NIATx

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Increasing Family Engagement

The SAMHSA/CSAT PPW Grantee Program 2006

A NIATx Process Improvement Pilot Project

The SAMSHA/CSAT Residential Treatment Programs

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) funds the Residential Treatment for Pregnant and Postpartum Women (PPW) and Residential Treatment for Women and their Children Program.

Historically, women have been underrepresented in substance abuse treatment due to stigma and fear of losing their children. The PPW Project was developed specifically to bring women to treatment and keep their children with them.

The purpose of these grants is to expand the availability of comprehensive, high quality residential substance abuse treatment services for low-income women, age 18 and over, who are pregnant; postpartum women, or other parenting women, and their minor children, age 17 and under, who have limited access to quality health services. The system of care should continue to improve the overall treatment outcomes for the women, their children, and the family unit as a whole.

In this publication, the 2006 grantees of the SAMHSA/CSAT PPW program/NIATx Process Improvement Pilot share the lessons they learned on how to improve family engagement.

2006 PPW Grantees Participating in the NIATx collaborative

• AK Cares, Little Rock, Arkansas	• SStarbirth of Rhode Island
• Family Works, Omaha, Nebraska	• Village South, Miami, Florida
• Mental Health San Diego	• Walden House, San Francisco
• Prototypes, Culver City, California	• WEKU, Portland, Oregon

About NIATx

NIATx is a pioneering improvement collaborative that works with substance abuse and behavioral health organizations across the country. We teach organizations to use a simple evidence-based process improvement model (McCarty et al., 2007). NIATx is part of the Center for Health Enhancement System Studies (CHESS) at the University of Wisconsin–Madison.

NIATx helps providers improve access to and retention in treatment for all of their clients, focusing on four aims:

- Reduce waiting times
- Reduce no-shows
- Increase admissions
- Increase continuation in treatment

Agencies and systems that adopt the NIATx model of process improvement report dramatic improvements in access to and retention in treatment.

NIATx Coaches for the 2006 PPW Grantee Program

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I. Increasing Family Engagement

A NIATx Process Improvement Pilot

The Issue

The SAMHSA/CSAT PPW grant programs focus on the needs of pregnant and parenting women who struggle with substance abuse. These women face multiple challenges, often reporting histories of physical or sexual abuse and significant health or mental health problems. Poor educational backgrounds and limited or no employment create barriers to quality health care and substance abuse treatment. In addition, women have resisted seeking substance abuse treatment due to the stigma and fear of losing their children.

Recognizing that women in treatment benefit from relationship-based programs, the 2006 PPW grantees worked to identify effective ways to engage family members who can support pregnant and parenting women in treatment and beyond—ideally, into long-term recovery.

Historically, women's residential treatment programs have not engaged family members or significant others in a meaningful way. However, newer research suggests that including the family contributes to treatment success.

The 2006 grantees identified a series of opportunities to engage families at key points in a client's treatment. While the examples described in this guide were taken from women's programs, we anticipate the issues and changes highlighted will be relevant to all treatment programs wanting to increase family engagement.

Defining a substance use disorder and its treatment has become easier in recent years, but the definition of family is becoming more complicated. A significant learning for the 2006 PPW grantees was in the way the agencies think about family. The approaches to engagement that they used helped them recognize who is important to women in treatment—often, individuals who do not fit the standard definition of family.

What is a family and who decides? This simple question is fundamental to addressing family engagement. Does a family need to be a legal entity? If a family member has a criminal or drug-addicted history, is that person excluded from the definition of family?

SAMHSA's 2004, TIP 39, "Substance Abuse Treatment and Family Therapy" offers some clarification:

> "For practical purposes, family can be defined according to the individual's closest emotional connections." (p. 3, TIP 39).

The 2006 PPW grantee agencies found that male family members were often excluded for a variety of reasons, generally having to do with concerns about client safety. Male family members or significant others represented potential domestic violence, legal issues, and relapse. There was an overarching concern that these men were simply not good for the women. Yet, they were the fathers—of either the unborn child or older children.

Is family a relevant concern beyond the target population—women and their children? Again, TIP 39 suggests a simple rationale for the extra effort involved in improving family engagement: "…prevention, especially keeping substance abuse from moving from one generation to another." (p. 9). Even the lowest level of family engagement improves the opportunity for prevention.

The 2006 PPW grantees defined family as all the people connected to a client, whether or not the connection is a legal one.

II. Aim – Increase Family and Significant Other Engagement in Treatment

Family engagement has been stated as a fundamental element of treatment (Etheridge & Hubbard, 2000), noted to predict improved retention in treatment (Liddell, 2004) and can lead to better outcomes (Coppello et al., 2005).

Within the PPW program, most of the treatment programs had low involvement with family members or those "of closest emotional connection." There was also often limited involvement as well as the children's fathers and the children's of families of origin. The clients are in residential treatment with their young children; while in treatment, the client has little or no contact with her older children.

Is family engagement a useful goal? Engagement can be defined as a spectrum of purposeful contacts. Positive engagement can serve as motivation for change. Fuller engagement in a woman's treatment episode allows family members to bear witness to the enormous changes she experiences in early recovery from substance use. They receive a "dose" of vicarious inspiration in real time. Change talk is normal in treatment centers, and family members hear it. Positive engagement can also reduce shame and blame, especially when members of multiple families gather in treatment centers, and realize they are not alone. When a person leaves treatment, these are her people. Building a therapeutic relationship with people of the closest emotional connection supports long-term recovery, especially since women in residential treatment often return to live with one or more persons who they define as family.

A working theory for the 2006 PPW collaborative was that improved family engagement would also improve retention.

….the evidence strongly supports the

notion that family involvement at various points in the

treatment process can lead to improved outcomes for

both the substance misuser and the family members

affected by the substance misuse.

Coppolo, et al. 2005

In addition, the opportunity for family therapy also presents itself with improved family engagement. Several types of family therapy have been identified as an evidence-based practice (http://www.nrepp.samhsa.gov). The benefits of family therapy include greater engagement by family members in treatment, and the ability to assist family members with related issues they may have. Family therapy has also been found to be cost effective.

Types of family therapy include brief strategic family therapy, family behavioral therapy, and multidimensional family therapy.

There is a general perception that including family in treatment at any level is a significant adjustment for the programs. However, as the 2006 PPW grantees improved their engagement practices they also experienced a shift in their capacity to use the family as an ally in the recovery process.

III. Results

An important result of the 2006 PPW collaborative was that the agencies found a different way to look at themselves and create ways to create family-centered cultures. By accepting a broader definition of family and recognizing natural opportunities for family engagement, they also began to see the potential for families to be active members of a client's recovery team.

Individual Results

- WEKU of Portland quadrupled participation in Family Night.
- Family Works of Omaha increased family participation from 50 to 83 percent.
- The Village of South Miami tripled family engagement contacts.

IV. Changes to Improve Family Engagement

"Perceived barriers become opportunities for improving family engagement…a key sign of a family-centered culture is the opportunity for the client to be asked about and identify the people who are important to her. We have learned that programs have to be prepared to hear the client's answer—and act on it." Lynn Madden, Lead Coach

An organization improves its ability to provide effective treatment by building a family-centered culture, where the family is welcomed based on its strengths and its undeniable impact on the addicted individual's life. A family-centered culture does not make the family feel like they are an intrusion, or worse yet, forbidden. The culture has systems to inform, engage, and include the family, as well as ways to identify and address negative family influences.

A family-centered culture realizes that recovery is rarely a solitary event. Individuals in recovery need support, love, and encouragement from those closest to them. Yet sometimes those closest to the client intentionally or unintentionally jeopardize long-term recovery, in part because they have not had the opportunity to learn about the disease and recovery processes. They need education on how they can be most helpful in supporting their loved ones in recovery. A family-centered culture accepts this premise as a core belief. Intake counselors, clinicians, and caseworkers integrate this belief into how they provide services to the addicted individual and her family.

Family-Centered Key Issue: In family therapy, clients identify who they think should be included in therapy. The counselor or therapist cannot determine which individuals make up another person's family.

Concerns about Family Engagement: Every opportunity to engage family is an opportunity to provide key education about addiction and recovery.

Discussions with the grantees often revealed underlying beliefs about the families of women with substance use disorders. There was a pervasive belief that clients were disaffected from their families of origin and, therefore, no outreach to families was necessary. Yet research on homeless addicted individuals has shown that family members usually know where the homeless individual is located, and that there is ongoing connection. Often women in residential treatment return to live with one or more family members as she defines family.

In some cases, staff members viewed the family of origin as the source of the client's addiction problems and a likely trigger for an impending relapse. Although many staff members have been trained on the disease concept of addiction, cultural habits of blame may persist. The opportunity for projective identification is constant in agencies with a strong family orientation—staff members may project their own experiences on to those of the women in treatment. It is important for an agency to provide ongoing supervision for staff to recognize issues of transference and counter transference and work through them.

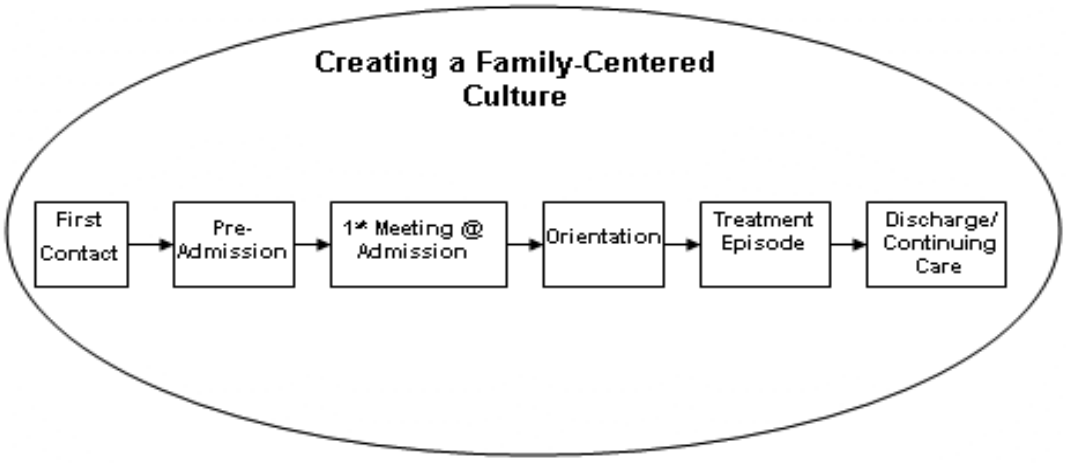
The strong and pervasive bias against the client's male partner or significant other was often the agency culture. Engaging male partners and those individuals identified as father of the baby (FOB) was often met with strong ambivalence or avoidance, due to concerns about domestic violence and/ or drug use. This attitude appears to be entrenched in practices of the programs. In some cases, the staff's protective stance towards the client created a barrier to inclusion of males.

Because the safety of the women and children is a vital goal for the programs, it must be examined as we improve client access to families. Redefining access to families can be very challenging. Some programs changed visitation to the weekday so that more staff could be available, while others considered having split visiting days to reduce the density.

V. Walk-through Observations

In a walk-through exercise, the treatment agency employees play the role of a client and a significant other to personally experience what it's like to be a patient and her significant other or family member.

The walk-through helped the agency change teams to experience their services as their clients do, giving them a new perspective on family engagement.



Universal Change Concept: Treat every point of contact as a family engagement opportunity.

The walk-through identified barriers to engagement at multiple points of contact. From the walk-through observations below, the 2006 PPW grantees recognized opportunities to improve family engagement.

- **Key of contacts**
- FC = First Contact
- PA = Pre-Admission
- Adm = First Meeting at Admission
- O = Orientation for Family Members
- TE = Treatment Episode
- D/CC = Discharge and Continuing Care

- Family members were usually discouraged from making the referral call, or were told to have the prospective client call herself. (FC)
- Agencies gathered little information from the family members about the client. (All)
- Information for family members was usually not provided. (All)
- Family members were often treated with suspicion, discouraged from engagement, or dismissed from consideration. (All)
- The role-playing family member was frequently ignored or asked to wait. (Adm)
- Paperwork was redundant and unwelcoming. (Adm)
- Orientation groups for family members were aimed at sharing the agency rules rather than family engagement. Agencies were concerned about family members bringing in contraband. (O)
- Other than children who were enrolled in the programs, family members were unwelcome. (TE)
- Visitation was allowed, but was usually scheduled on weekends when core staff members were not available. (TE)
- Family members of men more were likely to access services than women. (TE)
- Couples group was available after the treatment period. (D/CC)
- Many staff changes make it difficult to implement hand offs of new clients, and to inform family members who the woman's counselor will be. (D/CC)

See Appendix I for a more detailed sample of findings from the walk-through exercises. Appendix II describes how coaches used the point of contact approach to respond to findings from the walk-through exercises.

VI. Suggested Practices for Improving Engagement

First Contact

Welcome questions from family members and include family in referral process. Give contact name and follow-up phone number when possible. "If you have further questions, call (name, phone number.)

Pre-Admission

Working with women prior to admission, staff could engage family at the time of greatest concern for her welfare.

> Waldenhouse: an outreach worker meets with future residents while they are still in prison. At that time, the worker seeks consent to contact family members to provide information on Waldenhouse, offer support, and invite them to greet their loved one upon arrival at Waldenhouse.

- Greet family members.

  > The Village of South Miami sends staff to a separate building to meet family, rather than relying on admissions staff to engage the family. They also meet with the primary client and explain services available to family members. Twenty-one new family members have enrolled since June 2008, versus five to ten families in all prior efforts.

- Provide staff to describe the program.

  > The Village of South Miami Staff outlines services available to family and includes structured visitation for non-custodial parents.
  >
  > Waldenhouse invites family members to join their loved one for a meal on the first day of treatment. While there, staff members educate families about the program and related services.

- Reduce time spent on paperwork.

  > Arkansas CARES modified a lengthy intake process (6–8 hours) in favor of engaging the woman in the program after initial paper work.

- Provide a point of contact for questions after intake: provide phone numbers and names of staff members involved with the treatment, care, and/or dates of visiting times.
- Provide time to gather information about the individual entering treatment from the family. (See APPENDIX 4: Concerned Persons Questionnaire)
- Offer to address family questions.
- Offer a tour of program.
- Offer a family support system in the community (Al-anon, a peer family to contact).
- Offer supportive contact materials.

Orientation for Family Members

Develop engaging family orientation program.

WEKU added a family orientation and offers one-on-one meeting with family members. WEKU addressed concerns from staff and controlled potentially inappropriate contacts for multi-aged groups.

- Offer hope and information.

  Family Works of Omaha added a family handbook.

  SSTARBIRTH of Rhode Island developed a brochure for families and coached residents on how to engage their families.

- Offer a focus group with family members to get feedback on how to increase family member participation.

  SSTARBIRTH of Rhode Island used informal focus groups at dinner to solicit input from family members on how to increase family participation.

- Develop FAQs from family members.
- Ask family members for their questions.

  Family Works of Omaha called family members to welcome them and sent thank you letters.

  Village of Miami: within seven days (of client's arrival) a case manager or outreach specialist contacts family members identified by primary client, inviting them to participate in the program.

- Develop refusal skills for family members during orientation that differentiates addiction/recovery. This modifies the usual practice of explaining rules designed to prevent families from aiding in relapse.
- Predict typical problems ("What if my daughter/mother/loved one wants to leave treatment?")
- Provide information on additional support opportunities in the community. Consider adding a family alumni group.

Treatment Episode (Access for Families)

Programs typically restrict phone calls as well as drop-in visits. Programs may leave such policies in place, but supplement the family's need to know about the client's progress by setting up an update meeting during the visitation time, or by phone call. As the patient is nearing discharge, families are often quite concerned about relapse.

Through changes to phone accessibility, Family Works of Omaha helped another family member to access treatment and was able to facilitate reunification with children previously not in contact, due to Department of Family Services prohibition.

Treatment Episode (Engagement at Visitation)

Programs may increase collaboration in recovery programming by providing basic education. Some programs start with the four c's: families did not **c**ause, cannot **c**ontrol, and cannot **c**ure addiction. However, they can learn to **c**ollaborate in the recovery, or collaborate with the addiction. This formula becomes a basis for discussing the validity of rules, the difficulty of setting limits with the addicted individual. Shame is common in families due to the stigma of addiction, isolation, and lack of information about the chronic nature of addiction.

Bringing families together without the patient/client can foster change. Offering short sessions on issues pertinent to coming home often is a great help.

- Adding shared activities can ease communication during visits. Providing food to share or cooking food together can create a more relaxed atmosphere. Programs that allow residents to cook or allow family to bring food to the facility report more positive and less disruptive visitations.
- Offer family services such as a 30-minute question and answer time with staff. If staffing is available, consider offering an educational system that assists families in their grief, anger, fear, shame and frustration.

  Example: Village of Miami provides weekly family support/education groups on addiction and its impact on the family unit

Treatment Episode (Programming/Activities)

As programs become more comfortable with family engagement, a range of treatment activities becomes inevitable.

- A history of the family is collected and assessed for difficulties and for possible motivators. Genograms can be completed to look at strengths in the family, not just addiction and loss. Genograms can work as a bonding activity with families who are in longer treatment episodes.
- Family members may be considered as part of emergency intervention *team during treatment.*
- Family difficulties can be included in continuing care recommendations.
- Treatment staff is informed about family issues and how they influence the patient/client.
- Introduce communication skills that benefit the women and her children to the extended family.
- Role-plays can give everyone time to learn to talk situations through.
- Adding a family members' only support group.
- Provide structure with interactions—barbeque, ice cream social, picnic.

  PROTOTYPES held a potluck dinner that increased contacts from 81 to 115.

  SSTARBirth of Rhode Island increased attendance in family night by 86 percent by notifying families at admission of the event, distributing brochures, and by having an activity scheduled rather than a talk-based group.

  Waldenhouse has a family outreach event approximately once per month, such as an outing at a park.

WEKU quadrupled the participation in family night and has added a mother/daughter tea.

- Increase visitation hours.

  PROTOTYPES added a second five-hour block to weekend visits plus two-week day visiting times—increased contacts from 115 to 158.

  PROTOTYPES held a potluck dinner that increased contacts form 81 to 115.

  PROTOTYPES used family portraits as a very powerful engagement activity.

  SSTARBirth of Rhode Island increased attendance from two families per month to five to nine families by having an activity scheduled rather than a talk-based group.

  Village of Miami added programming to include weekend and holiday family oriented events

  Waldenhouse has a family outreach event once/month.

Programs can also engage families by connecting them to community resources. Vocational counseling resources, financial assistance agencies, mental health counseling, child care agencies—these are normal affiliations for substance abuse treatment centers that can be extended to families.

Treatment Episode (Family Therapy)

- Hire a family specialist or family therapist.
- Create linkages and open communication flow between family therapist and the rest of the clinical team so clinical team is aware of what was happening in the family sessions (and vice versa).

  Family Works of NE hired a family therapist and developed processes for family therapist and primary residential clinical staff to share information.

  WEKU added a couples group for the women and their significant others.

  Family Works of NE modified pre-existing family group to include a family only group, and included fathers in parenting group.

Discharge and Continuing Care Planning

Discharge and continuing care planning present an opportunity to provide a complete plan and/or develop a recovery contract that includes the family. In one model, the client lists all of her relapse triggers and proposes an action plan to respond to those triggers. The family often knows those triggers, and the plan can include healthy ways to cope with inevitable triggers. A continuing care plan can also consider the “what ifs.” What if the person relapses? What if the family witnesses behavior that could lead to relapse? The family and client create a contract agreeing to deal with the inevitable ups and downs of early recovery.

Family Works of Omaha includes family in discharge plan.

Outreach

Some programs have paid outreach workers who can meet with the family. However, supports in the community can also provide outreach services. In a strongly African American Community, staff were encouraged to offer information about their program's success after church socials. Inviting community collaborators, judges, and legislators to graduation events provides positive support for the concept of recovery.

> Family Works of Omaha called family members to engage them and offer support; this improved family participation from 50 to 83 percent. Family works of NE also uses their outreach worker to send thank you letters as well as follow-up phone calls.
>
> WEKU hired an African American minister to do outreach for its population and trained him to interview families about their needs.

Validating and addressing staff concerns

Challenging the normal procedures creates short-term discomfort in agency staff. Even a relatively benign issue such as allowing family members to bring food into the agency can spark debates, followed by multiple anecdotes of problems caused. Staff concerns that residents are more interested in engagement than their partners appear to be also need to be addressed.

Appendix 1: Sample Walk-through Report

NIATx Walk-through: WEKU Project, Portland Oregon
Completed September 26, 2007
Participants: Jeanne Cohen, WEKU Project Director, played the role of a client seeking treatment. Debi Elliott, WEKU Lead Evaluator and Clinical Psychologist posed as the client's sister.

1. Call for an appointment. Were you told to call back or transferred to voicemail? Were you given an appointment on your first call? How long would a typical client need to wait for an appointment? Would they have to miss work to get an appointment? Record your experience/feelings/reactions:

- I called the number I was given. I had to leave a voicemail, but received a callback right away. (The wait is probably closer to a day later, but I got a call right away probably because of who I am.)
- On the staff person's message, "If you can't reach me, here are the phone numbers of two other senior staff…" I didn't call anyone else, but could have.
- I was asked to come in ASAP, but I chose not to. I had identified myself as pregnant, so she wanted me in right away.
- It was hard to answer questions about exact quantities of alcohol drank, but the staff person was trying to assess my need for detox – I felt really pushed to determine the quantity, but couldn't.
- The staff person was really supportive and helpful.
- I was told that it is a predominantly African American program and the interventions are culturally sensitive, but applicable for anyone. I was asked if I was comfortable with that, which I was.
- The staff person was very flexible about getting me in as soon as possible – she emphasized that I could come in whenever it is convenient for me, but she really wanted me in sooner than later.
- Transportation was offered and she told me that if I needed to go back home to get things, they would help me with that, too.
- The staff person was clear about what I could bring and what I couldn't bring into the facility, but I think I didn't hear everything – it went right over my head.

2. On the day of the appointment, arrive at the clinic or office, thinking what it would be like if you had never been to the site before. Is transportation to your site an issue? Are parking, directions and signage at the site adequate? Does it feel welcoming or cold and harsh? Record your experience/feelings/reactions:

- The building was not hard to find – my sister dropped me off
- Took a little while for someone to answer the door and it wasn't clear which of two buzzers to use to get the door answered
- Residential Care Facilitator (RCF) answered door and directed me to the office

- It was welcoming, but chaotic. Lots of people in the hallway with babies and children; lots of people in and out of the main office. The person I had talked to on the phone wasn't there, but the staff knew my name and that I was coming. It was loud. RCF was kind, but didn't give me her full attention because she had to deal with all the other people coming in and out. RCF calmed me by saying that it was just temporary.

3. Once you arrive, think about the perspective of the client and client's family coming in for the first time. Go through the entire intake process. Fill out all required forms. Does the family member typically accompany the client through the entire intake process? How long does a typical client spend in the waiting room? Wait for that amount of time. If the client is required to undress, you should undress. Is a urine test required? Will you have to wait between your assessment and your first treatment session, and, if so, how long? Experience it all, and record your experience:

- Notes about the Process: The telephone intake staff sends the first email (to all staff) about a new client coming in. Another staff person sends an email (to all staff) with assignments (e.g., A/D counselor, mentor).

- My first stop: I walked in with all my things in bags and went into the main office to meet with the RCF.

- The RCF went through all of my things to make sure I didn't have anything I wasn't supposed to have. I had a small coffee maker, which she said had to be kept in the main office for someone to come pick up. I didn't understand, but she said it was because we couldn't add any electrical appliances in our rooms (the building has an old electrical system) and that coffee is a stimulant that I shouldn't have.

- I had to do a monitored urine test. It was intimidating and scary and I was worried someone might come into the office and see me.

- I was assigned and taken to a room, assigned and met my mentor. She gave me some personal supplies and a food box and offered that my big sister would make me dinner tonight, if I wanted it – which I did!

- The whole thing took about an hour.

My Intake:

- [The intake could take 40-60 minutes; no family members other than children are present.]

- The intake coordinator went through my history, had me sign consent to treatment and releases for anyone I will be in contact with or bring me things, including emergency contacts, physicians, etc.

- I was asked to sign the consent to treatment without having read the Client Consent to Treatment, Notice of Privacy Practices, and Rights and Responsibilities even though my signature meant I had read it. I blindly signed it.

- I was handed an intake packet of paperwork (e.g., Client Self-Assessment, incl. Readiness for Treatment, Substance Use Inventory; Infectious Disease Risk Assessment Form, South Oaks Gambling Screen, Anger Survey, alcohol survey) and asked to fill them out. The intake coordinator asked if it was ok for her to ask me other questions while I was filling out all of those forms. I just checked the boxes as quickly as possible and didn't care how I answered it. I just wanted to get it done as soon as possible.

- She asked me if I had my OHP card (Oregon's Medicaid card) because she wanted to copy it. I said I didn't have one so she told me that I should tell my mentor when I meet with her because she would help me get the things I needed until I got my card back.

- She asked me how much I could "donate" as treatment fees, but since I don't have TANF I don't have to pay anything. I asked what the fees would be for since I knew the county pays for my treatment and I would be expected to pay once I get my baby back. I didn't get a really good answer. [Women don't like having to pay and frequently are late paying. They are expected to pay half of the TANF amount they receive, unless they have too many other outstanding bills that need to be paid first.]

Meeting with My A&D Counselor:

- Since I'm a Family Involvement Team (FIT) member, the A&D counselor had a report from them based on the assessment I already went through.

- I told her about the issues I was dealing with, like my legal problems and having had my 8-month-old taken away.

- She asked me all about my substance use and how I feel about that.

- She went through the questions on the computer and had to type in all of my answers, which took a long time.

- It was also awkward for me and for the A&D Counselor to deal with the computer – it was impersonal!

- She asked me about my domestic violence and how I feel about that.

- She told me that it would be important to include my significant other in treatment to make sure it would be good for me – if I chose to stay involved with him.

- She said that the male mentor can work with my SO. The mentor would meet with me next week and we could set up a time for my SO to come in.

- It was hard for me to deal with the rating scales (e.g., how difficult it is for me, from not at all to extremely).

- She made me go through a questionnaire that I had already filled out, but she apologized and said that she had to enter it now anyway.

- I asked when I could have my sister involved and she said that she could come to family night after I'm here for seven days, but I could call her now (on speaker phone with a staff person present) and she could bring me things.

- People kept walking in and out of the office because my A&D Counselor shares her office with two other people.

- She asked me really personal questions about physical and sexual abuse. Because I said I had experienced both of them, she had to go into a lot of even more personal questions. She didn't push me on things and said we could get back to them later – she was really kind about it. I went ahead and answered them anyway, but knew I could give them more details later.

- She asked a lot of things about my family, especially my mom and dad – alcohol and drug abuse, mental illness, etc.

- She told me that I could get into a program to get my GED.
- She went through a lot of questions I already answered, about education, employment, marital status, children, etc.
- She asked me about my treatment history with other agencies.
- Since I said I had used today, she thought I might need detox, but I wanted to try to go without – especially if I get my psych meds.
- She asked me a lot about my substance use, especially why I relapsed after being clean for six months. I told her it had a lot to do with being in a manic episode while I was off my meds.
- [The questions on the screen were not complete and the A&D Counselor had to elaborate into a complete sentence that made sense. Also, the response choices weren't always logical or meaningful – hard to pick and open to different interpretation.]
- Since I mentioned that I feel like walking out in front of a Mack truck, she wanted me to talk to a mental health counselor right away. I was able to convince her that I am not going to do anything right now or else I would have had to go to the ER. I went ahead and signed a no harm contract to make her feel better about me not going to the ER. I agreed that if I got worse, I would call the crisis line or go to the ER.
- Since it's a Thursday, I couldn't see the nurse today. I am on the list to see her next Tuesday, but if I need something sooner, they would get me into the walk-in clinic.

Meeting with my WEKU Mentor:

- [The client meets with mentor alone – no family members, but maybe their baby. The meeting with the mentor is usually two to three days after walking through the door and doing the intake.]
- My mentor started by giving me an overview of WEKU services and what the experience will be like.
- She asked questions about which services I thought I'd want or need.
- She asked me about my children and how I was involved in their lives. I explained how much I was concerned about my kids, especially my 9-year-old son.
- She encouraged me about involvement of my children, but noted that today it was important to get focused and comfortable.
- I received a lot of information about getting things in place to be able to parent and take care of basic needs for my children and me.
- She told me how my big sister (another current WEKU client who has been in the program a while) can help and support me, especially as I'm getting settled in treatment.
- She asked me to sign another consent to participate in WEKU and explained that it's because it's a special federal program – beyond what the agency (LifeWorks NW) normally does. She also asked me to sign releases for sharing information with other providers related to WEKU & PSU for evaluation.

- I needed to get my psych meds refilled because I have bipolar disorder. She said she would have tried to get me an emergency meeting with psychiatrist today, but since it's not Wednesday (the only day she's here), she would just try to call the last pharmacy her Rx was at or get in touch with her last psychiatrist. She also said I could go to a walk-in clinic to see someone else.

- I got a little upset at one point, but the mentor comforted me. She said that she is a graduate of Project Network and has been through it herself before. That helped a lot!

- She said she will set up a meeting with the children's staff to go over the services available and recommended for my children. I asked questions specifically concerning my about 9-year-old son, but the mentor couldn't answer them and encouraged me to ask those questions of the children's staff person I'll meet with later.

- While I was there, other staff kept walking in and out of office during my interview. They were picking up garbage, checking messages on the speakerphone, talking with each other (office is shared by three to four people). Apparently, one staff person is changing offices today and is in the process of moving in.

- She went through a bunch of paperwork, asking me about who referred me to this program, other agencies I work with, my PO/caseworker/etc. names/contact info.

- I told her all about not liking my previous TANF and food stamp worker and she said she would deal with telling my current TANF and food stamp worker that I didn't want to work with her anymore and would get me a new one – there is one specifically assigned to Project Network.

- She asked about needing any basic needs (e.g., birth certificates or other documentation, clothes, HBA).

- She asked be about all of my medical, dental, vision needs and recorded the things that needed to be arranged.

- She asked me about my current legal/court involvement and I told her that I'm going to have to go to a hearing about my baby. She told me that she or someone else from the agency could go with me.

- She asked me about any outstanding fees/expenses I still had to pay and she told me that I should work with my mentor to see how I can get help paying those off.

- She asked me to list all of my children's names/locations/custody/etc. I was concerned about that and asked why she needed that information. She explained that it helps them to know about my children and any needs they might have because they want to help my entire family. That was a relief! So, she also asked about my SO and how involved I am with him. She also wanted to know about his substance abuse and criminal issues. We talked about my other family members who are supportive of my recovery, and I told her that only my sister is helpful to me.

- She asked me about my goals for treatment and life in general, and what my transition plans (e.g., living arrangements) are for when I move out. She also asked about my goals related to my children and said we could develop a plan for regaining custody of them.

- We went over my plans to be involved with my SO while I'm in treatment. She also told me what my responsibilities are vs. my SO's responsibilities. She wondered if I wanted him to go to treatment or not, and I told her I did.

- She informed me that she would contact the PSU interviewer to schedule a baseline interview with me. She explained what that was about, but told me that the interviewer would give me a lot more information and answer any questions I might have. She told me that doing the interview was completely voluntary.

- [All staff get an email from the staff person who screens and accepts clients, notifying everyone of a new client. It has basic information (age, race, kids with her) about the new woman coming.]

4. What most surprised you during your walk-through?

- I was surprised that the intake worker (an administrative person) gave me all of those forms to fill out. She just stuck them in my face without knowing if I could read or was struggling with detoxing. She did not explain them or help me with them.

- The lack of privacy.

- I felt sincere warmth from the staff, which I knew happened, but I did not expect to come away with feeling it so strongly.

- I was so drained after going through all of that first day – I didn't know it would be so bad.

- I didn't like the experience of everyone talking more to their computer than to me. The computers seemed to interfere with the interpersonal connection that made me less comfortable with the process.

- I didn't like the intercom system – voices kept blurting out of the phones while we were meeting, sometimes calling for the staff person I was meeting with.

5. What two things would you most want to change?

1. Technology improvements, including a better (more sophisticated) phone system that doesn't rely on intercoms and laptops that would allow better interpersonal connection when doing an assessment and mobility to increase privacy (i.e., move to some other place in the building if other people need to be in the office where the assessment is occurring).

2. Have all of the forms or questions that are clinical or personal be asked by clinicians and not part of the administrative intake worker's process. That could also reduce redundancy of questioning.

Appendix 2: NIATx Coach Site Visit Summary

SITE VISIT: PPW/CSAT Program: The Village of Miami-May 16, 2008
Tommie Ann Bower, NIATx Process Improvement Coach

Present: Cathy Rogers, Clinical Director of PPW and Adult Programs, Children's Services Coordinator (Ainsley), Janet Nichols, Director of PPW, Denise Connors, Evaluator. Also met with data assistant, admissions rep, director of plant and facilities and the director of the Families in Transition program, Sharon Thomas.
Reviewed progress on goals: They are at 103% of admissions; six-month follow-up is lower than the target number.

Goal: Increase continuation by increasing family engagement.

A. Increase continuation by increasing family engagement

We reviewed the natural points of family contact within the program and looked for easy improvements to family engagement.

1) Admission: During prior phone coaching, we had explored the possibility of having PPW staff meet the family at the point of admissions. Staff meeting family could offer a card, and follow up with a phone call.

This approach is much more reliable as the program staff has high motivation for engagement whereas admissions staff is less likely to have sustained commitment, especially if the practice of greeting family is unique to PPW.

The program will implement this practice, insuring that business cards are complete and that staff is trained to the priority of family.

2) First week engagement. Advice given to program to place its interventions with families in the first week when the family is still the most concerned, and most likely to have need.

3) Family orientation. The Tuesday evening family orientation is geared to the client's and the program's needs—how to be supportive of the client when they are in treatment, contraband rules, and a referral to Al-anon. Discussed putting in an opportunity for welcoming families and asking for their questions.

Suggested Improvement: Take time for family questions during part of the orientation group. Practice engaging families at this point of connection by learning what their typical questions and needs are. Assemble these questions into a Family FAQ sheet.

Suggested Improvement: Insure that family members have a point of contact for their questions.

4) Family Visitation. There are onsite afternoon hours visiting on both Saturday and Sunday. The program will consider adding an ice cream social to the visiting hours. As we discussed this issue, Denise Connors reported that many of her perception/satisfaction surveys had noted difficulties with the visiting time. The issue was that there is nothing to do—no games, no easy topic of conversation.

Suggested Improvement: Although the program cannot encourage families to bring food onto the property, they may adopt something like the ice cream social to improve conversation and engagement. Other possibilities are to offer brief (30 minute) sessions on special topics to families.

5) Clinical. We discussed the possibility of seeking information from family members about the primary patient.

Suggested Improvement: There is an opportunity to help families with concerns about relapse. This might even extend to refusal skills for family members, rehearsal of problems.

B. Completion rate criteria: Reviewed the criteria for successful completion which is ASAM-based level of care criteria. During the day, we talked about the discrepancy that often exists between administrative understanding and the line staff. For example, when asked about length of stay, one staff reported six months, while researchers stated it was ASAM-based.

Suggested Improvement: review the criteria with staff to determine the actual functioning of the completion criteria.

Suggested Improvement: If the program is marketed through direct or indirect admissions as a six-month program this may influence the flow-through of admissions. The brevity, conciseness of the six-month program message means it will have staying power above and beyond fuzzier "individualized stay" formulations.

The evaluators have conducted perception surveys about program service elements. They are familiar with focus groups and have conducted one asking. "Why did you stay in treatment?" as opposed to "why did you leave treatment?" The conclusion is that the group of completing clients had developed a strong commitment to a purpose of abstinence, which they identified as differentiating them from the clients who leave. They articulate the effort it requires to distance themselves from "negativity" and that this is not a passive decision.

Suggested Improvement: The idea of using these kinds of focus group statements as marketing to families as their loved one enters treatment emerged from the discussion. The thought was that families need hope at the point they bring their loved one to treatment.

C. Data Gathering:

The evaluators will use a perception survey to track family responses to the changes in orientation group. In addition, counts will be taken of attendance at all family elements.

Appendix 3: WCFT Grantee Contact List

Little Rock, Arkansas
Nicola Conners, PhD
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Project Director
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Portland, Oregon
Jeanne Cohen LCSW
Lifeworks Project Network
Project Director
Email: cofull@msn.com

Appendix 4: Sample Questionnaire for Family and Friends

Dear Friend or Family Member: we ask for your thoughts and experience with the person we are treating for addiction.

1. What is your biggest worry about this person?

2. What do you hope might happen if he/she stays sober?

3. What is his/her biggest problem with staying sober/clean?

4. Are there people in his/her life that worry you?

5. How has his/her addiction affected you?

Please check anything you have noticed about the impact of his/her addiction on her functioning:

- ☐ Not showing up for important events (jobs, school, birthdays, etc.)
- ☐ Stealing
- ☐ Lying
- ☐ Staying up all night, sleeping during the day
- ☐ Fighting
- ☐ Forgetting things
- ☐ More than usual anger
- ☐ More than usual sadness
- ☐ Threatening to kill self, or others
- ☐ Talking about giving up
- ☐ Running away
- ☐ Isolating, avoiding family and friends
- ☐ More health problems What kind of health problems has she/he had recently?
- ☐ Difficulty deciding what to do
- ☐ Behind in bills
- ☐ Not washing regularly
- ☐ Broken bones, bruises
- ☐ Overdoses

5. Has she/he ever attempted suicide? What do you know about this?

6. Is she/he in an abusive relationship?

7. Does he/she have legal problems?

8. Are there any medical problems he/she has?

9. What strengths, talents, and qualities does he or she have?

10. Is there anything else that you think would help his/her treatment for addiction?

May we share this information with the person in treatment?

Thank you. If you have questions about this questionnaire please call:

Appendix 5: The NIATx Process Improvement Model

The NIATx Process Improvement Model

Founded in 2003, NIATx (formerly known as the Network for the Improvement of Addiction Treatment) resulted from the unique collaboration of two national initiatives: **Paths to Recovery**, funded by the Robert Wood Johnson Foundation (RWJF); and **Strengthening Treatment Access and Retention (STAR)**, funded by the Center for Substance Abuse Treatment (CSAT) and the Substance Abuse & Mental Health Services Administration (SAMHSA). What was particularly notable about these projects was their emphasis on systems and process—using existing resources, not more money to improve operations—and their shared focus on supporting people on their path to recovery.

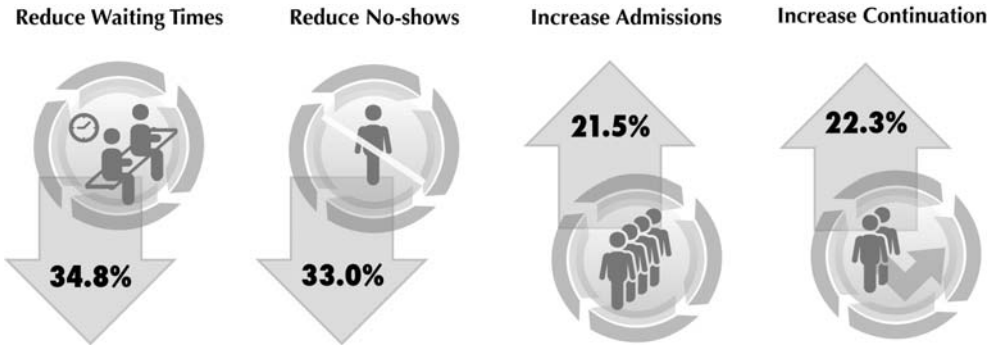
Quick facts about NIATx

- NIATx is a learning collaborative within the University of Wisconsin–Madison's Center for Health Enhancement Systems Studies.
- Founded in 2003
- Purpose: to promote peer networking and provide research, case studies, and innovative tools that encourage process improvement

Originally, NIATx focused on four aims related to improving treatment provided in addiction treatment centers:

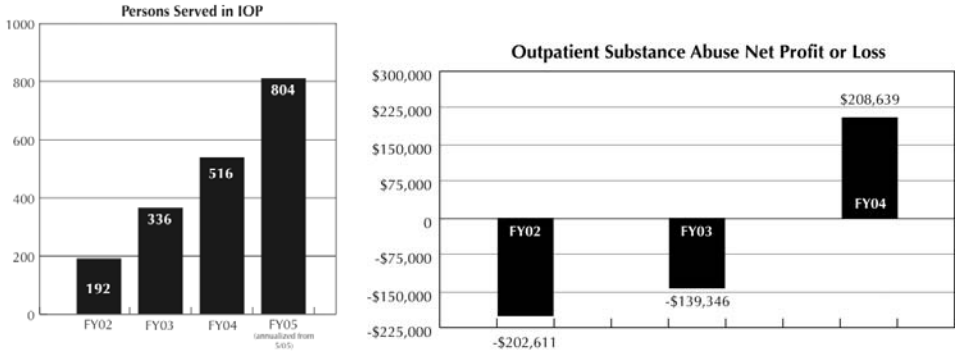
1) Cutting the time between when patients make first contact and when they get treatment
2) Reducing the number of appointment no-shows
3) Increasing the number of admissions
4) Keeping patients in treatment longer

To drive progress towards these aims, NIATx developed a process improvement model specifically designed for application in clinical settings. Application of that model across the country has proven highly effective. Here is a summary of results across all projects:



Equally important, these productivity and effectiveness gains have been shown to translate directly onto the balance sheet. The Acadia Hospital in Bangor, Maine, for example, was able to more than double the number of admissions it handled per month, with a direct translation into net contribution to margin (see Figure 1).

Figure 1: Increased admissions linked to improved profitability



Similar business impact has been demonstrated by NIATx members for each of the aims we target. Another facility, for example, changed to a walk-in appointment system; with the resulting increase in admissions, it increased annual fees by more than $300,000. (We made these outcome and impact links because we know that economics drive a treatment center's ability to offer services. A positive economic position is a better leverage point for clinical and/or organizational change. Programs that drain resources from the organization are rarely expanded.)

Experience with the NIATx improvement model in clinics has proven that focused problem solving and process improvement can have a real impact on many kinds of processes. For that reason, NIATx has begun offering its improvement model to other health care organizations. This workbook describes how to apply the basic NIATx process improvement model to any situation, not just in clinical settings.

Set the Foundation: Define Your Aims

Unfocused improvement efforts are almost surely a waste of time and money. That's why our model insists that organizations define their aims up front. As noted above, the treatment clinics where this improvement model was originally used had four aims they could choose from. Having clear, precise aims has been incredibly powerful. Our collaborating partners have come back to us and said many times, "Thank heavens you limited what we were allowed to do in this work!"

In a way, the treatment clinics benefited because the aims were given to them up front. Unless you also work for a clinic, you will have to do the work of defining aims yourself. If your organization already has strategic goals, start there. If not, you'll need to get your leadership together to agree on performance improvements that are required to achieve your strategic goals or mission.

To help you get started, we've included some background on why the four original aims were chosen (see sidebar, next page). As you can see, each of the aims has a clear link to a known problem in addiction treatment, and that achieving the aims will therefore have a real impact on treatment.

Why the four NIATx aims?

The four aims support the NIATx conviction that:

- Addiction is a chronic, progressive disease characterized by the need to change behavior to prevent further decline. Any interruption or delay in a patient's smooth entry into and progress through the treatment system represents a serious threat for exacerbation in this chronic illness.
- To maximize access and retention, treatment organizations must redesign work systems.
- Most treatment agency staff are committed to their jobs, but their work can be frustrating and stressful. Inefficiencies in administrative and clinical practices combine with low pay to create low job satisfaction and high turnover. High turnover makes it difficult to invest in training as the solution to the field's challenges, since the expertise leaves with the employee.
- Efficient administrative practices that reduce delays, facilitate the patient's entry into the system, minimize stress and task complexity, and maximize rewards to staff improve quality service and staff job satisfaction.

Introduction to the NIATx Improvement Model

Through experience with hundreds of organizations, NIATx has developed a model for conducting improvement projects. It has five phases:

1. Understand how the process operates (do a walk-through):

Experience has proven time and again that there is almost always a huge difference between what people *think* is going on in a process and what is *actually* going on! Actually experiencing a process through a "walk-through" is an excellent way to ground people in reality and spark improvement ideas. In the clinical settings where this model was first used, this action was completed by having team members pretend to be clients and go through the process exactly as a real client would. That helped them understand what it was like to do business with their facility and gave them a new appreciation for what it was like to be a customer.

If your organization works directly with clients or patients, you should consider doing something similar, having team members pretend to be your customers and go through your process. If your operations are more typical "office work," you will need to be creative in finding ways to track work through your processes (we'll give some suggestions later in the book). The point is that you can't just sit around in a room talking about what you think is going on, you have to actually experience your process in action.

2. Decide what you want to accomplish (what problem is most closely linked to your organization's aims):

The walk-through will help you understand which areas of your business are feeling the most pain, and therefore define a specific aim that should be addressed first. This is true no matter whether you are a clinic and will be using one of the predefined aims provided by NIATx or if your organization has developed its own aims (more on aims later).

3. Identify how you will know if a change is an improvement:

Before implementing changes, you need to know how you will evaluate progress. The answer lies in picking the right metric and gathering baseline data. Again, this step is the same no matter what your environment.

4. Select and test changes (rapid-cycle PDSA):

Now that you know what problems appear in your process, what aim you want to improve, and how you will evaluate the impact of a change, you're set to actually make changes. Rather than spend a long time developing and then implementing comprehensive or multi-faceted solutions, the NIATx approach is to do rapidly test a series of small changes using the PDSA (Plan-Do-Study-Act) Cycle. We found that this latter approach drives improvement much more reliably and quickly for people with limited time and limited improvement experience.

5. Sustain the gains:

Most process improvement projects do not sustain their gain beyond six months. According to Lynne Maher of the British National Health Service, there is considerable evidence that, in general, 70 percent of improvement projects do not survive more than six months. That being the case, you can safely assume yours won't survive either, unless you are proactive in taking steps to ensure that new procedures are kept in place.

"Sustaining the gain in organizational improvements is very similar to sustaining recovery in substance abuse treatment. Once the gain is accomplished, sustaining it is an ongoing process."

Dave Gustafson, Director, NIATx

The Three Change Roles

In the NIATx model of process improvement, staff members work together on teams to improve businesses processes that affect your specific aims. There are three roles needed to make this happen:

1) An **Executive Sponsor**—typically an influential manager or executive—is responsible for authorizing the time and resources needed to complete a project successfully.

2) The Executive Sponsor also designates a staff member as **Change Team Leader** to improve a process that influences one of the specific process improvement aims. Together, the Executive Sponsor and the Change Team leader agree on a plan for a Change Project. The Change Team Leader is responsible for organizing and conducting the project.

3) Together, the Executive Sponsor and Change Team Leader also assemble a **Change Team**, which includes staff members and in same cases, consumers. Each of these roles is discussed in more detail in Parts I and II of this book.

An optional fourth role:
A champion for change and improvement

The three roles we focus on in this guide are those needed to successfully complete a given improvement project: you need to involve the people who do the work (who participate on the Change Team), assign a leader for that team, and make sure the team is guided by the manager of the process or area involved (the "executive sponsor").

Many organizations have found that they can drive meaningful gains faster if they have someone at the executive level who has the overall responsibility for fostering improvement across the organization. This position has many titles—generically, you can think of it as a "champion" for change. The Champion is either a top executive or reports directly to one. He or she makes sure that the senior leadership include support for change projects in their overall plans for the organization.

Principles behind the NIATx Improvement Model

In developing our improvement model, we looked for research on process improvement and adoption of innovation to find evidence for what are truly the essential ingredients for process

improvement. We found three studies that had analyzed organizational change by comparing 640 successful and unsuccessful organizations in 13 industries. The studies examined 80 different factors that might possibly explain why some organizations were great at successful change efforts, while others floundered. (Gustafson and Hundt; 1995.)

Only five factors emerged as significantly important in organizational change. From all these factors, NIATx developed the Five Principles**:**

1. Understand and involve the customer
2. Fix key problems and help the CEO/Director sleep at night
3. Pick a powerful Executive Sponsor and motivated Change Team Leaders
4. Get ideas and encouragement from others, both inside and outside the organization or field
5. Use rapid-cycle testing to test effective changes

Principle 1. Understand and involve the customer

This factor had more predictive power in discriminating successful from unsuccessful organizations than all other factors combined. Among the original users of the improvement model (various NIATx agencies), those who put in the effort to understand customer needs and perceptions were far more likely to identify and implement improvements that had a big impact on the organization. As described earlier, getting this knowledge was done primarily through what we call a "walk-through," where staff members personally experience the treatment processes just as a customer does. The goal was to see the agency from the customer's perspective. Taking this perspective of treatment services—from the first call for help, to the intake process—and through final discharge proved to be a highly effective way for staff to understand how the customer feels, and to discover how to make improvements that will serve the customer better.

> The NIATx process improvement model considers staff another customer group. Involving staff in Change Projects and requesting their reactions to and advice about improvements helps agencies implement changes that meet their staff's unique needs.

As the improvement model has moved into applications beyond treatment services, the concept of the customer remained important, but is used in a broader interpretation, including everyone from "the next step in the process" to the ultimate end user.

Principle 2. Fix key problems and help the CEO/Director sleep at night

One of the mistakes we made in process improvement when we first started was that we picked "low-hanging fruit." We chose a process that was easy to change, spent nine months changing it, and created yawns from people who looked at it and said, "It took you nine months to do that?"

Thus, the second key principle, supported by research, is to solve a problem that is important to the CEO or executive director. And that is usually a problem related to the strategic goals or

financial position of the organization—something directly related to providing services or to improving the bottom line. The NIATx model of process improvement, as you will see, helps member organizations improve their service quality as well as the organization's finances, workforce development, and competitive advantage.

Principle 3. Pick a powerful Executive Sponsor and motivated Change Team Leaders

Improvement takes time and effort and energy. The only way to drive effective improvements that will have a lasting positive impact on your organization is to make sure that someone at the top (the Executive Sponsor) is leading the efforts and that the people leading your teams (Change Team Leaders) are motivated to get the job done.

The Executive Sponsor needs to needs to know the telephone number of the CEO or director by heart. This person needs to feel comfortable calling that person at 2:00 on Sunday afternoon or at 10:00 in the evening to talk about all kinds of issues, including those of business.

Change Team Leaders should be people who are highly respected, with a reputation for getting things done and an interest in trying out these new methods in order to make a real difference for your organization.

Principle 4. Get ideas and encouragement from others, both inside and outside the organization or field

Getting ideas for improvement from outside the organization was one of the most predictive factors of all those in the literature review that NIATx conducted. The organizations most successful in improvement look outside for ideas—to other fields, and to their peers. Moreover, those organizations tend to participate in multi-organizational relationships that motivate continuous improvement. Because of this importance of this principle, we give it expanded treatment in the coming pages.

Principle 5. Use rapid-cycle testing or pilot test to evaluate whether changes will be effective

Rapid-cycle testing dispels the myth that change is hard. The premise is that organizations can make progress much more quickly if they drive change via a rapid series of "small scale tests" vs. trying to plan and deploy a larger change all at once.

For example, in the original NIATx model application, clinic or agency teams would identify one test they would try one week in a limited context (one office, on one set of clients, etc.). They would then stand back to see what worked and what didn't. If the change worked, they would try it out on a slightly larger scale the following week. If it didn't work, the second week would be trying out a different change, again on a limited scale. By working a series of small changes, and incorporating lessons learned along the way, the teams quickly established a new process that the clinic or agency members would willing to adopt.

Conclusion

Launching Change Teams in your organization is no different from undertaking any other new endeavor. The ultimate responsibility resides with the leaders: the people who have the authority to allocate staff time, make sure the organization is accepting of the effort, and provide support to help everything go smoothly.

Appendix 6: Grantee PowerPoint Presentations

Arkansas Cares

Prototypes

Sstarbirth

The Village South

Waldenhouse

WEKU

Heartland Family Service

Mental Health Systems, Inc.

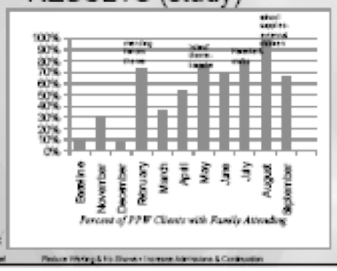
Arkansas Cares: AIM (plan)

- Increase Family Involvement in Treatment for External Family
  - Off-site children
  - Spouses/Partners
  - Fathers
  - Other Family of Mothers and Children
- Starting Point: Increasing Attendance at Family Visitation Days

CHANGE (do)

- Emphasize FUN – Focus on fun while still providing education
  - Get creative with crafts, games, meals, etc.
- Spread the word about Family Fun Day
  - Individualized invitations and follow-up phone calls
- Remove barriers
  - Provide gas cards, food, activities for kids of all ages

RESULTS (study)



NEXT STEPS (act)

- Continue with these strategies
- Find additional ways to support families once initial contact is made.
  - Family therapy
  - Case management
  - Referrals

IMPACT (business case, lessons learned)

- Strategies generally successfully in increasing attendance over baseline
- Difficult to know which strategies were most important
- Need to think about family work in continuing care phase
  - Often still 'getting started' when intensive phase ends

Prototypes AIM (Plan)

GOAL:

Increase family contacts & Reduce barriers to contacts

STRATEGIES:

- Small focus groups & family surveys
- Increase staff communication through database activity log
- Evaluate intake process to reduce barriers to treatment
- Use new tracking forms to collect data of program "changes"

NIATx

CHANGE (Do)

- Family picnics
- Thanksgiving Feast
- Family Movie Night
- Family Photos for Fathers

- Increased visiting schedules at varied rates
- Weekly Family Strengthening Group for clients and family members
- Father's Day Brunch

NIATx

RESULTS (Study)

Increases in Clients with Outside Support Contacts

- 763 contacts with outside supports*
  - 73% had face-to-face visits with off-site family/friends
  - 75% phone contacts
- Connections increased with various sources of support
  - 61% with off-site children
  - 38% with partners/fathers
  - 48% with parent of client
  - 23% with sibling of client
  - 47% with other family (e.g., aunt, in-laws, grandparent)
  - 14% with a non-family source of support

* Dec. 2002 – July 2004

NIATx

NEXT STEPS (Act)

- Focus groups & family surveys gave Prototypes a framework for change

- After each change, Prototypes tabulated & evaluated change plans looking at increase or decrease in family participation & anecdotal client input
- Plan new change to increase family participation keeping cost, impact on staff, & impact on entire program in mind

NIATx

IMPACT
(business case, lessons learned)

- COMMUNITY IMPACT:
  - Reduced costs of foster care
  - Reduced recidivism in treatment
  - Reduced costs of welfare through vocational linkages
  - Increased family support through community based linkages
- PROGRAM IMPACT:
  - Increased retention
  - Help broader program to become more family focused
  - Use "changes" as pilot studies for program enhancement
  - Increased family bonding
- LESSONS LEARNED:
  - Supplemental staff significantly increased effectiveness
  - Clients welcomed increased family contacts in "safe" setting
  - Staff resistance needs to be addressed

NIATx

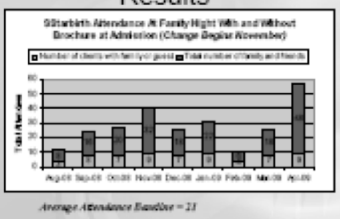
Sstarbirth AIM (plan)

- Baseline:
  - Family participation prior to Family Night [illegible] approximately two families per month involved in treatment beyond visiting hours.
  - Usually, only one family member per family was involved: Average of 24 family members per year
- NIATx Mascot: Little Tweak
- Plan:
  - Increase number of families/significant support people engaged with residents in treatment by increasing number of attendees at family and friends night.

CHANGE (do)

- Our 1st Little Tweak: A new brochure describing the family night was given to clients upon intake, rather than posting a flyer one week before a scheduled event. Clients were encouraged to discuss this with family/significant others during week of admission to program (vs. waiting for week of family night).
- *These contacts were the most important element of the brochure.*
  - *Clients and families were avoiding family night*
- Brochures were mailed to family members who had [illegible] visited Sstarbirth.

Results



Average Attendance Baseline = 21

Average Attendance Post-Change = 36

NEXT STEPS (act)

- Address family and residents' fears – to build a culture of enthusiasm for the events
- Utilize the most popular elements of Family Night to build participation further
  - Required residents' attendance (we are all family)
  - Contests (front door placement-acts as grounding exercise, dispels fear of what to do, results=prize)
  - Food (soothing, social skills, feels like home)
  - Projects/Games (Non-threatening focus [don't need to talk about family issues], mini-NIATx project family by family i.e. achieve one task together in a healthy, respectful, fun and caring way, have a souvenir of the evening)
  - SEEKING SAFETY- principles and tech[illegible]

IMPACT (business case, lessons learned)

- Little Tweaks set a lot of unseen and unexpected motion in motion
- Successful Little Tweaks created an appetite for more of them
- Noticing the effects of Little Tweaks, in a deliberate way at first, generated an appreciation for change that has become second nature

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Change Project Presentation

The Village South

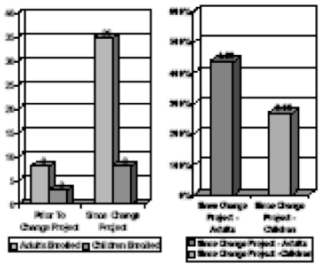
AIM (Plan)

- The Family In Transition (FIT) program at The Village South will focus on increasing the engagement of the Population of Focus during intake process.
  - Specifically biological fathers, children residing off-site and other family members of the primary clients
- Offering more family orientated services

CHANGE (Do)

- Intake Process:
  - Program staff meets the primary client and explains services available to family members
- Follow Up/Engagement (within 7 business days):
  - Case Manager and/or Outreach Specialist will contact family members indentified by primary client to engage in program participation
- Activities:
  - Weekly family support/education groups to understand drug addiction and its effects within the family unit
- Additional Programming:
  - Include weekend and holiday family orientated events

RESULTS (Study)



NEXT STEP (ACT)

- The Village South is designing and implementing a Family Centered System of Care
  - Where the family is the client
  - Additional services and resources can be offered to the family
- Each case is conceptalized and treated as a unit
  - Collaborative approach to clinical decisions

Case & Lessons Learned)

- The current SAMHSA cost band is based on individual clients instead of an entire family unit
  - With family members living off-site there are extra costs associated with providing services
- Women whose children are off-site may not be in the same household therefore requires home visits to each residence
- There is a service vacuum within the community and currently do not have enough staff to meet the extra demand. Staffing patterns need to be altered
  - Number of staff, Hours of operation (evenings/weekends), Home based visits and Reliable transportation
- The follow-ups only pay family members $20
  - May not be enough of an incentive to cover additional transportation and time commitments

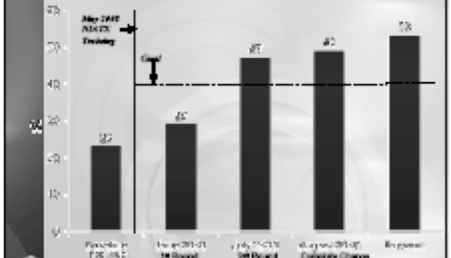
Waldenhouse: AIM– To Increase Family Participation

- Pre-change rate of family participation was = 23%
- AIM was to increase family participation to 40%

THE CHANGE PROCESS

- Family members were invited to share the participant's first meal when she arrived at the program.
- A personalized letter from our Child & Family Therapist was sent out to the participants family members and weekly follow-up phone calls were made to motivate and encourage family participation.

Walden House Family Participation



NEXT STEPS

- A second change process occurred and during this process the Family Psycho-education Group was moved to Saturdays to accommodate family schedules; lunch and raffles were provided as an incentive.
- Monthly Family Events (i.e. Holidays, picnics, etc.) began to be held in order to involve all members of the participants family and improve family program involvement.
- As a result of the Change Process the program staff have not only been able to sustain the changes but integrated them into the culture of the program.

IMPACT ON PROGRAM

- Increased Admissions from 20 in pre-change to 23 post-change, Retention for completers from 217 days pre-change to 229 post-change and for non-completers from 35 days pre-change to 55 days post-change, and finally our completion rates from 46% pre-change to 53% post-change.
- Program has also developed a Family Culture; it is no longer a women and children's program it is now a family program.

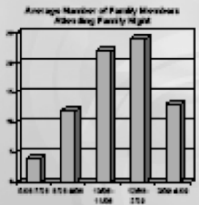
WEKU: AIM (plan)

- Increase engagement of family members of the women enrolled in Weku
- Increase participation of extended family in weekly Family Night
- Increase participation of Significant Others (SOs) in Couples Group

CHANGES (do)

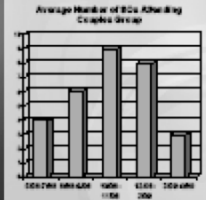
- Hold a Mother-Daughter Tea *[7/08]*
- Add individual meetings with new families *[7/08]*
- Add monthly new family orientation *[7/08]*
- Add couples group for the women and their SOs *[7/08]*

RESULTS (study)



- Increase in Family Night participation sustained 7 months after changes
- Multiple changes could not be sustained
- Too many family activities per week – burden on families

RESULTS (study)



- Increase in Couples Group participation gradual, but sustained 7 months after changes
- Greatest influence on participation – male staff person

NEXT STEPS (act)

- Identify one or two changes that can be sustained
- Ensure that change(s) don't add to staff burden
- Address other challenges that occurred with increased Family Night participation (e.g., where to put everyone!)
- Address challenge of incorporating men into a women's residential center

IMPACT (business case, lessons learned)

- Increased people in the building
  - Not the goal for staff – viewed as chaos
  - Need more staff help (e.g., daycare staff)
  - Need more rules
- Adding too many different things on different nights too burdensome
  - Staff stretched
  - Families stretched
  - Learned to combine activities on one night
- "It ain't gone be easy!"

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Heartland Family Service Family Works

AIM (plan)

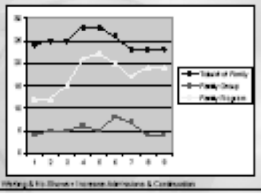
- Increase family members participation in client's treatment
- Develop positive engagement strategies

CHANGE (do)

- Hired Family Therapist
- Called family members, sent thank you letters
- Added a family handbook
- Modified pre-existing family group to include a family only group
- Included fathers in parenting group
- Family picnics
- Include family in discharge plan

RESULTS (study)

- Improved family participation from 50% to 83%



NEXT STEPS (act)

- Continue successful engagement strategies
- Train and update new staff
- Develop survey tool and periodically conduct family surveys
- Plan for increased use of incentives

IMPACT (business case, lessons learned)

- Increased motivation for client to follow recovery plan
- Family member roles identified in addiction process and education and support provided to help change behaviors
- Assistance provided to family members for their addictions when needed

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STAR-SI

Mental Health Systems, Inc.

- Program: Family Recovery Center Oceanside, Ca
- Evaluator: UCSD

STAR-SI

What: Increase Involvement of Fathers in Treatment Process

- Improve retention rates and child well being
- Encourages healthy development of father-child relationship
- Provide adequate funding and staff to effectively serve fathers

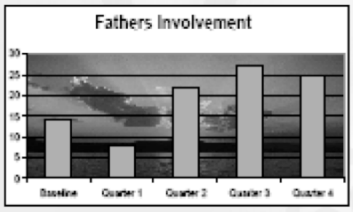
STAR-SI

How: Change Stuff

- Create non-threatening event(s)
- Ask for input
- Provide information
- Change staff schedules

STAR-SI

Results



STAR-SI

Program Changes

- Fathers offered conjoint therapy, family class, and supportive services
- FRC invites fathers to visit weekly
- Fathers provide feedback about desired level of involvement in the lives of their child(ren) and family member

STAR-SI

Coming Attractions

- Beginning Fall 2009:
  - Weekly "Focus on fathering" group
  - Curriculum derived from Strengthening Families and Fatherhood Project.