models may reinforce and help maintain	Contingency management strategies to reward abstinence, reduce reinforcement of substance use, and increase positive behaviors and social interactions incompatible with substance use	Suitable for all families dealing with SUDs
Brief Strategic Family Therapy (BSFT)	Draws on structural and strategic family theory and interventions; assumes that adolescent substance misuse and other risk behaviors are linked to dysfunctional family interactions	Interventions target family interactions that are most likely to affect youth substance misuse and other risk behaviors; strategies include: joining, enactments, working in the present, reframing negativity, reversals, working with boundaries and alliances, addressing power structures that affect conflict, and opening closed systems	Adolescents and other relatives dealing with cultural factors around engagement; families in which parental alcohol use is present

APPROACH	PHILOSOPHY AND KEY PRINCIPLES	CORE METHODS/GOALS	POPULATIONS/ ISSUES
FOR SUD TREATMENT			
Network Therapy	A team-based approach to SUD treatment that enlists the help of family and friends to work with the counselor in promoting abstinence; includes components of various approaches to SUD treatment (e.g., cognitive–behavioral therapy, community reinforcement) as well as individual plus group sessions	Engaging family and friends to work with the counselor to help the client to achieve and maintain abstinence; the network also serves as a source of emotional support and encouragement	Adults with SUDs
FOR RECOVERY SUPPORT			
Family Treatment Engagement as a Foundation for Ongoing Recovery	Family, social supports, and community resources are keys to successful long-term recovery for people with SUDs; recovery is not a solo endeavor, but rather, a social process— and family members and CSOs often need their own recovery supports, in addition to the person with the SUD needing such supports	Forging emotional bonds; establishing social cohesion and support; maintaining goal direction; gaining structure; monitoring by family, friends, and other recovery supports; observing good role models; expecting negative consequences for risk behaviors; building self-efficacy; developing coping skills; and participating in rewarding, substance- free social activities	Suitable for all families dealing with SUDs
Family Recovery Support Groups	Family members of people recovering from SUDs benefit from gathering together to help one another learn how to cope with living with a person who has a chronic, debilitating illness	Counselors link families to groups and, in counseling sessions, explore family members' reflections on group participation	Suitable for all families dealing with SUDs

APPROACH	PHILOSOPHY AND KEY PRINCIPLES	CORE METHODS/GOALS	POPULATIONS/ ISSUES
FOR RECOVERY SUPPORT			
Case Management	Addresses the needs of the client with an SUD and family issues related to the client's substance misuse via comprehensive, integrated management of services and service linkages	Assesses major life concerns (e.g., substance misuse), develops an action plan, actively links clients to community-based resources, coordinates care, and monitors participation in services	Families who are or should be involved intensely with larger systems (e.g., criminal justice, child welfare, mental health)
Family Peer Recovery Support Services	Family peer recovery support specialists have lived experience with having a family member with an SUD, mental disorder, or co-occurring disorder; they offer education, emotional support, and resources to family members of those with an SUD	Actively links family members to family-based resources for SUDs, mental health, criminal justice, and child welfare service systems; introduces and actively links them to community-based recovery supports	Suitable for all families dealing with SUDs
Relapse Prevention	Just as people with SUDs are at risk for a return to substance misuse after initiating recovery, family members can also experience a "relapse" or return to old behaviors and strategies for trying to manage the stress of living with a family member's active substance use	Family members create their own relapse prevention plans: • Identify triggers/cues of returns to problem behaviors. • Identify cognitive distortions that may precede relapse. • Learn or reengage coping skills to manage stress of family members' returns to misuse. • Plan for self-care activities to do and supportive people and crisis numbers to call.	Suitable for all families dealing with SUDs

Note: The Johnson Intervention, which was included in the previous version of this TIP, has been removed. After further scrutinizing the research on this treatment approach, several factors raise serious concern. Although there is some evidence of potential benefit in terms of treatment engagement and SUD outcomes (mainly negative urine tests), this evidence is largely from 1999 to 2004 with no recent data in support. Also, it appears this model may do more harm than good, with several researchers noting that many families find it overly confrontational, judgmental, and blaming, and hence most families do not go through with the session wherein they actually confront the client. More importantly, the Surgeon General's recent report on addiction singles out the Johnson Intervention as being ineffective and notes that confrontational approaches in general may lead to negative outcomes (https://addiction.surgeongeneral.gov/executive-summary/report/prevention-programs-and-policies).

MST

Much research on family-based treatment interventions is on adolescents. A meta-analysis found family counseling for adolescent SUDs to be more effective than several individual and group approaches or treatment as usual (Tanner-Smith, Wilson, & Lipsey). Advances in family-based treatment approaches for adolescent SUDs can serve as pilot models for adult treatment. For example, MST was specifically developed as a method for treating adolescents with SUDs who are involved in the criminal justice system. A recent adaptation of MST for emerging adults who are aging out of the child welfare system follows the principles of MST but shifts the primary agent of change from parents to the emerging adult and the emerging adult's social network, which may or may not include the parents. Pilot testing of this adapted approach shows promising outcomes (Sheidow, McCart, & Davis). Another pilot study of MST adapted for mothers with SUDs (MST-Building Stronger Families) found significant reductions in substance use among adults and significantly fewer symptoms of anxiety among children paired with their mothers (Schaeffer, Swenson, Tuerk, & Henggeler).

Systemic–Motivational Therapy

Systemic–motivational therapy is a model of SUD family counseling that combines elements of systemic family therapy and MI. It was developed by Steinglass to treat alcohol use disorder (AUD) in the family but can be applied to other substance misuse. Goals include assessing the relationship between substance misuse and family life, understanding family beliefs about substance misuse, and helping the family work as a team to develop family-based strategies for abstinence.

You can help the family make a hypothesis about the causes of SUDs and create "mini-experiments" to address alcohol misuse in the family. You and the family will collaborate to develop specific criteria to assess the relative success of the mini-experiments. Then adjust treatment strategies according to how successful the mini-experiments were in addressing misuse (Steinglass).

Family interventions are good options in SUD treatment. Use them starting with the least intensive (e.g., counseling and Al-Anon or CRAFT) before moving to the most intensive.

Psychoeducation

Psychoeducation is more than just giving families information about the course of addiction and the recovery process. Goals include engaging family members in

treatment, providing information, enhancing social support networks, developing problem-solving and communication skills, and providing ongoing support and referral**s** to other community-based services (McFarlane, Dixon, Lukens, & Lucksted). Psychoeducation can take place in individual or group sessions with family members, single family group sessions, and multiple family group sessions.

Engaging family members in more intensive treatment is a possible outcome of psychoeducation, but many family members benefit just from learning about mental illness, addiction, recovery, and ways to respond to a family member. Psychoeducation can include providing Internet access and links to information and family recovery resources such as pamphlets, multimedia, and recovery-oriented books. Psychoeducational interventions can also inform families about and provide referral to community-based family supports like Al-Anon and Nar-Anon.

Psychoeducation helps family members:
➡ Understand the biopsychosocial effects of SUDs on the client and family.
➡ Learn what to expect from treatment and the ongoing recovery process of their relative.
➡ Grasp the importance of their support in helping the client initiate and sustain mental health goals.
➡ Build their own support systems and learn coping strategies and skills from other family members.
➡ Increase a sense of support and reduce feelings of isolation and shame.
➡ Including family members in psychoeducation can improve treatment outcomes for clients and enhance the entire family's functioning and well-being.

Family psychoeducation has emerged as a primary treatment choice for people with serious co-occurring SUDs and mental disorders (McFarlane et al.). It has demonstrated effectiveness in reducing returns to use in medium-term outcomes in this population (Zhao, Sampson, Xia, & Jayaram) and is an empirically supported cognitive– behavioral therapy (CBT) approach to SUD relapse prevention (Sudhir).

Psychoeducation is a useful component of relapse prevention in individual, family, and group work. Psychoeducational strategies that can help prevent returns to substance use include:
✓ Offering brief in-session education on SUDs, returns to use, and strategies for relapse prevention.

✓ Assigning homework in the session for the client and family members to do between sessions.
✓ Teaching and practicing problem-solving and communication skills during sessions.
✓ Providing educational handouts for the client and family members to take home and review.
✓ Suggesting reading, audio, or video material the client and family members can review at home.
✓ Creating a family recovery maintenance notebook with educational handouts, homework exercises, in-session exercises, and journal notes on new insights and awareness, the effectiveness of problem-solving and communication strategies, and topics and questions for further exploration.

MDFT

MDFT is a flexible, family-based counseling approach that combines individual counseling and multisystem methods to treating adolescent conduct-related behaviors (Horigian, Anderson, & Szapocznik). MDFT targets both intrapersonal processes and interpersonal factors that increase the risk of adolescent substance misuse (Horigian et al.). Clinicians work in four MDFT treatment domains (Liddle et al.). Each domain has specific goals:

1. **Adolescents:** Enhance their emotional regulation, social, and coping skills; communicate more effectively with adults; discover alternatives to substance use; reduce involvement with peers who use substances, antisocial peers, or both; and improve school performance.
2. **Parents:** Increase their behavioral and emotional involvement with the adolescent, reduce parental conflict, work as a team, discover positive and practical ways to influence the adolescent, improve the relationship and communication between parent and adolescent, and increase knowledge about positive parenting practices.
3. **Family members and relevant extrafamilial others** (e.g., neighbors, teachers, coaches, spiritual mentors): Decrease family conflict, increase emotional attachments, improve communication, and enhance problem-solving skills.
4. **Community:** Enhance family members' competence in advocating for themselves in larger social systems such as school and criminal justice systems.

The multidimensional approach suggests that behavior change occurs via multiple pathways, in different contexts, and through diverse mechanisms. MDFT "retracks" the adolescent's development via treatment in the four domains. Knowledge of adolescent development and family dynamics guides overall counseling strategies and interventions. In MDFT, clinician focus shifts as the

adolescent and family progress through three stages. The stages and related counseling strategies are (Horigian et al.; Liddle et al.):

✓ **Stage I: Build the foundation.**
  - Develop therapeutic alliances with all family members.
  - Explain the MDFT process.
  - Assess risk and protective factors of the individual, parents, family, and extrafamilial systems.
  - Identify personally relevant treatment goals of family members.
  - Use crises and stress to build motivation for change.

> **RESOURCE ALERT: MDFT ONLINE**
>
> The MDFT website (www.mdft.org) provides information about the MDFT method, summaries of its effectiveness in SUD treatment, and training resources, including a no-cost, downloadable clinician manual and training videos.

✓ **Stage II: Prompt action/activate change.**
  - Promote positive change in feelings, thoughts, and behaviors of all family members.
  - Use active listening to empathize and raise hope that change is possible and aligned with goals.
  - Encourage the adolescent to share inner thoughts and experiences.
  - Enhance parenting skills through psychoeducation and behavioral coaching.
  - Encourage parents to set limits on, monitor, and support the adolescent.
  - Teach parents to manage difficult family interactions in the session.
  - Teach advocacy skills to improve family interactions with extrafamilial community systems.
  - Engage community-based supports to help family members sustain family system changes.

✓ **Stage III: Seal the change and exit.**
  - Reinforce behavioral changes of all family members.
  - Explore strategies to maintain change and prevent recurrence of adolescent substance misuse and conduct-related behaviors.
  - End treatment when changes have stabilized.

The MDFT treatment format includes individual and family sessions, sessions with various family members, and extrafamilial sessions. Sessions are held in the clinic; in the home; or with family members at the court, school, or other community

location. The format of MDFT has been modified to suit the clinical needs of different clinical populations. A full course of MDFT ranges between 16 and 25 sessions over 4 to 6 months, depending on the target population and individual needs of the adolescent and family. Sessions may occur multiple times during the week.

MDFT has been applied in geographically distinct settings with diverse populations (it is available in Spanish and French as well as English), including ethnically diverse adolescents at risk for substance misuse. Most families in MDFT studies have been from low-income, inner-city communities; adolescents in these studies have ranged from youth in early adolescence who are at high risk to older adolescents with multiple problems, juvenile justice involvement, and co-occurring SUDs and mental disorders.

Several randomized clinical trials have shown clinically significant effects of MDFT on reducing adolescents' drug use and related behavioral problems in controlled and community-based settings (Rowe). Data also show that family functioning improves during MDFT, and families and adolescents maintain these gains at follow-up (Rowe). For some adolescents, MDFT may be an effective alternative to residential treatment (Liddle et al.).

Behavioral Couples and Family Counseling
Behavioral couples and family counseling promote the recovery of the family member with an SUD by improving the quality of relationships, teaching communication skills, and promoting positive reinforcement within relationships. Two variations of this approach are BCT and BFT.

BCT
BCT is a structured counseling approach for people with SUDs and their intimate partners. It focuses on an intimate partner's ability to reward abstinence and other efforts to change and to promote continuing recovery for the person with an SUD. BCT aims to lessen relationship distress, improve partners' patterns of interaction, and build more cohesive relationships to reduce risk of returns to use for the partner with an SUD (Klostermann & O'Farrell). The goals of BCT are to support abstinence from substances and improve relationship functioning (O'Farrell & Schein).

Typically, clients and their partners attend 12 to 20 weekly sessions. Although there are exceptions to these criteria (McCrady et al.), appropriate participants for BCT are generally couples in which (Klostermann & O'Farrell):

✤ Partners are married or living together for at least 1 year.
✤ Neither partner has a co-occurring mental disorder that would significantly affect participation.
✤ Only one member of the couple has a current problem with substance misuse.
✤ There is no indication of risk of severe intimate partner violence.

The overall therapeutic approach has two main components (O'Farrell & Clements):
1. Substance-focused interventions to build support for abstinence.
2. Relationship-focused interventions to enhance caring behaviors, shared activities, and communication.

The goal of BCT is to create a 'virtuous cycle' (i.e., enlisting the . . . partner's support in the client's goals) between substance use recovery and relationship functioning by using interventions designed to address both sets of issues concurrently and reinforce positive behaviors." (Klostermann, Kelley, Mignone, Pusateri, & Wills). Clinicians begin with substance-focused interventions to promote abstinence, then add relationship-focused interventions after abstinence is stable, with an emphasis on teaching communication skills and increasing positive relationship activities (O'Farrell & Schein).

There is a mutual relationship between substance use and marital conflict. Unpredictable behavior associated with substance misuse contributes to high levels of relationship dissatisfaction, instability, conflict, and stress—all linked to returns to use in people with SUDs. Substance use and relationship conflict reinforce each other in a damaging cycle of interactions that partners have difficulty breaking.

Couples counseling helps couples take substance misuse out of the equation, harness partner support to positively reinforce the client's efforts to remain abstinent, and change relationship dynamics to promote a family environment that is more conducive to ongoing recovery. Stress decreases, the risk of return to use for the person with the SUD is lowered, and interpersonal violence and other relationship problems are reduced (Klostermann, Kelley, et al.).

BCT Interventions

BCT sessions are very structured. Each session has three clinical tasks: (1) review any substance use, relationship concerns, and homework assignments; (2) introduce new material; and (3) assign home practice (Klostermann, Kelley, et al.). Much of the work in BCT happens during completion of out-of-session

assignments. The clinician initially works with the couple to develop a recovery contract that lays the foundation for the ongoing couples work. Counseling strategies include a recovery contract between the couple and clinician, activities and homework exercises that increase positive feelings between partners, shared activities, constructive communication, and relapse prevention planning.

BCT is a family-based treatment with strong evidence of efficacy in treating SUDs. BCT is significantly more effective than individual treatment for both men and women with SUDs in reducing substance use, increasing abstinence, and improving relationship functioning and satisfaction (O'Farrell & Clements).

A review of the research on BCT also found that it is a cost-effective approach to SUD treatment, especially when the cost of fewer returns to use is factored in (Fletcher). Although earlier research focused on men with SUDs and their female partners, BCT used with female clients with SUDs is also associated with better substance- and relationship-related outcomes than the use of individual therapy (O'Farrell, Schreiner, Schumm, & Murphy; O'Farrell, Schumm, Murphy, & Muchowski). Some evidence shows that BCT is effective in treating lesbian and gay couples (Fletcher).

It is generally recommended that BCT be used when only one partner has an SUD (Klostermann & O'Farrell), but BCT appears as effective in couples when both partners have a current SUD and are pursuing recovery as in couples when just one partner is in treatment (Schumm, O'Farrell, & Andreas). Research on elements of BCT that are related to treatment outcomes found that the partner's involvement in couples treatment, less confrontation, and more supportive language for the client's efforts to change drinking behaviors were associated with greater couple satisfaction and reduced drinking (McCrady et al.). Thus, BCT treatment may be particularly effective when both partners are motivated to change and are willing to support each other.

The following sections discuss adaptations of BCT that have been found to be effective in pilot studies. These adaptations open up possibilities for SUD treatment programs to integrate BCT in ways that might better ft your treatment philosophy and approach than standard BCT.

Parenting Skills Training in BCT
BCT not only positively affects the couple, but also has a secondary effect on children in the family (e.g., enhancing children's psychosocial adjustment) even when the children do not participate in treatment (Fletcher). Adding specific

content to BCT on parenting skills enhances the positive effects of this approach, not only on the couple but on the entire family. A randomized controlled study of BCT plus parenting skills training (PSBCT) found significant differences in child adjustment measures between PSBCT and individual treatment of the parent with an SUD and clinically meaningful effects between PSBCT and standard BCT (Lam, Fals-Stewart, & Kelley). Adding six sessions of parent training, which reinforced the skills training sessions in BCT (e.g., adding a "Catch Your Child Doing Something Nice" exercise after the couple practiced the "Catch Your Partner Doing Something Nice" activity), did not compromise the effectiveness of traditional BCT for the couple and enhanced parenting skills to a greater degree than BCT alone (Lam, Fals-Stewart, & Kelley).

BCT for Family Counseling
Many clients live with a family member other than an intimate partner. **There is a mutual relationship between substance use and marital conflict.** O'Farrell, Murphy, Alter, & Fals-Stewart) in which a client and a family member (usually a parent of an adult child) attend 12 adapted behavioral family counseling sessions. The sessions focus on helping the client and family member establish a "daily trust discussion." The family member reinforces the client's intention to remain abstinent from substances, reduce conflict, improve communication, and increase positive alternative activities for the client.

Behavioral family counseling emphasizes daily support for abstinence as in BCT, but focuses less on sharing rewarding activities and practicing communication skills at home. These adaptations provide a better ft with the developmental needs (e.g., increased autonomy, separation) of an emerging adult living with a parent. Research supports the efficacy of this adaptation over individual treatment on treatment retention, increased abstinence, and reduced substance misuse (O'Farrell & Clements).

BFT
BFT treatment approaches are based on social learning and operant conditioning (i.e., using positive and negative reinforcements to change behavior) theories. BFT emphasizes clients' substance use behaviors in a family context (Lam, O'Farrell, & Birchler). Clinicians view substance misuse as a learned behavior that peers, parents, and role models may reinforce (Lam et al.).

To counteract these influences, treatment emphasizes contingency management strategies that reward abstinence, reduce reinforcement of alcohol and drug use, and increase positive behaviors and social interactions incompatible with substance

CLINICAL SCENARIO: INDIVIDUAL COUNSELING WITH A FAMILY FOCUS

If you work with adult clients in individual counseling, you can still work with them following a family systems perspective. This clinical scenario, developed by the consensus panel, describes how the counselor brings the family of origin into counseling metaphorically by using a family genogram to help the client make the connection between his substance misuse and family-of-origin issues. The clinician also initiates brief couples work to help the client stabilize an intimate relationship as a way to support his recovery.

Darius, a 21-year-old man, was referred to a clinic for court-mandated SUD counseling after his third DUI violation; he had been on probation since age 13 for charges including burglary and domestic violence. He had a long history of substance misuse, had been on his own for 8 years, and had no family involved in his life. Darius had participated in several residential treatment programs, but he could not maintain abstinence on his own.

When Darius entered outpatient treatment, he was furious with "the system" and refused initially to cooperate with the counselor or participate in his treatment plan. The counselor was pleased that he did show up for his weekly sessions. The following interventions seemed to help Darius:

➡ The clinician suggested that one treatment goal might be for Darius to get off probation. At the time, he had 18 months of probation remaining.
➡ The clinician helped Darius see how his substance misuse was linked to his criminal justice involvement.
➡ The clinician made a genogram of three generations of Darius' family of origin. It showed family disintegration linked to poverty, substance misuse, and intergenerational trauma (e.g., Darius' experience of childhood neglect; his parents' and grandparents' experiences of racism and culturally influenced childhood trauma).
➡ The clinician initiated couples counseling to help Darius stabilize a significant relationship. After conferring with the probation officer, the counselor decided Darius would benefit from a 6-month trial of naltrexone.
➡ The probation officer required that Darius find regular employment.

During the course of treatment, Darius was able to stop drinking and reevaluate his belief system against the backdrop of his family and the larger judicial system in which he had been so chronically involved. He came to be able to express anger more appropriately and to recognize and process his many losses from family dysfunction. Although many of his family members continued to misuse alcohol, Darius reconnected with an uncle who was in recovery and who had taken a strong interest in Darius' future. Eventually, Darius formed a plan to complete his GED and to begin a course of study at the local community college. The counselor helped Darius examine how his behaviors and the family responsibilities he took on shaped his substance use.

use (Lam et al.). The clinician coaches family members to engage in new behaviors that increase positive interactions and improve communication and problem-solving skills (Lam et al). BFT is not manual based, but it applies evidence-based practices in SUD treatment (e.g., contingency management, communication skills training, CBT) to family counseling. To facilitate behavioral change in a family to support abstinence, use BFT techniques, including:

✓ **Contingency contracting:** These agreements stipulate what each member will do in exchange for rewarding behavior from other family members. For example, an adolescent might agree to call home regularly while attending a concert in exchange for her parents' permission to attend it.

✓ **Skills training:** The counselor may start with general education on communication or conflict resolution skills, practice skills in sessions, and get the family to agree to use the skills at home.

✓ **Cognitive restructuring:** The counselor helps family members voice unrealistic or self-limiting beliefs that contribute to substance misuse or other related family problems. An example of a self-defeating personal belief might be: "To ft in (or to cope), I have to use drugs." Distorted messages from the family might include: "He uses drugs because he doesn't care about us." or "He's irresponsible; he'll never change." The counselor helps the family replace these self-defeating beliefs with those that facilitate recovery and individual and family strengths.

Family Behavior Loop Mapping

The family behavior loop map is a step-by step behavioral chain analysis of the family's interactions and the sequence of events that lead to substance use behaviors and episodes when the client with an SUD refrains from substance use (Liepman, Flachier, & Tareen). The entire family is involved in the mapping process. Older children and adolescents contribute verbally to mapping, and younger children offer information about family interactions via their behavior (Liepman et al.). This visual representation helps family members see their contributions to this systemic, interactive process. It emphasizes that no one person is the cause or victim of the negative effects of substance use behaviors (Liepman et al.). The map identifies alternative behaviors, thoughts, and feelings that lead to "not using" and presents possibilities for discussing ways to break the chain of events. This strategy is rather involved. Providers who wish to use it in their work with families in SUD treatment should seek training by a family counselor experienced in its application.

CLINICAL: COGNITIVE RESTRUCTURING AND PROBLEM-SOLVING
The following clinical scenario, demonstrates the BFT strategies of promoting cognitive restructuring and enhancing problem-solving:

Family: Peter, a 17-year-old White adolescent, was referred for SUD treatment. He acknowledged that he drank alcohol and smoked marijuana but minimized his substance use. Peter's parents reported he had come home a week earlier with a strong smell of alcohol on his breath. The next morning, they confronted him about drinking and drug use. He denied currently using marijuana, saying, "It's not a big deal. I just tried marijuana once."

Despite Peter's denial, his parents found three marijuana cigarettes in his bedroom. For at least a year, they had suspected Peter was using drugs. Their concern was based on Peter's falling grades, his increasingly disheveled appearance, and his new tendency to borrow money from relatives and friends, usually without repaying it.

Peter's older sister Nancy (age 18), and his parents attended the first two family sessions. During the sessions, Peter revealed that he resented his father's overt favoritism toward Nancy, who was an honor student and popular athlete in her school, and his parents' conflicts with each other about unequal treatment of Peter and Nancy. The father was often sarcastic and sometimes hostile toward Peter, criticizing his attitude and problems. Peter viewed himself as a failure and experienced depression, frustration, anger, and low self-esteem. Peter wanted to retaliate against his father by causing problems in the family. In this respect, Peter was succeeding. His substance misuse and falling grades had created a stressful environment at home.

Treatment: The therapist used CBT to address Peter's irrational thoughts (e.g., seeing himself as a total failure) and teach him and other family members communication and problem-solving skills. The therapist also used BFT to strengthen the marital relationship between Peter's parents and to resolve conflicts among family members. The family ended treatment prematurely after eight sessions, but some positive treatment outcomes were realized—an improved relationship between Peter and his father, improved academic performance, and an apparent cessation of drug use based on negative urine test results.

Family Check-Up
A lack of parental involvement in the activities of their children predicts later substance use, according to research. Conversely, research consistently shows that parental monitoring and parent–child communication about substance use reduces the risk of early initiation of substance use and lowers rates of adolescent substance use (Hernandez, Rodriguez, & Spirito).

Family Check-Up (FCU) is a brief assessment and feedback intervention that targets family risk factors linked to substance use, including lack of parental monitoring and low-quality parent–child relationships (Hernandez et al.). FCU integrates principles and techniques of MI and individualized feedback to motivate families to change current family practices to prevent future substance use in children and address current substance use in adolescents (Hernandez et al.).

FCU for adolescents consists of two family sessions (Hernandez et al.):
1. **An initial intake interview** to identify family strengths and challenges, engage the family, and videotape a structured assessment protocol of parent–adolescent interactions.
2. **A feedback session** using MI to support parents to maintain positive parenting practices and change parenting practices associated with adolescent substance misuse.

The feedback session has four components (Hernandez et al.):
1. **Self-assessment:** Parents are asked what they learned about their family from participating in the family interactional assessment.

2. **Support and clarification:** The counselor provides support and clarifes family issues and practices that reduce the risk of adolescent substance use.

3. **Feedback:** The clinician provides personalized feedback on family expectations about substance use, parental supervision and monitoring, and parent–adolescent communication.

4. **Parenting plan:** The clinician facilitates a discussion of the adolescent's strengths and the importance of parents praising positive behavior. The counselor works with the parent to develop a brief written plan to improve family communication and monitor the adolescent's behavior.

Research shows lower levels of adolescent substance use and risk for SUD diagnosis when parents complete the FCU intervention (Hernandez et al.). A systematic review and meta-analysis found that FCU as part of a larger school-based approach reduced marijuana use among adolescents (Stormshak et al.; Vermeulen- Smit, Verdurmen, & Engels).

BSFT
BSFT aims to reduce or eliminate youth drug misuse and change family interactions that support drug misuse through its problem-focused, directive, and practical approach (Gehart; Horigian et al.). Drawing on structural and strategic

family theory and interventions, Szapocznik, Hervis, and Schwartz first developed BSFT to address drug misuse among Cuban youth in Miami. The central assumption of BSFT is that adolescent substance misuse and other risk behaviors are linked to dysfunctional family interactions (e.g., inappropriate alliances, boundaries that are too rigid or loose, parents' tendency to blame adolescents for family problems) (Horigian et al.).

BSFT interventions target family interactions that are most likely to affect youth substance misuse and other risk behaviors. Structural family counseling strategies in BSFT include (Gehart):

✓ **Joining:** The clinician establishes a working alliance with each family member and connects with the family system. The counselor identifies and adjusts to family members' ways of relating to one another, conveys understanding and respect, and listens as each family member expresses feelings.

✓ **Enactments:** The clinician invites the family to recreate dysfunctional interactional patterns that support substance misuse to assess and then restructure them through coaching, modeling alternative ways of interacting, or both. These patterns are typically rigid, so the counselor must take a directive role and have family members develop and practice different interaction patterns.

✓ **Working in the present:** The clinician emphasizes current interactions and focuses less on the past. The family is more likely to get stuck in negative interactional patterns if the conversation focuses on past events. The discussions emphasize events happening in the present.

✓ **Reframing negativity:** The clinician reframes negative interpretations of thoughts, feelings, and actions to promote caring and concern in the family. For example, a counselor may reframe a parent's insistence on a 9:00 p.m. curfew as an act of caring, not a way of controlling the adolescent.

✓ **Reversals:** The clinician may coach one or more family members to do or say the opposite of what they typically do or say to shake up typical interactional patterns. Doing so encourages other family members to change their position in the interaction as well. The counselor then explores the effect on the family's typical interactional pattern.

✓ **Working with boundaries and alliances:** Roles, boundaries, and power establish the order of a family and determine whether the family system works. Standard structural techniques are used to loosen or strengthen boundaries to better meet the developmental needs of family members. The counselor helps family members mark individual boundaries while respecting the individuality of others. To strengthen boundaries, the counselor supports parents' efforts to reestablish authority as a parental unit and makes the

CLINICAL SCENARIO: JOINING AND ESTABLISHING BOUNDARIES

The following clinical scenario, developed by the consensus panel, describes strategies for joining and establishing boundaries in the family.

Family: The client is a 22-year-old White woman who misuses prescribed medication and has depression and schizophrenia. She is the younger of two children whose parents divorced when she was 3. She stayed with her mother, while her brother (age 7 at the time) went with their father. Both parents remarried within a few years. Initially, the families lived near each other, and both parents were actively involved with both children, despite ill feelings between the parents. When the client was 7, her stepfather was transferred to a location 4 hours away, and the client's interactions with her father and stepmother were curtailed. Animosity between the parents escalated. When the client was 8, she chose to live with her father, brother, and stepmother, and the mother agreed. The arrangement almost completely severed ties between the parents. At the time the client entered a psychiatric unit for detoxifcation, the parents had no communication at all. The initial family contact was with the father and stepmother. As the story unfolded, it became clear that the client had constructed different stories for the two-family subsystem of parents. She had artfully played one against the other. This was possible because the birth parents did not communicate.

Treatment: The first task was to persuade the father to ask the mother to attend a family meeting. He and the stepmother agreed, although it took great courage to make the request. The father believed his daughter's negative stories about her relationship with her mother. The older brother (the intermediary for the past 4 years) and his wife also attended the next session. The relationship between the counselor and the paternal subsystem was well established, so it was critical to also join with the maternal subsystem before starting family system work. The counselor helped the mother and stepfather build equal parental status in the group, which gave the mother free rein to tell the story as she saw it and express her beliefs about what was happening.

A second task was to establish appropriate boundaries in the family system. Specifically, the counselor sought to join the separate parental subsystems into a single system of adult parents and to remove the client's brother and sister-in-law as a part of that subsystem. This exclusion was accomplished by leaving them and the client out of the first part of the meeting. This procedural action realigned the family boundaries, placing the client and her brother in a subsystem different from that of the parents.

This activity proved to be positive and productive. After the first hour of a 3-hour session, the parents were comparing information; reframing incorrect assumptions about each other's beliefs and behaviors; and forming a healthy, reliable, and cooperative support system for their daughter. This outcome would have been impossible had the counselor not joined with the mother and father in a way that allowed them to feel equal as parents. Removing the brother from the parental subsystem required the client to deal directly with the parents, who were committed to communicating with each other and to speaking to their daughter in a single voice.

family aware when a family member:
- Speaks about, rather than to, another person who is present.
- Speaks for others, instead of letting them speak for themselves.
- Sends nonverbal cues to influence what another person says or to stop that person from speaking.

✓ **Detriangulation:** In families dealing with SUDs, a child or less powerful person in a conflict is often involved in interactions that can defect or diffuse tension between two family members who are in conflict. This involvement is called "triangulation." One strategy is to literally or metaphorically remove the third, less powerful person from a conflict between two other family members so they can resolve the conflict directly.

✓ **Opening closed systems:** Families dealing with SUDs tend to be "closed" systems that disallow open conflict. Counselors should "open" the system to let each family member express feelings and coach the family on constructive ways to resolve differences instead of avoiding or diffusing conflict.

Research over more than three decades shows the effectiveness of BSFT in engaging and retaining adolescents and family members in treatment, addressing cultural factors related to engagement, reducing adolescent drug use, reducing parental alcohol use, and improving family functioning (Horigian, Feaster, Robbins, et al.; Rowe). BSFT is effective in long-term reductions in adolescent arrests, incarcerations, and externalizing behaviors like aggression and rule-breaking (Horigian, Feaster, Brincks, et al.).

BSFT is a somewhat complex, manual-based treatment approach. Fidelity in community-based settings tends to be low (Lebensohn-Chialvo, Rohrbaugh, & Hasler). Implementation requires extensive training and ongoing supervision.

Functional Family Therapy
Functional family therapy is another behaviorally based family counseling approach. Its goals are to change the dysfunctional family's behavioral and interactional patterns that maintain the adolescent's substance misuse and reinforce positive problem-solving responses to adolescent risk behaviors (Rowe, 2012). It is based on an ecological model of risk and protective factors.
This approach has three treatment phases and associated counseling strategies: engagement and motivation, behavior change, and generalization (Hartnett, Carr, Hamilton, & O'Reilly; Horigian et al.):
✓ **Phase 1: Engagement and motivation** - Engage all members of the family to enhance motivation. - Frame the counselor–family therapeutic relationship as a cooperative effort between experts.

- Reduce negativity and blaming interactions through reframing.

✓**Phase 2: Behavior change** - Assess risk factors and evaluate relational patterns.
  -Help families develop behavioral competencies for parenting, communication, and supervision. - Encourage active listening and clear communication. - Help parents develop/implement rules and consequences for substance use and risk behaviors.

✓**Phase 3: Generalization** - Teach families how to generalize the skills they developed in Phase 2 to new situations and contexts other than the initial target behavior.
  -Anticipate and plan for the possibility of future problems. - Reframe continuing challenges as normal, not as failures of the family or the counseling process.
  -Actively link family members to community-based supports.

Functional family therapy has been widely disseminated in the United States and other countries. A meta-analysis of comparison and randomized controlled studies found significant support for the effectiveness of functional family therapy compared with other treatment approaches, including CBT, psychodynamic, individual, and group counseling for adolescents, parenting education groups, and probation and mental health services (Hartnett et al.). randomized controlled studies found significant support for the effectiveness of functional family therapy compared with other treatment approaches, including CBT, psychodynamic, individual, and group counseling for adolescents, parenting education groups, and probation and mental health services (Hartnett et al.).

Solution-Focused Brief Therapy

In the 1980s and 1990s, Berg and Miller and de Shazer developed a family counseling approach to help family members find solutions to their problems instead of using the problem-solving approach of structural and strategic counseling. The main assumptions of solution-focused therapy are that pinpointing the cause of problematic family functioning is unnecessary and that counseling focused on solutions to specific problems is enough to help families change.

In solution-focused brief therapy, families generate treatment goals. The role of the clinician is to emphasize times when the problem (e.g., substance use behavior) does not occur and help the family identify achievable solutions that enhance motivation and optimism for behavioral change (Klostermann & O'Farrell).

In solution-focused brief therapy, the clinician helps the family develop a detailed, carefully articulated vision of what the world would be like if the presenting

problem were solved. The counselor then helps the family take the necessary steps to realize that vision. Because of its narrow focus on a specific target problem, this therapeutic approach works well with many SUD treatment strategies.

Many family counseling strategies and techniques in solution-focused therapy are basic to any family counseling approach—joining with the family, managing the emotional intensity of family sessions, negotiating treatment goals with the family, and attending to family patterns of interaction (McCollum & Trepper). The following techniques characterize solution-focused therapy, specifically:

✓**Developing a vision of the future:** The counselor invites family members to envision what life would be like without the problem, such as substance misuse. This process engages family members in using their imagination to open up new possibilities for generating solutions to the problem, enhances the family's hope that things can and will change, and highlights the benefits of change.

✓**Asking the miracle question:** This is perhaps the most representative of the solution-focused therapy techniques. It elicits each family member's vision of life without substance misuse. The miracle question traditionally takes this form (De Jong & Berg):

> I want to ask you a strange question. Suppose that while you're sleeping tonight and the house is quiet, a miracle happens. The miracle solves the problem that brought you here. But you're asleep, so you don't know that the miracle has happened. When you awake tomorrow morning, what will be different to show you that a miracle happened and that the problem that brought you here has been solved?

✓**Envisioning interpersonal change:** Counselors help family members set goals that respect the views and needs of other family members. Ask the person with the SUD questions like (McCollum & Trepper):

-What will other family members notice about you as you move closer to your goal to stop drinking?
-If we video recorded your family at Sunday dinner after you quit drinking, what would it look like?
-How would family members be interacting differently?

✓**Identifying exceptions to the problem:**
Sometimes the substance use behavior that brings the family to counseling is absent or less severe. It is important to help the family identify these exceptions and build solutions from there. For example, you might ask each family member about a time when the substance use behavior did not happen. You might ask a

spouse, "Can you tell me about a time when you and your spouse were arguing, but he did not grab a beer from the refrigerator?"

✓**Identifying problem sequences:** The counselor helps the family identify a specific target behavior, like the adolescent leaves the house and smokes marijuana to reduce stress during a parental argument. You then ask a series of questions to identify the sequence of behaviors of all family members that contributed to the problems. These questions might include (McCollum & Trepper):
-When does Tony typically leave the house to get high with his friends?
-Who is there during this event?
-What happens first?
-What did each of you do first?
-What happened next?
-How did this situation end?

✓**Identifying solution sequences:** The next step is to identify the solution sequence of family member behaviors during an exception to the problem sequence. This helps the family shift the focus from the problem to the solution. Families often get stuck in the problem sequence and begin to believe that there is only one outcome to the problem. Questions you can ask to identify the solution sequence during an exception might include (McCollum & Trepper):
-Can you tell me about a time when the sequence started, but Tony didn't go get high with his friends?
-How was this different?
-What did each of you do differently to short-circuit the problem sequence and help with a solution?
-What did each of you do first?
-What happened next?
-What can each of you do differently to make the solution sequence happen again?

Solution-focused brief therapy replaces the traditional expert-directed approach aimed at correcting pathology with a collaborative, solution-seeking relationship between the clinician and the family. It encourages the family to focus on what life will be like when the problem is solved. The emphasis is on the development of a solution in the future, rather than on understanding the development of the problem in the past or its maintenance in the present.

Research supports the effectiveness of solution-focused brief therapy. A review of controlled outcome studies found that it provided significant positive benefits to adults with mental disorders and showed promise for improving family

CLINICIAN NOTE: ASKING THE MIRACLE QUESTION

If the answer to the miracle question is "I don't know," as it often is, encourage the client to take time before answering. Prompt the client, if necessary, with questions like: "Lying in bed, what would you notice that would tell you a miracle had occurred? What would you notice at breakfast? What would you notice at work?" Then: Expand on each change noticed. For example, the counselor might ask, "How would that make a difference in your life?" If the client answered that he would not wake up thinking about drinking, ask, "What would you think about? How would that make a difference?"

Accept the client's answer and do not request alternative responses. Some clients say their miracle would be to win the lottery. The counselor should not dismiss the response by saying, "Think of a different miracle." Instead expand the response by asking questions such as: "What would be different in your life if you won the lottery?" "What would be different if you paid all your bills on time?"
Make the vision interpersonal. Ask, "If your miracle comes true, what would others notice about you?"

Help the client see that elements of the miracle are already part of life. Even if those elements are small, ask, "How can you expand the influence of those small parts of the miracle?"

functioning, particularly for families under stress of having a family member with a mental disorder (Gingerich & Peterson). A study of parents with SUD and trauma-related symptoms who were involved in the child welfare system found that solution-focused brief therapy was effective in reducing substance use and trauma-related symptoms (Kim, Brook, & Akin).

CRAFT
Another much-studied family-based intervention that focuses on CSOs is CRAFT. CRAFT is a structured, family-focused, positive reinforcement approach, usually four to six sessions in length, that teaches family members and CSOs strategies for encouraging the family member who is misusing substances to change his or her substance use behaviors and enter SUD treatment. For example, a positive reinforcer may tell the family member how much the CSO enjoys spending time with him when he is not smoking marijuana or going to a movie with him after a day without drinking. The underlying assumption of CRAFT is that environmental contingencies are important in promoting treatment entry (Bischof, Iwen, Freyer-

Adam, & Rumpf). The counselor's role in CRAFT is to work with family members to change the way they interact with the person who has an SUD and that, in turn, will have an impact on his or her substance use behaviors.
The focus of this intervention is the family.

Community Reinforcement
CRAFT is a prime example of an SUD treatment approach that uses community reinforcement, which promotes SUD recovery by engaging family members and other natural supports in treatment. The goal of community reinforcement is to work together to provide positive incentives for people with SUDs to stop using substances; get progressively involved in alternative, meaningful, positive social activities not associated with substance use; and enter or stay in treatment. Community reinforcement helps family, friends, and social supports positively reinforce behavior change instead of confronting continued substance use or other risk behaviors. People pressed into SUD treatment by confrontation are more likely to return to use than those encouraged to enter through positive reinforcement. CRAFT is effective for clients with SUDs, people with co-occurring SUDs and mental disorders, and people in urban and rural communities.

A Less Structured Approach
CRAFT is highly structured, which works well in some scenarios. It can also be adapted to provide a less structured family-focused approach. This involves providing families and CSOs with psychoeducation on the effects of substance misuse on the family and coaching on communication skills, which include:
• Refraining from blaming and shaming the family member.
• Expressing concern about the family member's substance use behavior and its effects on the family.
• Expressing hope that the family member will get help.
• Offering affirmations and positive reinforcement for any positive change in substance use behaviors.

Family members and CSOs may need encouragement to attend community-based recovery support groups like Al-Anon and Nar-Anon. Research has associated Al-Anon with positive psychosocial and physical outcomes for family members and CSOs (Roozen, de Waart, & Van der Kroft).

Network Therapy
Network Therapy combines aspects of individual, group, and family-based counseling by enlisting the help of a client's family and friends (ideally, three or four people) to work with the counselor to help the client achieve and maintain

abstinence (Galanter; Galanter). It uses three key elements to help people with substance misuse attain lasting recovery: cognitive–behavioral relapse prevention techniques, the client's existing supportive social "networks," and community-based resources that support abstinence (e.g., mutual-aid support programs).

Engagement of Families in Treatment

It is well documented that family, social supports, and community resources are keys to successful long-term recovery for people with SUDs and co-occurring disorders. Recovery is not a solo endeavor; it is a social process. Recovery supports can include spouses, intimate partners, CSOs, parents, extended family members, friends, community members, spiritual mentors, teachers, clergy, recovering peers, employers and coworkers, case managers, and primary care and behavioral health service providers.

Moos noted that **social factors protect people from developing SUDs and may also help them initiate and maintain recovery.** These include forging emotional bonds; establishing social cohesion and support; maintaining goal direction; gaining structure through school, work, or faith-based organizations; monitoring by family, friends, and other recovery supports; observing and imitating positive role models; expecting negative consequences for engaging in risk behaviors; building self-efficacy; developing effective coping skills; and participating in rewarding, substance-free social activities. These processes "are reflected in the active ingredients that underlie how community contexts, especially family members, friends, and self-help groups, promote recovery" (Moos).

Additional Types of Marriage and Family Therapeutic Approaches

Marriage and Family Therapy includes a wide variety of therapeutic approaches including but not limited to:
➡*Structural Family Therapy*: A therapeutic approach that centers on functioning difficulties within the family. This approach guides the practice of marriage and family therapy with an understanding that each family has implied rules which govern it. The therapist strives to "enter" the family to understand and disrupt the dysfunctional patterns, leading to healthier habits and stronger relationships.
➡*Milan Family Therapy*: Emphasis on family systems and behaviors. Milan family therapists work to uncover games families play at both non-verbal and unconscious levels. Once these are recognized, clinicians help families confront and overcome these issues.
➡*Solution Focused (Brief) Therapy*: A solution-focused, short-term form of therapy that focuses on the present and the future, using past events only to gain an

empathetic history. The marriage and family therapist understands that the root cause of problems may be complex, but the solution doesn't have to be. This approach uses specific questions to find appropriate solutions, not confrontation or interpretations.

➡️*Narrative Therapy*: To help clients develop a new narrative about themselves, clinicians use narrative therapy to have couples and families create stories that help to identify their own values and skills and develop an understanding of how they can be applied to live life to those values.

➡️*Cognitive Behavioral Therapy (CBT)*: A short-term, goal-oriented therapeutic approach to problem solving, CBT approaches encourage clients to recognize how they think and behave impacts how they feel. By changing these thoughts, the behavioral and emotional responses change. Focus is on replacing irrational thoughts with more reality based thoughts.

➡️*Contextual Family Therapy*: Contextual Family Therapy integrates individual psychological, interpersonal, existential, systemic, and intergenerational approaches into family therapy. This approach recognizes family dysfunction as being the possible result of imbalance in giving and taking, entitlement and fulfillment, as well as caring and responsibility. By working to establish balanced responsibility, the family dysfunction dissipates and returns to a healthier state.

➡️*Bowen Family Therapy*: This approach emphasizes the balance of two forces within a family unit of togetherness and individuality. This balance is necessary for functioning. Without it, issues arise that are often multigenerational and include triangulation, projection, and differentiation of self.

➡️*Psychodynamic Family (Object Relations) Therapy*: This therapeutic approach works under the principle that all people are motivated by the need to form relationships with others. This approach emphasizes that current problems are often caused by early mental images.

➡️*Experiential Therapy*: Through role play, guided imagery, and props, this approach utilizes an experiential. This approach also includes equine therapy, wilderness therapy, and music therapy. Through these activities, the couple isn't necessarily focused on the "therapy" and is therefore more able to experience success, identify obstacles, problem solve, improve self-esteem, and take responsibility for themselves.

➡️*Emotionally Focused Therapy (EFT)*: A short-term approach that is based on the concept that human emotions are connected to human needs and attachment. This approach can be used to help clients regulate interpersonal emotions.

➡️*Gottman Method Couples Therapy*: The underlying principle of the Gottman Method Couples Therapy is that couples must be willing to be friends, work through conflict, and support each other. This approach focuses on nine key areas that make relationships healthy, referred to as the "Sound Relationship House".

5. Cultural Competence

Chapter 5 of this course will guide clinicians in delivering family-based treatment that is culturally responsive and evidence based. It addresses:
✓**General information about diverse family cultures** and why you, as a provider, need to be aware of their specific treatment/service needs and challenges.
✓**Background issues and aspects of family structure and functioning in specific populations,** which will help guide your approach to meeting the needs of families from a cultural perspective.

CLINICIAN NOTE: CULTURAL CONSIDERATIONS

Culture: Become familiar with roles, boundaries, and power structures in families from cultures that differ from your own. These elements influence the techniques and strategies that will be most effective in family counseling.

Age and gender: Cultural attitudes toward age and gender can affect how you assume the directive role that you take in structural and strategic family-based counseling approaches.

Hierarchies: Certain cultures are very attuned to relative positions in the family hierarchy. Sometimes, children may not ask questions of the parent. Other children will remove themselves from the situation until the parent notices they are not there. You should attend to who is who in the family. Who is revered? Who are friends? What is its history? Where is its place of origin? These are clues to understanding a family's hierarchy.

Family-based interventions are evidence-based, effective approaches to achieving and sustaining treatment goals and long-term recovery, particularly for adolescents (Hartnett, Carr, Hamilton, & O'Reilly; Horigian, Anderson, & Szapocznik; Ventura & Bagley). But the diverse makeup and culture of a family can affect the degree to which individuals and families facing substance misuse can successfully access, engage in, and benefit from SUD treatment. That partly may be because of culture-

related barriers that can make achieving recovery difficult for some families (e.g., language barriers, stigma, or negative attitudes about help seeking).

To successfully use family-based interventions, you must be aware of and pay attention to the unique features of certain family cultures. These features include, for example, the family's structure, communication style, immigration history, experience of individual and historical trauma, and interrelationships with one another.

KEY POINTS

✳ Family cultures often have specific practices, structures, values, and belief systems that can affect mental health issues, substance use and substance-related outcomes.

✳ Understanding the ways in which diverse family cultures function is critical to identifying and addressing family-related factors such as communication patterns, parenting practices, and level of acculturation.

✳ Family separation (e.g., because of immigration or military deployment) a lack of communication may be present across many family cultures. Similarly, racial discrimination, stigma, shame, and prejudice may exert influence across multiple generations, influencing families' help-seeking behaviors. Family characteristics and feelings related to these factors should be addressed as a part of family therapy.

✳ Much of the empirical literature is silent on how best to adapt family-based counseling interventions to the specific needs of the diverse family cultures discussed here. However, to the extent possible, you should still try to use family-based treatment/services that meet families where they are—that is, services matched to the family's level of motivation to change and responsive to their unique change goals.

Scope of This Chapter
The focus of this chapter is on families and the ways in which family-based interventions can be adapted to, and thus more effective for, specific family cultures (i.e., those of diverse racial/ethnic backgrounds, LGBT families, military families).

Resources
To learn more about culture and diversity issues in behavioral health services, SUD treatment, and ongoing recovery support, review these publications from the Substance Abuse and Mental Health Services Administration (SAMHSA):

Advancing Best Practices in Behavioral Health for Asian American, Native Hawaiian, and Pacific Islander Boys and Men: This report offers tools and best practice guidance for working with Asian American, Native Hawaiian, and Pacifc Islander boys and young men ([https://store.samhsa.gov/product/ advancing-best-practices-behavioral-healthasian-american-native-hawaiian-pacifc-islander/ SMA17-5032](https://store.samhsa.gov/product/advancing-best-practices-behavioral-healthasian-american-native-hawaiian-pacifc-islander/SMA17-5032)).

A Provider's Introduction to Substance Abuse Treatment for LGBT Individuals: This manual informs clinicians and administrators about SUD treatment approaches that are culturally responsive to LGBT individuals. It covers cultural, clinical, health, administrative, and legal issues as well as alliance building ([https:// store. samhsa.gov/product/A-Provider-s-Introductionto-Substance-Abuse-Treatment-for-LesbianGay-Bisexual-and-Transgender-Individuals/ SMA12-4104](https://store.samhsa.gov/product/A-Provider-s-Introductionto-Substance-Abuse-Treatment-for-LesbianGay-Bisexual-and-Transgender-Individuals/SMA12-4104)).

Continuity of Offender Treatment for Substance Use Disorders from Institution to Community— Quick Guide for Clinicians Based on TIP 30: This publication guides SUD treatment providers in helping offenders transition from the criminal justice system to life after release, including adaptation to community and work cultures and the culture of recovery. It discusses assessment, transition plans, special populations, family involvement in treatment and transition where appropriate, and confidentiality ([https://store.samhsa.gov/product/ Continuity-of-Offender-Treatment-for-SubstanceUse-Disorder-from-Institution-to-Community/ sma15-3594](https://store.samhsa.gov/product/Continuity-of-Offender-Treatment-for-SubstanceUse-Disorder-from-Institution-to-Community/sma15-3594)).

TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women:* This guide assists providers in offering treatment to women living with SUDs. It reviews gender-specific research and best practices, such as common patterns of initial use and specific treatment issues and strategies (https://store.samhsa.gov/

product/TIP-51-Substance-Abuse-TreatmentAddressing-the-Specifc-Needs-of-Women/ SMA15-4426).

TIP 55, *Behavioral Health Services for People Who Are Homeless:* This manual emphasizes that SUD treatment and mental health service providers can improve their service delivery by understanding the cultural context of clients and having the skills to adapt to a variety of cultures of people who are homeless. It also describes intervention methods to address SUDs during a variety of stages of homelessness rehabilitation and discusses methods providers can use to support recovery from mental illness and substance misuse among people and families who are homeless (https://store. samhsa.gov/product/TIP-55-Behavioral-Health-Services-for-People-Who-Are-Homeless/ SMA15-4734).

TIP 56, *Addressing the Specific Behavioral Health Needs of Men:* This guide addresses specific treatment needs of adult men living with SUDs. It reviews gender-specific research and best practices, such as common patterns of substance use among men and specific treatment issues and strategies (https://store. samhsa.gov/product/TIP-56-Addressing-theSpecifc-Behavioral-Health-Needs-of-Men/ SMA14-4736).

TIP 57, *Trauma-Informed Care in Behavioral Health Services:* Trauma can affect individuals, families, groups, communities, specific cultures, and generations. This manual helps behavioral health professionals understand the impact of trauma on those who experience it. The manual discusses trauma-informed, culturally responsive assessment and treatment planning strategies, and it highlights the importance of context and culture in people's response to trauma and SUD recovery (https:// store.samhsa.gov/ product/TIP-57-Trauma- Informed-Care-in-Behavioral-Health-Services/ SMA14-4816).

TIP 59, *Improving Cultural Competence:* This manual provides more information on working with people from various cultures and providing culturally competent

RESOURCE ALERT: SOCIAL DETERMINANTS OF HEALTH
The Office of Disease Prevention and Health Promotion maintains a website with summaries of many social determinants of health, as well as data and other evidence-based information regarding these determinants (www. healthypeople.gov/2020/topics-objectives/topic/ social-determinants-of-health). The site also provides many links to additional educational resources on this topic.

treatment ([https://store.samhsa.gov/product/ TIP-59-Improving-Cultural-Competence/ SMA15-4849](https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849)).

TIP 61, *Behavioral Health Services for American Indians and Alaska Natives:* This publication offers practical guidance for addressing the social challenges and behavioral health needs of Native American populations in culturally responsive ways ([https://store. samhsa.gov/product/tip-61-behavioral-healthservices-for-american-indians-and-alaska-natives/ sma18-5070](https://store.samhsa.gov/product/tip-61-behavioral-healthservices-for-american-indians-and-alaska-natives/sma18-5070)).

Terminology is important. The term **specific populations** refers to the features of families based on specific, common groupings that influence the process of therapy. The term **culture** often brings to mind concepts related to race and ethnicity but is used more broadly here. In this chapter, **culture** refers to the thoughts, interactions, beliefs, and values of a family that shape the way that family feels, thinks, and talks about and reacts to substance use issues. Indeed, the family cultures described here are known to have their own attitudes, ideas, customs and, in some cases, language that shapes the family and the ways in which its members relate to one another.

Cultural background can shape attitudes about factors like "proper" family behavior, family hierarchy, acceptable levels of substance use, and methods of dealing with shame and guilt. Forcing families or individuals to follow the customs of the dominant culture can create mistrust and lower the effectiveness of counseling. A competent treatment provider, however, can work with a culture's customs and beliefs to improve treatment rather than cause resistance to treatment. Some families may prefer alternative interventions in place of or along with family counseling. In cultures that place a high value on indigenous healing practices and spirituality, such as in some Latino, Asian American, African American, and American Indian/Alaska Native (AI/AN) communities, you can actively support clients with SUDs or mental disorders in using traditional healing approaches, faith-based community resources, and spirituality as supports in their efforts to lower the likelihood of relapse. The key is for you to keep your clients in the center of the conversation about what will be the most effective relapse prevention and recovery strategies for them based on cultural considerations and to adapt approaches to ft the needs of each individual and family.

Behavioral health disparities are real and, if unaddressed, can keep people from achieving and maintaining recovery. Some racial and ethnic groups have higher rates of poverty (which can be intergenerational), domestic violence, childhood and historical trauma, and involvement in the criminal justice system

than the general population. These risk factors can increase the chances of relapse or recurrence of SUDs and mental disorders. Levels of education and of health literacy can also influence awareness of and access to treatment and recovery supports. These and other gaps in treatment access and retention exist for a number of populations, including the groups described in this chapter. Your organization can help reduce disparities in SUD treatment and recovery support by improving outreach and sharing of information, promoting active linkages to culturally diverse community resources, and implementing relapse prevention treatment and recovery promotion initiatives that specifically serve these populations.

Culturally Responsive Family Counseling

Cultural competence is an important feature in family counseling because family therapists must work with families from many cultures. Integrated family counseling works for people from many races, ethnicities, faiths, and educational backgrounds. In many cultures, it is important to include families in treatment. However, a culture's high regard for families does not always equate to healthy family functioning.

Furthermore, **using culturally competent, family-based services may help clients reach better outcomes.** A meta-analysis of seven studies looking at culturally responsive SUD interventions for racial and ethnic minority youth (including studies that used family-based approaches like MDFT, brief strategic family therapy [BSFT], and the Culturally Informed and Flexible Family-Based Treatment for Adolescents [CIFFTA] Program) showed, on average, that these treatments resulted in greater reductions in substance use than nonculturally adapted treatments (Steinka-Fry, Tanner-Smith, Dakof, & Henderson).

To add culture into your treatment approaches:
➡ Engage aspects of the family's culture or religion that promote healing.
➡ Consider the role that drugs and alcohol play in the culture.

You can be culturally competent even if you don't belong to the same cultural groups as the families you serve. You can develop the cultural competence to work with families who affiliate with cultures other than your own. Cultural competence means you pay attention to cultural nuances, learning from diverse clients. Even if you identify with the same culture as a family you treat, don't assume you understand all their cultural views and beliefs. The ways and extent to which culture influences them may differ from your experience.

➡ **Be flexible** and meet families where they are.
➡ Be continuously aware of and sensitive to the differences between yourself and the members of the group you are counseling.

Is the family a homogeneous group or one that represents different backgrounds? What is the significance that family members assign to their own identities and to the identity of the therapist? Does the family live in one community or several different communities? Are those communities the same as or different from the one in which you live? These considerations and responsiveness to the specific cultural norms of the family in treatment must be respected from the start of counseling. Differences within the family also should be explored. If these factors are not apparent or explicit, ask.

✓**Be aware of and sensitive to your own family culture.** Therapists bring their own cultural issues to treatment. Your age, gender, ethnicity, local community, and levels of health literacy and education, as well as other traits, may affect therapeutic processes.

General Considerations When Working With Diverse Family Cultures

Families and family cultures will differ in their structures, values, and beliefs; they also will differ in their treatment needs. However, certain common family features may be present across many family cultures, such as their immigration status and history, level of acculturation (that is, the degree to which individuals or groups adopt the practices of the dominant culture), communication style, and hierarchical structure. **Be aware of these general features, but also remember that each family is different and will operate in its own unique way.**

1. How Is This Family Structured?
The ways families are organized can affect the relationships family members have with each other. These, in turn, can directly affect their communication style, expectations for behavior, and more.

For instance, White, Latino, Hmong, and Somali students living with nuclear families (i.e., families made up of only the parents and their children) have a significantly lower rate of exposure to substance-related risk behaviors and substance use than students living in single-parent or cohabitating households (Areba, Eisenberg, & McMorris).

Hierarchical family structures (i.e., the order/ rank of power and authority within the family, such as patriarchal versus matriarchal) are prevalent in some cultures, including Latino populations (Santisteban, Mena, & Abalo) and Asian populations (Chuang, Glozman, Green, & Rasmi). For example, military families often adopt the same core values and principles that define military culture in general, like respect for authority and adherence to chains of command. The focus on hierarchies and parents as authority figures can affect parent–child conflict and resolution, especially as children age into adolescence and potentially begin to challenge parental authority.

EXHIBIT 5.1. Eight Questions To Consider When Offering Treatment for Families of Diverse Racial/Ethnic Backgrounds

To help lay the groundwork for better understanding a particular family's response to and treatment/service needs for substance use, here are eight questions to ask yourself:
➡ How is this family structured?
➡ What is the role of the extended family?
➡ What is the role of religion or spirituality within this family?
➡ What is the family's immigration/nativity status? How does this affect family members' level of acculturation?
➡ Are there culture-specific family values to be aware of?
➡ How does the family's culture affect their communication style?
➡ How does this family experience racism and discrimination? How do those experiences, along with historical trauma, affect the family?
➡ Has the family experienced any periods of separation (particularly between parent and child)?

A related aspect of a family's hierarchy and power structure is the way in which the family views and uses child discipline. For instance, many African American households value child discipline as a critical part of childrearing that can effectively shape children's behavior and help them make good life choices (Adkison- Johnson). Understanding the intent and use of specific disciplinary strategies, as well as whether discipline is carried out primarily by male or female adult relatives, can help you better work with families to improve parenting

practices and reduce negative child behavior (like substance use) in a way that matches their cultural values.

2. What Is the Role of the Extended Family?

Extended family members within the household are typical in many cultures, especially those of diverse racial and ethnic backgrounds. For example, some families consist of grandparents raising their grandchildren; other families have multiple family groups dwelling together (e.g., two sisters and their spouses and children share a single-family home). Still others may include multiple generations —perhaps a single parent, grandparent, and adult sibling—all sharing the responsibility of raising a child. But how does extended family relate to substance misuse?

In a nationally representative survey (Cross), 35 percent of children reported ever living in an extended family unit. Responses differed significantly by race and ethnicity, with only 20 percent of White children reporting having lived with an extended family versus 57 percent of African American children, 35 percent of Latino children, and 34 percent of "other race" children ("other race" was not defined by the study authors).

When it comes to substance misuse, extended families can be both positive and negative. Findings from the Los Angeles Family and Neighborhood Study and the decennial census (Kang) suggest that children living with extended family members are at an 18-percent increased risk of internalizing disorders and a 22-percent increased risk of externalizing disorders compared with children living in nuclear families. Extended families may exacerbate child misbehavior by increasing strain on family resources (e.g., leaving less time and money for the child), interfamily conflicts, and ineffective collective monitoring of children by multiple family members (Kang, 2020). In some research, extended family members introduced youth to substance use (Gilliard-Matthews, Stevens, Nilsen, & Dunaev). Other studies suggest extended families can be protective against child/adolescent misbehavior and maladjustment (Bai, Leon, Garbarino, & Fuller), including substance use (Areba et al.) and can be an effective part of family counseling for SUDs (Zweben et al.). For example, in a qualitative study of Mexican youth (Strunin et al.), extended family members acted as mentors who provided guidance about safe and acceptable alcohol consumption and modeled negative effects of alcohol misuse, positively shaping youth behavior.

3. What Is the Role of Religion or Spirituality Within This Family?

Many diverse family cultures find strength and support from their spiritual or religious beliefs and activities, including prayer and attending services at faith-based institutions.

Religious or spiritual beliefs or activities may influence the family's engagement and participation in counseling. For instance, African American individuals may seek help from spiritual or religious leaders (Wong, Derose, Litt, & Miles,) or may view mental illness through a spiritual or religious lens. In Latino communities, church leaders, such as priests, may be sources of help seeking or referrals for formal treatment (Cuadrado). Treatment providers should understand that cultural beliefs and practices may influence help-seeking behaviors. Thus, some families may be reluctant to accept services or may decline them altogether.

Family encouragement of faith-based activities can help people seeking assistance. In the National Longitudinal Study of Adolescent Health, Latino emerging adults engaged in public religious activities (e.g., attending church services, participating in church-related social activities) were less likely to binge drink or use cannabis than youth who were not "publicly religious" (Escobar & Vaughan).

4. What Is the Family's Immigration/ Nativity Status? How Does This Affect Family Members' Level of Acculturation?

To understand family cultures and their subgroups, you must learn about their immigration history (Marsiglia, Nagoshi, Parsai, & Castro). Family-based interventions, including prevention programming, also may have different effects depending on nativity (Cordova, Huang, Pantin, & Prado).

Some people leave their home country voluntarily to pursue opportunities or escape poverty. Refugees, on the other hand, may fee persecution, fear for their safety, and have much more pain and anger associated with their migration. Those who come from war-torn countries may show symptoms of posttraumatic stress disorder (PTSD) and other associated trauma.

Immigration status can affect parent–child relationships when one or both parents immigrate before the child. Parent–child separation can cause major stress and dysfunction in family relationships (e.g., poor attachments, feelings of abandonment). When people immigrate to the United States, it is not uncommon for them to feel family, work, and money-related stressors, which can increase the chances of family disturbance.

Degree of acculturation is linked to mental health, substance use behaviors, and treatment outcomes. Among Latinos and Asians, greater acculturation may increase the risk of alcohol use, whereas lower acculturation and more recent immigration status may lower the risk of substance misuse because of the presence of protective factors like stronger family cohesion (Vaeth, Wang-Schweig, & Caetano).

Differences in acculturation may be particularly relevant in cases where a person is using substances to cope with stress related to parent–child differences in acculturation. A study of SUD treatment outcomes from motivational enhancement provided to Latino individuals found differences among subgroups (e.g., Cuban Americans, Mexican Americans, Puerto Ricans, and other Latino Americans) and among levels of acculturation, including differences in treatment retention and percentage of days abstinent (Chartier et al).

5. Are There Culture-Specifc Family Values To Be Aware Of?

Strong and stable cultural values may be protective against mental illness, mental health disorders, and substance misuse in racially and ethnically diverse families, such as Latino families (Cruz, King, Cauce, Conger, & Robins):

> **CLINICIAN NOTE: AFFILIATION WITH MULTIPLE CULTURES AND CULTURES WITHIN A CULTURE**
>
> People often affiliate with multiple cultures to varying degrees—cultures centered on race/ ethnicity, gender, profession, age, economic class, geographic location, education level, and so on. For example, a married heterosexual African American couple from a rural parish in Louisiana might view their cultural identity very differently than a single gay African American father living in Manhattan. All may identify with aspects of African American culture; this facet of their cultural identities may figure more or less prominently than being part of married versus single culture, rural versus urban culture, straight versus gay culture, and so forth. Additionally, there are often cultures within a culture—one may, for example, be part of Korean culture, and within that culture, affiliate strongly with the subculture of Korean Catholicism.

▶Familism or familismo may be present in Latino families (Santisteban et al.). These terms refer to the primary values, structures, and expectations of the family, which shape each family member's behavior. Familism may lead family members to make decisions that are best for the family as a whole as opposed to the individual. It has three components:

(1) Perceived duties related to helping family members;
(2) Dependence on family members' support; and
(3) Use of family members as behavioral and attitudinal referents. Familism emphasizes enmeshment within the family, high family loyalty, and pride in the family as a cohesive unit.

High familism may be beneficial in shaping healthy behaviors if that is what is valued by the family. However, if unhealthy behaviors occur within the family, especially across generations, familism may reinforce these negative behaviors by normalizing them.

6. How Does the Family's Culture Affect Their Communication Style?

Understanding the culture-specific ways in which family members talk with one another will help you better understand the context for how the family functions, the dynamics between family members, and what contributes to the family's dysfunction. This in turn can inform the person's chances of achieving and sustaining recovery from substance misuse. Communication style also can shape the way families resolve conflicts.

➡The concept of respeto refers to Latino values of respect in the family, which can influence communication and dealing with conflict between parents and children. Openly disagreeing with parents or voicing one's opinion goes against the concept of respeto and is considered negative behavior (Santisteban et al.). Thus, counseling techniques that fail to account for respeto and that urge adolescents to "speak out" against their parents may be counterproductive.
➡Simpatía, a focus on interpersonal relationship harmony, is another aspect of traditional communication styles in many Latino families. Greater respeto and simpatía have been linked to lower levels of Latino youth drug and alcohol use over 3 months and to abstinence from substances (Ma et al.).

7. How Does This Family Experience Racism and Discrimination? How Do Those Experiences, Along With Historical Trauma, Affect the Family?

Feelings of racism and discrimination can increase the risk for substance misuse among people of diverse races and ethnicities. In the National Latino and Asian American Study (Savage & Mezuk), discrimination increased the risk of lifetime AUD and drug use disorder by 1.4 to 1.54 times.

Structural racism has led to multiple systemic effects on African American families in many forms, such as socioeconomic disparities, voter suppression, educational disadvantages, and racial discrimination (Kelly, Maynigo, Wesley, &

Durham). These challenges are significant stressors and may increase the changes seen in individuals misusing substances as a coping mechanism.

Also, be sure to acknowledge the significance of historical trauma, and consider whether it is playing a role in the family's problems. Certain cultures, like African American and AI/AN populations, have suffered for decades from social injustices, extreme physical and emotional trauma, and ongoing discrimination and prejudice. These experiences have had lasting effects on individuals and families. For instance, there is a widely held belief in AI/AN cultures that loss of culture because of historical trauma and ongoing mistreatment is a primary cause of mental disorders and SUDs in this population today (SAMHSA). It may be important to address such issues with families before families with substance misuse can fully recover.

8. Has the Family Experienced Any Periods of Separation (Particularly Between Parent and Child)?

In certain family cultures, parent–child separations may happen, sometimes repeatedly. Notable examples include families in which parents and children have immigrated separately and military families in which a parent has been deployed. In some of these cases, one parent may take over parenting responsibilities alone, grandparents may take over the duties of raising children, or children may stay with other members of their extended family or with family friends.

Parental separation from children is a strong independent risk factor for early substance use in children. In a sample of more than 3,000 adolescent and adult children (about 26 percent of whom were African American and 8 percent of whom were of unspecified race or ethnicity), parental separation happening between ages 12 and 17 was as strong a predictor of initiating alcohol use before age 13 and of initiating cigarette and cannabis use before age 16 as living in a household with two parents with AUD (McCutcheon et al.).

Youth in military families are at an increased risk of substance misuse compared with adolescents from civilian families. In one study, military family youth were 50 percent more likely than civilian youth to report both current and lifetime substance use (Sullivan et al.). Long deployments are particularly stressful to children and parents and increase the odds of psychological maladjustment (Nicosia, Wong, Shier, Massachi, & Datar,).

6. Telehealth

State Telehealth Laws and Regulations
This section is for informational purposes only, and is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative. Always consult with counsel or appropriate program administrators.

Introduction
The Center for Connected Health Policy's (CCHP) Fall 2019 release (most recent release as of 2021) of the "State Telehealth Laws and Reimbursement Policies" report highlights the changes that have taken place in state telehealth policy. The report offers policymakers, health advocates, and other interested health care professionals a summary guide of telehealth-related policies, laws, and regulations for all 50 states and the District of Columbia. While this guide focuses primarily on Medicaid fee-for-service policies, information on managed care is noted in the report as well. The report also notes particular areas where we were unable to find information. Every effort was made to capture the most recent policy language in each state as of 2019. Recently passed legislation and regulation have also been included in this version of the document with their effective date noted in the report (if applicable). This information also is available electronically in the form of an interactive map and search tool accessible on our website cchpca.org. Consistent with previous editions, the information will be updated biannually, as laws, regulations and administrative policies are constantly changing.

Telehealth Policy Trends
States continue to refine and expand their telehealth reimbursement policies though they are not treated across the board in the same manner as in-person delivered services. Limitations in regards to reimbursable modality, services and location of the patient continue to be seen. Although each state's laws, regulations, and Medicaid program policies differ significantly, certain trends are evident. Live video Medicaid reimbursement, for example, continues to far exceed reimbursement for store-and-forward and remote patient monitoring (RPM). Reimbursement for RPM and store-and- forward continue to be limited. There has been some increased interest in reimbursing for eConsult as California Medicaid joined Connecticut Medicaid in reimbursing for at least one eConsult code. Other noteworthy trends include the addition of the home and schools as an eligible originating site in some states, and the inclusion of teledentistry and substance use disorder services as a specialty qualifying for Medicaid reimbursement and/or required to be reimbursed by private insurers. The Fall 2019 release of the Center for Connected Health Policy's (CCHP) report of state telehealth laws and Medicaid

reimbursement policies is the eighteenth updated version of the report since it was first released in 2013. Like its previous 190 iterations, the report is updated on a biannual basis, in spring and fall. An interactive map version of the report is available on CCHP's website, cchpca.org. Please check this website for updates as needed. Due to constant changes in laws, regulations, and policies, CCHP will continue to update the information in both PDF and map formats twice a year to keep it as accurate and timely as possible. It should be noted that even if a state has enacted telehealth policies in statute and/ or regulation, these policies may not have been incorporated into its Medicaid program. Throughout the report, CCHP has notated changes in law that have not yet been incorporated into the Medicaid program, as well as laws and regulations that have been approved, but not yet taken effect.

Methodology

CCHP examined state law, state administrative codes, and Medicaid provider manuals as the report's primary resources. Additionally, other potential sources such as releases from a state's executive office, Medicaid notices, transmittals or Agency newsletters were also examined for relevant information. In some cases, CCHP directly contacted state Medicaid personnel in order to clarify specific policy issues. Most of the information contained in this report specifically focuses on fee-for-service; however, information on managed care plans has also been included if available from the utilized sources. Newly approved regulations related to specific telehealth standards for various professions are noted in the "Miscellaneous" section of the state's Professional Regulation/Health & Safety category area. The survey focused on three primary areas for telehealth policy including Medicaid reimbursement, private payer laws and professional regulation/ health & safety requirements. Within each category, information is organized into various topic and subtopic areas. These topic areas include:

▸Medicaid Reimbursement
▸Definition of the term telemedicine/telehealth
▸Reimbursement for live video
▸Reimbursement for store-and-forward
▸Reimbursement for remote patient monitoring (RPM) •
▸Reimbursement for email/phone/fax
▸Consent issues
▸Out-of-state providers Private Payer Laws
▸Definitions
▸Requirements 191
▸Parity (service and payment) Professional Regulation
▸Definitions

‣Consent
‣Online Prescribing
‣Cross-State Licensing

Key Findings

No two states are alike in how telehealth is defined and regulated. While there are some similarities in language, perhaps indicating states may have utilized existing verbiage from other states, noticeable differences exist. These differences are to be expected, given that each state defines its Medicaid policy parameters, but it also creates a confusing environment for telehealth participants to navigate, particularly when a health system or practitioner provides health care services in multiple states. In most cases, states have moved away from duplicating Medicare's restrictive telehealth policy, with some reimbursing a wide range of practitioners and services, with little to no restrictions. As noted previously, even if a state has enacted telehealth policies in statute and/or regulation, these policies may not have been incorporated into its Medicaid program. In the findings below, there are a few cases in which a law has passed requiring Medicaid reimbursement of a specific telehealth modality or removal of restrictions, but Medicaid policies have yet to reflect this change. CCHP has based its findings on current Medicaid policy according to those listed in their program regulations, manuals or other official documentation. Requirements in newly passed legislation will be incorporated into the findings section of future editions of CCHP's report once they are implemented in the Medicaid program, and CCHP has located official documentation confirming this. While this Executive Summary provides an overview of findings, it must be stressed that there are nuances in many of the telehealth policies. To fully understand a specific policy and all its intricacies, the full language of it must be read. Below are summarized key findings in each category area contained in the report.

Definitions

States alternate between using the term "telemedicine" or "telehealth". "Telehealth" is sometimes used to reflect a broader definition, while "telemedicine" is used mainly to define the delivery of clinical services. Additional variations of the term, primarily utilizing the "tele" pre x are also becoming more prevalent. For example, the term "telepractice" is being used frequently as it relates to physical and occupational therapy, behavioral therapy, and speech language pathology. "Telepsychiatry" is also a term commonly used as an alternative when referring specifically to psychiatry services. Some states put specific restrictions within the definitions, which often limit the term to "live" or "interactive", excluding store-and-forward and RPM from the definition and subsequently from

reimbursement. The most common restriction states place on the term telemedicine/telehealth is the exclusion of email, phone, and/or fax from the definition. Forty- nine states and the District of Columbia have a definition in law, regulation, or their Medicaid program for telehealth, telemedicine, or both. Only Alabama lacks a definition for either term.

California State Telehealth Regulations
The following is a summary of the Board of Behavioral Sciences regulations on the standards of practice for telehealth: The Board of Behavioral Sciences (BBS) developed regulations on the standards of practice for telehealth that became effective July 1, 2016. All therapists licensed or registered with the BBS, who are interested in or are engaged in the practice of telehealth, need to be aware of these regulations. Non compliance could possibly y result in unprofessional conduct (Regulatory and Legal Considerations for Telehealth, Tran A., The Therapist) Definitions Under law, "telehealth" is the mode of delivering health care via information and communication technologies, including, but not limited to, telephone and/or internet Licensees may deliver health care, under their scope of practice, via telehealth, under certain conditions Licensees are responsible for understanding all applicable laws, to deliver health care via telehealth Failure to comply with any provisions regarding telehealth may be subject to disciplinary action by the Board The two most common modes of telehealth for psychotherapy are via 1) live videoconferencing either through a personal computer with a webcam or a mobile communications device with two-way camera capability, and 2) telephone. According to Tran A, "The BBS recognizes the practice of psychotherapy via telehealth as falling within its jurisdiction and subject to the same statutes and regulations that apply to in-person psychotherapy. Therefore, all California and/or federal laws regarding the confidentiality and privacy of health care information and a client's right of access to his or her medical information apply to telehealth services." (Regulatory and Legal Considerations for Telehealth, Tran A., *The Therapist.*)

Regulations
- Individuals providing psychotherapy or counseling, either in person, via telephone, or via internet, must be licensed in California. LMFT, LCSW and LPCC must have a current license issued by the BBS in order to provide psychotherapy services to clients who are physically located in California.
- MFT Trainees, while under appropriate supervision and working in lawful, exempt settings, may provide psychotherapy services via telehealth (Business and Professions Code Section 2290.5)

- All laws regarding the confidentiality of health care information and a patient's right to their medical information shall apply to telehealth interactions. § 1815.5. Standards of Practice for Telehealth. "(a) All persons engaging in the practice of marriage and family therapy, educational psychology, clinical social work, or professional clinical counseling via telehealth, as defined in Section 2290.5 of the Code, with a client who is physically located in this State must have a valid and current license or registration issued by the Board. (b) All psychotherapy services offered by board licensees and registrants via telehealth fall within the jurisdiction of the board just as traditional face-to-face services do. Therefore, all psychotherapy services offered via telehealth are subject to the board's statutes and regulations. (c) Upon initiation of telehealth services, a licensee or registrant shall do the following: (1) Obtain informed consent from the client consistent with Section 2290.5 of the Code. (2) Inform the client of the potential risks and limitations of receiving treatment via telehealth. (3) Provide the client with his or her license or registration number and the type of license or registration. (4) Document reasonable efforts made to ascertain the contact information of relevant resources, including emergency services, in the patient's geographic area. (d) Each time a licensee or registrant provides services via telehealth, he or she shall do the following: (1) Verbally obtain from the client and document the client's full name and address of present location, at the beginning of each telehealth session. (2) Assess whether the client is appropriate for telehealth, including, but not limited to, consideration of the client's psychosocial situation. (3) Utilize industry best practices for telehealth to ensure both client confidentiality and the security of the communication medium. (e) A licensee or registrant of this state may provide telehealth services to clients located in another jurisdiction only if the California licensee or registrant meets the requirements to lawfully provide services in that jurisdiction, and delivery of services via telehealth is allowed by that jurisdiction. (f) Failure to comply with these provisions shall be considered unprofessional conduct. Note: Authority cited: Sections 4980.60 and 4990.20, Business and Professions Code. Reference: Sections 2290.5, 4980, 4989.50, 4996, 4999.30 and 4999.82, Business and Professions Code." Summary of Above stated Code Prior to the delivery of health care via telehealth, the provider initiating the use of telehealth shall:

Obtain Consent
This is required by the Telehealth statute Business and Professions Code Section 2290.5 where the therapist must
✓ Inform the client/patient about the use of telehealth
✓ Obtain, and document, verbal or written consent from the client/ patient for this use.

Discuss Risks/Limitations

The therapist must inform the client either verbally and/or in writing of the potential risks and limitations of receiving psychotherapy via telehealth which may include but are not limited to technical failures; interruption by unauthorized persons; unauthorized access to transmitted and/or stored confidential information; and decreased availability of the therapist in the event of a crisis.. 3. The CAMFT Code of Ethics (2019) "Section 1.4.2 ELECTRONIC THERAPY: When patients are not physically present (e.g., therapy by telephone or Internet) during the provision of therapy, marriage and family therapists take extra precautions to meet their responsibilities to patients. Prior to utilizing electronic therapy, marriage and family therapists consider the appropriateness and suitability of this therapeutic modality to the patient's 195 needs. When therapy occurs by electronic means, marriage and family therapists inform patients of the potential risks, consequences, and benefits, including but not limited to, issues of confidentiality, clinical limitations, transmission difficulties, and ability to respond to emergencies. Marriage and family therapists ensure that such therapy complies with the informed consent requirements of the California Telemedicine Act. 4. Licensee License/Registration: The therapist must either verbally or in writing, provide the client with their license or registration number and the type of license or registration. This is usually located on the informed consent form. 5. Provide Contact Information of Relevant Resources:

CAMFT Code of Ethics (2019) "1.5.3 EMERGENCIES/CONTACT BETWEEN SESSIONS: Marriage and family therapists inform patients of the extent of their availability for emergencies and for other contacts between sessions. When a marriage and family therapist is not located in the same geographic area as the patient, he/she shall provide the patient with appropriate resources in the patient's locale for contact in case of emergency." According to Tran A, "The therapist may achieve this by sending or emailing the relevant resources to the client or by providing the information verbally and documenting in the client's record (e.g., the therapist informed the client of the University Hospital, located on Washington Street, which provides emergency services and inpatient psychiatric services, including specialized services for children). The emergency services near the client's location may include telephone numbers and addresses for nearby emergency rooms, the psychiatric emergency team telephone number; and telephone numbers to local crisis hotlines/centers." (Regulatory and Legal Considerations for Telehealth, Tran A., The Therapist. September, 2016). During every Telehealth Session the Therapist Must:

1. Verbally obtain from the client the client's name and document such name and the address of the client's present location for identify confirmation and emergency purposes.
2. Assess whether the client is appropriate for telehealth. This includes but is not limited to, consideration of the client's psychosocial situation. This is intended to evaluate the client's possible changing mental health from session to session thereby determining continued appropriateness for telehealth. The therapist should document accordingly.
3. Utilize industry best practices for telehealth including ensuring both client confidentiality and the security of the telehealth platform. Documentation of the therapist's due diligence in this process is necessary.

Telehealth Outside of California

Licensees or registrants who wish to engage in telehealth with a client located in another jurisdiction need to check with that jurisdiction to determine its laws related to telehealth, and if licensure in that jurisdiction is required. Several states currently consider a client located in their state to be under their jurisdiction. Therefore, a practitioner needs to comply with that jurisdiction's laws in order to avoid any potential violations of those laws. Currently, there are six states (Arizona, Colorado, Florida, New Jersey, Utah, and Wyoming), including D.C., that allow for out-of-state licensed MFTs to temporarily practice marriage and family therapy (and via telehealth) to clients located in those states. Because states vary in their regulations, it is recommended for a therapist to contact the state's MFT licensing board for an inquiry into the requirements for lawful practice of marriage and family therapy, or if the jurisdiction has relevant telehealth statutes, the practice of marriage and family therapy via telehealth in that state. Resources The California Telehealth Resource Center (CTRC) is nationally recognized as one of fourteen federally designated Telehealth Resource Centers around the country. CTRC has a vision to achieve the fully optimized use of telehealth and other technology enabled health care in order to: 1) improve access to health care for all California citizens; 2) improve clinical efficiency and access to health information and education; and 3) reduce the cost of providing needed health care. Visit the CTRC website at http://www.caltrc.org. The Center for Connected Health Policy (CCHP) is a program of the Public Health Institute which was established in 2008 to integrate telehealth virtual technologies into the health care system through advancing sound policy based on objective research and informed practices. Visit the CCHP website at http://cchpca.org. The California Telehealth Network (CTN), an independent 501(c)(3) non-profit, focuses on increasing access to healthcare, including telehealth, telemedicine and health information exchange, through the innovative use of technology. CTN is funded through the Federal Communications

Commission's Rural Health Care 197 Pilot Program. CTN is California's authorized FCC broadband consortium for healthcare. Visit the CTN website at http://www.caltelehealth.org. California Telehealth Resource Center Legislation & Regulation The CA Telehealth Resource Center provides telehealth technical assistance to the state of California. California Current and Upcoming Bills Jurisdiction: CA Bill Number: AB 32 Bill Title: Telehealth. Sponsor: Rebecca Bauer-Kahan Introduced Date: 12/08/2020 Last Action: Bill Created - (12/09/2020) Status: CCHP Classification: Medicaid Reimbursement Coronavirus Notes: This bill would delete the above-described references to contracts issued, amended, or renewed on or after January 1, 2021, would require these provisions to apply to the plan or insurer's contracted entity, as specified, and would delete the exemption for Medi-Cal managed care plans. The bill would subject county organized health systems, and their subcontractors, that provide services under the Medi-Cal program to the above-described Knox-Keene requirements relative to telehealth. The bill would authorize a provider to enroll or recertify an individual in Medi-Cal programs through telehealth and other forms of virtual communication, as specified. This bill would require the State Department of Health Care Services to indefinitely continue the telehealth flexibilities in place during the COVID-19 pandemic state of emergency. The bill would require the department, by January 2022, to convene an advisory group with specified membership to provide input to the department on the development of a revised Medi-Cal telehealth policy that promotes specified principles. The bill would require the department, by December 2024, to complete an evaluation to assess the benefits of telehealth in Medi-Cal, including an analysis of improved access for patients, changes in health quality outcomes and utilization, and best practices for the right mix of in-person visits and telehealth. The bill would require the department to report its findings and recommendations from the evaluation to the appropriate policy and fiscal committees of the Legislature no later than July 1, 2025. 198 Jurisdiction: CA Bill Number: AB 14 Bill Title: Communications: broadband services: California Advanced Services Fund. Sponsor: Cecilia M. Aguiar-Curry Introduced Date: 12/08/2020 Last Action: Bill Created - (12/09/2020) CCHP Classification: Miscellaneous Notes: This bill would require that the CASF program promote remote learning and telehealth, in addition to economic growth, job creation, and the substantial social benefits of advanced information and communications technologies. Jurisdiction: CA Title: Standards of Practice for Telehealth Action:

PROPOSED ACTION ON REGULATIONS
Type: Proposed Rule Published Date: 08/15/2020 Agency: Board of Psychology CCHP Classification: Regulatory, Licensing and Advisory Boards Notes: Creates telehealth practice requirements for the CA Board of Psychology. Conditions of

service include holding a valid license, obtaining consent, determining the provision of services is appropriate, posessing the appropriate knowledge and abilities, ensuring appropriate security of any transmitted client data, and complying with all Psychology Licensing laws. 8B. Telehealth in the Age of Coronavirus The Following notification was issued by California Health and Human Services (HHS): Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency We are empowering medical providers to serve patients wherever they are during this national public health emergency. We are especially concerned about reaching those most at risk, including older persons and persons with disabilities. – Roger Severino, OCR Director. 199 The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) is responsible for enforcing certain regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, to protect the privacy and security of protected health information, namely the HIPAA Privacy, Security and Breach Notification Rules (the HIPAA Rules). Telehealth Discretion During Coronavirus During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies. Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules. OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. This notification is effective immediately.

A covered health care provider that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use any non-public facing remote communication product that is available to communicate with patients. OCR is exercising its enforcement discretion to not impose penalties for noncompliance with the HIPAA Rules in connection with the good faith provision of telehealth using such nonpublic facing audio or video communication products during the COVID-19 nationwide public health emergency. This exercise of discretion applies to telehealth provided for any reason, regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19. For example, a covered health care provider in the exercise of their professional

judgement may request to examine a patient exhibiting COVID- 19 symptoms, using a video chat application connecting the provider's or patient's phone or desktop computer in order to assess a greater number of patients while limiting the risk of infection of other persons who would be exposed from an in-person consultation. Likewise, a covered health care provider may provide similar 200 telehealth services in the exercise of their professional judgment to assess or treat any other medical condition, even if not related to COVID-19, such as a sprained ankle, dental consultation or psychological evaluation, or other conditions. Under this Notice, covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency. Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications. Under this Notice, however, Facebook Live, Twitch, TikTok, and similar video communication applications are public facing, and should not be used in the provision of telehealth by covered health care providers. Covered health care providers that seek additional privacy protections for telehealth while using video communication products should provide such services through technology vendors that are HIPAA compliant and will enter into HIPAA business associate agreements (BAAs) in connection with the provision of their video communication products. The list below includes some vendors that represent that they provide HIPAA-compliant video communication products and that they will enter into a HIPAA BAA. Skype for Business / Microsoft Teams Updox VSee Zoom for Healthcare Doxy.me Google G Suite Hangouts Meet Cisco Webex Meetings / Webex Teams Amazon Chime GoToMeeting Spruce Health Care Messenger Note: OCR has not reviewed the BAAs offered by these vendors, and this list does not constitute an endorsement, certification, or recommendation of specific technology, software, applications, or products. There may be other technology vendors that offer HIPAA-compliant video communication products that will enter 201 into a HIPAA BAA with a covered entity. Further, OCR does not endorse any of the applications that allow for video chats listed above. Under this Notice, however, OCR will not impose penalties against covered health care providers for the lack of a BAA with video communication vendors or any other noncompliance with the HIPAA Rules that relates to the good faith provision of telehealth services during the COVID-19 nationwide public health emergency. OCR has published a bulletin advising covered entities of further flexibilities available to them as well as obligations that remain in effect under HIPAA as they respond to crises or emergencies at https://

www.hhs.gov/sites/default/files/ february-2020-hipaa-and-novel-coronavirus.pdf - PDF. Guidance on BAAs, including sample BAA provisions, is available at https:// www.hhs.gov/hipaa/for-professionals/covered-entities/sample-business-associateagreement-provisions/index.html. Additional information about HIPAA Security Rule safeguards is available at https://www.hhs.gov/hipaa/for-professionals/security/guidance/index.html. HealthIT.gov has technical assistance on telehealth at https://www.healthit.gov/ telehealth. The following was issued by the Board of Behavioral Sciences (BBS): Updated Statement on Telehealth to Reflect Governor's Executive Order N-43-20 New Telehealth Information Pursuant to Executive Order N-43-20 The Governor's new Executive Order, N-43-20, issued on April 3, 2020, does the following: 1. Suspends the requirements specified in Business and Professions Code (BPC) section 2290.5(b). BPC §2290.5(b) states the following: (b) Before the delivery of health care via telehealth, the health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented. 2. Acknowledges and permits compliance with the current federal order issued by the Office for Civil Rights in the U.S. Department of Health and Human Services (issued March 17, 2020). This means that if you are a "covered health care provider" subject to the HIPAA Rules and described in the "Notification of 202 Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency" ("Notification"), your delivery of telehealth services is permitted to be consistent with that Notification. Where the Notification encourages particular measures to safeguard patient privacy, but does not require such measures, covered health care providers shall give due consideration to such measures and shall endeavor to adopt them to the extent possible. The following link on the Board's website contains further information about the Notification, and contains a link to the U.S. Department of Health and Human Services' full announcement. Board Licensees, Registrants, and Trainees and Telehealth Except for the items discussed above from the Executive Order, Board licensees, registered associates, and trainees utilizing telehealth are still required to comply with the laws and regulations related to telehealth. The Board strongly urges review of its statutes and regulations related to telehealth to ensure compliance with the law. These can be found by visiting the following link and clicking on "Telehealth": https://bbs.ca.gov/licensees/hipaa.html

Licensees and Telehealth
All California licensed marriage and family therapists, educational psychologists, clinical social workers, and professional clinical counselors are permitted to

perform services with clients who are located in California via telehealth. Associates and Telehealth All associate marriage and family therapists, associate clinical social workers, and associate professional clinical counselors who are registered in California are permitted to perform services via telehealth with clients who are located in California under the supervision of their supervisor. If the associate is working in a governmental entity, school, college, university, or an institution that is nonprofit and charitable, the required weekly direct supervisor contact may be via two-way, real-time videoconferencing. If the associate is working in a setting other than the types listed above, the law requires the supervisor contact to be in person.

Social Work Interns and Telehealth

The law defines social work interns as individuals enrolled in a master's or doctoral training program in social work in an accredited school or department of social work. These individuals are not yet under the jurisdiction of the Board. It is up to the school and the school's accrediting agency to determine the permissibility of telehealth for social work interns. Clinical Counselor Trainees and Telehealth Clinical counselor trainees are unlicensed and unregistered individuals who are currently enrolled in their master's or doctoral degree program designed to qualify them for licensure as a professional clinical counselor, and who have completed at least 12 semester units or 18 quarter units of their degree program. The law does not prohibit clinical counselor trainees from providing services via telehealth. The school must approve and have a written agreement with the site detailing, among other things, the methods by which supervision shall be provided. Therefore, they may perform services via telehealth and receive supervision via videoconferencing as long as the school allows it. Marriage and Family Therapist Trainees and Telehealth Marriage and family therapist trainees are unlicensed and unregistered individuals who are currently enrolled in their master's or doctoral degree program designed to qualify them for licensure as a marriage and family therapist, and who have completed at least 12 semester units or 18 quarter units of their degree program. MFT trainees are permitted to provide services via telehealth. The school must approve and have an agreement with the site detailing, among other things, the methods by which supervision shall be provided. MFT trainees can count predegree hours toward licensure, so they need to make sure they follow the law regarding counting experience hours. If they are working in a governmental entity, school, college, university, or institution that is nonprofit and charitable, they may obtain supervision via videoconferencing. If they are working in a setting other than the types listed above, the law requires the supervisor contact to be in person.

7. Resources

National Organizations:

The APA (American Psychological Association) Help Center
An excellent resource for mental health related issues.

American Association for Marriage and Family Therapy (AAMFT)
Information and resources concerning the Marriage and Family Therapy Profession (MFT) and educational programs.

California Association of Marriage and Family Therapists
is an independent professional organization representing the interests of licensed marriage and family therapists.

National Board of Certified Counselors (NBCC)
Non-Profit certification board for counselors.

The National Council on Family Relations
Resources for members of the helping professions.

National Association of Social Workers (NASW)
The National Association of Social Workers (NASW) is the largest membership organization of professional social workers in the world.

American Counseling Association

The National Institute of Mental Health

National Healthy Marriage Resource Center
a clearinghouse for high quality, balanced, and timely information and resources on healthy marriage. The NHMRC's mission is to be a first stop for information, resources, and training on healthy marriage for experts, researchers, policymakers, media, marriage educators, couples and individuals, program providers, and others.

HelpGuide.org
Helpguide's mission is to help people understand, prevent, and resolve life's

challenges. Their goal is to give you the information and encouragement you need to take charge of your health and well-being and make healthy choices.

Practitioner Resources:

[Therapy Sites](#)
Use coupon code **promoFMC** to get a month FREE. [TherapySites.com](#) specializes in websites for therapists.

[Information for Practice](#)
IP is a new, free, resource for social service professionals that is updated daily. The focus is on: professionally relevant stories in the world's news outlets; new articles in scholarly journals; and new resources appearing in the grey literature.

[Successful Therapist](#)
Provides custom web design for therapists at reasonable pricing.

[Aspirace](#)
Continuing Education Provider

[Interactive Teddy Bears](#)
Play therapy tools.

Treatment Centers

[Castlewood Treatment Center](#)
Residential treatment center for eating disorders.

[Monte Nido Treatment Center](#)
Residential treatment center for eating disorders.

Other Resources

[Childhelp](#)
Childhelp is a leading national non-profit organization dedicated to helping victims of child abuse and neglect.

[Gift From Within](#)
Dedicated to those who suffer post-traumatic stress disorder (PTSD), those at risk for PTSD, and those who care for traumatized individuals.

[Eating Disorder Referral and Information Center](#)
The Eating Disorder Referral and Information Center is dedicated to the prevention and treatment of eating disorders. They provide information and treatment resources for all forms of eating disorders.

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