International Journal of Drug Policy 87 (2021) 102996

Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Research Paper

Perceptions of professionals regarding interventions involving family members responsible for justice-involved youth with substance use disorders in Santiago, Chile.

Mónica Lobato[a,*], Robbert Sanderman[a,b], Marcela Soto[c], Decio Mettifogo[c], Mariët Hagedoorn[a]

[a] University of Groningen;University Medical Center Groningen, Health Psychology Section, FA12, P.O. Box 196, 9700 CE, Groningen, Netherlands
[b] Department of Health Psychology, Health & Technology, University of Twente, Enschede, Netherlands
[c] Universidad de Chile, Facultad de Ciencias Sociales, Departamento de Psicología, Santiago, Chile

ARTICLE INFO

Keywords:
Justice-involved youth
Substance use disorder
Professionals' perceptions
Family intervention
Qualitative research

ABSTRACT

Background: Eliciting professionals' experiences of current drug treatment programmes can lead to improvements of these youth-centred programmes through the involvement of the concerned youths' families. We explored perceived barriers amongst professionals concerning interventions incorporating parents or guardians responsible for justice-involved youth with substance use disorders.

Methods: We conducted semi-structured in-depth interviews with fourteen female and four male professionals, each representing one of eighteen programmes under the Chilean National Drug Treatment Programme (2016–2017), who were tasked with contacting and/or intervening in the families of justice-involved youth. Subsequently, we performed traditional content analysis.

Results: The professionals identified four key barriers impeding interventions: (1) parents' non-adherence to the treatment and issues relating to their role fulfilment; (2) tensions within the programme design that constrain the families' involvement in the interventions; (3) the lack of a supportive professional network offering interventions that complement drug treatment; (4) the problematic and dangerous living contexts of these families that discourage family involvement. Additionally, professionals identified intervention needs for improving treatment outcomes.

Conclusions: The negative perceptions of professionals regarding the interventions as well as families and family contexts of justice-involved youth, and the lack of support from other programmes, induced feelings of hopelessness and pessimism amongst the professionals regarding the effectiveness of the Chilean National Drug Treatment Programme. It is essential to consider professionals' perspectives not only to benefit from their expertise, but also to assess whether their perspectives may hinder the implementation of changes when attempting to innovate drug treatment modalities aimed at improving their outcomes.

Introduction

Substance use disorders have become an increasing concern worldwide because of associated health, social and legal problems (Hogue, Henderson, Becker & Knight, 2018; Keaney et al., 2011; Kopak, Chen, Haas & Gillmore, 2012; Rigter et al., 2013; van der Pol et al., 2017). Although global drug use rates have remained stable in recent years (about 5.6% of individuals aged between 15 and 64 years use drugs), more than 10% of drug users are estimated to suffer from drug use disorders that require treatment (UNODC, 2018b). Moreover the risks of using drugs and developing a substance use disorder are higher amongst young people (UNODC, 2018a). Drug use rates are also higher amongst justice-involved youth (40–70%) compared with this rate for the general youth population (Schubert, Mulvey & Glasheen, 2011; Young, Dembo & Henderson, 2007). A Cochrane Review conducted to assess the effectiveness of intervention trials amongst drug-using offenders (youth and adults) revealed that they had limited success in reducing self-reported drug use and only some success in reducing re-incarceration rates (Perry et al., 2014). Furthermore, although studies have shown that the treatment of adolescents with a substance use disorder is more effective when their families are included (Hogue & Liddle, 2009; van der Pol et al., 2017), families are only included in a minority of such interventions of justice-involved youth (Young et al., 2007). Additionally, it is not known whether professionals working within youth-centred programmes would be willing to incorporate the families within these interventions and what they perceive as barriers

* Corresponding author.
E-mail address: m.e.lobato.concha@umcg.nl (M. Lobato).

https://doi.org/10.1016/j.drugpo.2020.102996

0955-3959/© 2020 The Authors. Published by Elsevier B.V. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/)

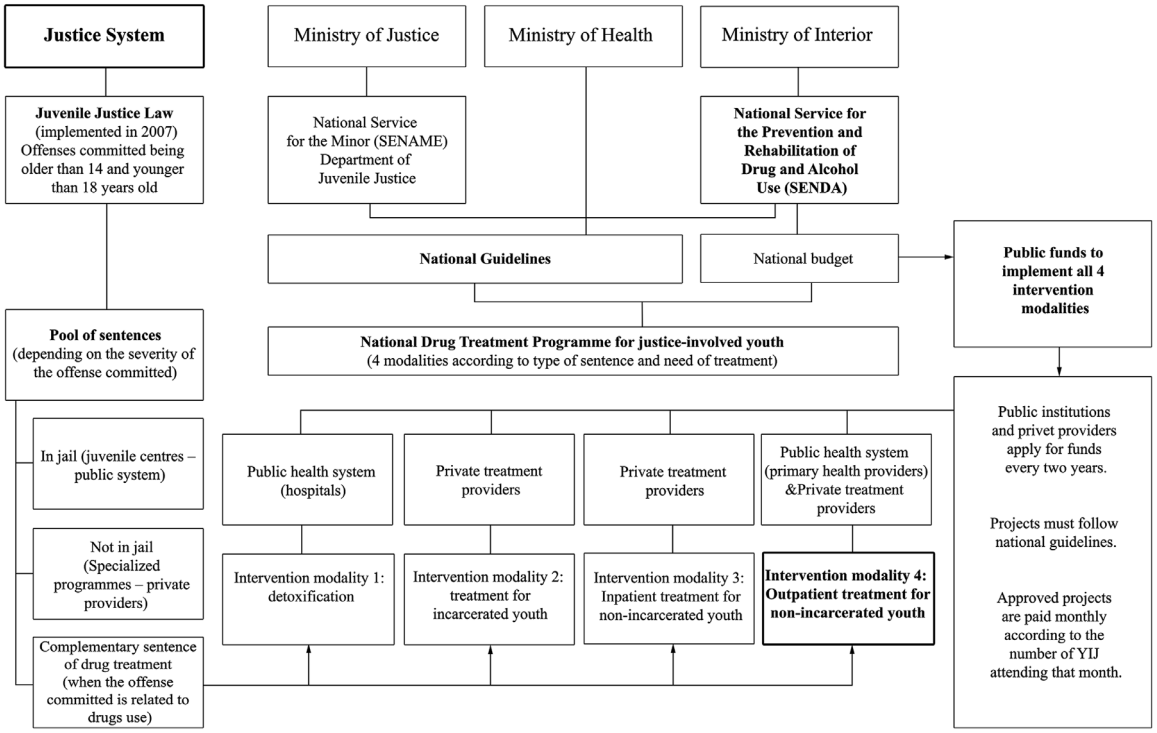


Fig. 1. Organization of the National Drug Treatment Programme for Justice-Involved Youth. JIY are sent to drug treatment by the justice system when the offence committed was related to drug used. Treatment is supplied by public and private providers (treatment teams) that every two years apply for public funds coming from the National Service for the Prevention and Rehabilitation of Drug and Alcohol Use (SENDA).

that could impede the inclusion of families. Our study was aimed at investigating whether professionals working with justice-involved youth in Chile are receptive to the inclusion of new or complementary family-orientated interventions based on their experiences of interacting with the family members of justice-involved youth and their beliefs about working with these families.

In Chile, where drug use rates are high amongst justice-involved youth (70%), the national drug treatment programme for justice-involved youth entails a youth-centred rather than a family-centred design (Ministerio de Salud, 2006). This programme was launched in 2007 (Fig. 1) as a component of a juvenile justice system (Corporación OPCIÓN & UNICEF, 2009). Drug use is not a crime per se in Chile, with the exception of drug use in public places (Ministerio del Interior, 2005). However, in cases where the crimes committed relate to drug use, the juvenile justice law provides for a complementary sentence, entailing the participation of the offender in a drug treatment programme (Ministerio de Justicia, 2005). The sanction delegate may also stipulate attendance of a drug treatment programme in the intervention plan presented to the court that provides guidance on the fulfilment of the sanction (Lobato, 2008).

The national guidelines for implementing the national drug treatment programme, which are based on a child development-centred approach, incorporate comprehensive diagnostics and interventions (Ministerio de Salud, 2006). However, a decade after the programme's implementation, formal assessments of its effectiveness remain to be conducted. Moreover, there is no evidence suggesting that its outcomes are any better than those of other international youth-centred programmes for justice-involved youth that have achieved limited success. Notably, the Chilean national guidelines for implementing the national drug treatment programme declare the importance of involving the families of justice-involved youth in their drug treatment. However, with the exception of a brief reference to several therapeutic modalities that have been found effective (i.e., family therapy, multidimensional family therapy and functional family therapy), neither the national guidelines nor the supplementary guidelines present clinical guidance on working with the youths' families (CONACE, 2008). Moreover, despite reported gaps in the national drug treatment programme identified by one study conducted at its inception (Lobato, 2008), the guidelines have not been updated in the last decade. Given the focus on youth in the Chilean programme, each team decides whether or not they will implement any (complementary) interventions involving the families. Consequently, independent assessments of the programme are needed.

In the context of this youth-centred drug treatment programme for justice-involved youth, it is critical to ascertain whether the concerned professionals are receptive to new or complementary interventions involving the families. Despite the likelihood of professionals being aware of the need for health and substance use disorder interventions, their associated perceptions (e.g., stereotypes and judgmental attitudes towards patients) constitute a potential barrier affecting the implementation of these programmes (Adams, 2008; Vorilhon et al., 2014). Thus, it is necessary to ascertain professional's working experiences within existing youth-centred drug treatment programmes before attempting to improve them through the involvement of the families. Our aim was to explore professionals' experiences of interacting with family members of justice-involved youth, their beliefs and the barriers they perceived regarding interventions that included family members within a youth-centred programmatic approach for treating substance use disorder.

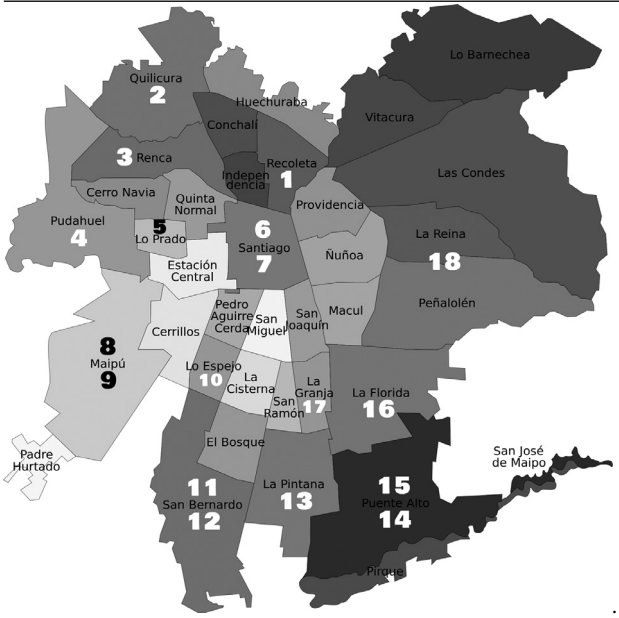
Methods

Participant selection

We applied a purposive sampling method to select participants for our study. Eligibility criteria were as follows: (1) professionals working in an outpatient drug treatment programme for justice-involved youth from the Metropolitan Region, (2) professionals having direct contact

Table 1
Social context of interviewed drug treatment teams.

Research ethics committees [a]	Municipality	Inhabitants[b] (under 18 years old)		Poverty by income [c] (%)	Multi dimentional poverty rate [d] (%)	Interviewed drug treatment teams [e]	Number of JIY per month [f]
MHS North	Recoleta	157,851	(41,041)	13.9	26.2	1. Talita Kum Joven	29
	Quilicura	210,410	(66,700)	7.8	18.5	2. Ágora Quilicura	20
MHS West	Renca	147,151	(47,235)	8.5	26.2	3. Solidaridad	18
	Pudahuel	230,293	(67,936)	7.8	20.5	4. Ágora Pudahuel	30
	Lo Prado	96,249	(25,987)	4.3*	19.7*	5. Pierre Dubois	17
MHS Central	Santiago	404,495	(61,483)	5.9	11.6	6. Ágora Santiago Centro	19
						7. Ágora Santiago Poniente	18
	Maipú	521,627	(141,361)	5.2	12.5	8. Ágora Maipú Oriente	18
						9. Ágora Maipú Poniente	18
MHS South	Lo Espejo	98,804	(28,357)	11.2*	26.7*	10. Caleta Sur	18
	San Bernardo	301,313	(99,735)	9.2	22.0	11. CTA Orión	34
						12. Los Morros	27
MHS South East	La Pintana	177,335	(61,890)	13.9	42.4	13. El Castillo	25
	Puente Alto	568,106	(173,840)	8.0	27.1	14. Amancay	25
						15. CEIF Puente Alto	10
	La Florida	366,916	(97,600)	3.1	17.0	16. Ágora La Florida	17
	La Granja	116.571	(32,873)	7.2	24.5	17. CAID La Granja	23
MHS East (Adults & children)	La Reina	92,787	(24,589)	4.3*	9.4*	18. Ágora La Reina-Peñalolén	18
	Peñalolén	241,599	(70,789)	4.8	20.7		



[a] The public health system in Santiago is divided into 6 Metropolitan Health Services (MHS).

[b] The information provided here correspond to the census carried out in 2017. The information between brackets refers to the inhabitants under 18 years old in the municipality.

[c] Poverty by income (data from 2015) is the percentage (%) of the inhabitants of the municipality who have less than $172 United States Dollars per month. The poverty by income percentage for the Metropolitan region was 7.1%, with a range of 0.6%–14.5%.

[d] Multidimentional poverty rate (data from 2015) is an index that includes different dimensions: education, health, housing, job placement, social security, and social cohesion. The multidimentional poverty rate for the Metropolitan region was 20.9%, with a range of 4.6%–42.4%.

[e] Numbers indicate the location on the map of the Metropolitan region (Santiago) beneath the table.

[f] Number of justice-involved youth (JIY) that can be cared for per month by a team, according to the project approved. The standard time for a treatment for a JIY is 24 months.

* Rates were obtained indirectly, using the average of the range where the municipality was rated.

with parents or guardians responsible for justice-involved youth enroled in a drug treatment programme and (3) membership of the treatment team for at least 12 months prior to the interview.

In the case of outpatient treatment, programmes for small groups of youth are implemented in residential zones inhabited by most of these youth (Table 1). The interventions are led by three members of a professional team comprising a psychologist, a social worker and a rehabilitation specialist assigned to the same individual. Complementary interventions are conducted by other professionals within the team (a psychiatrist, an occupational therapist, a general physician, a teacher and a psycho-pedagogue) (CONACE, 2004).

At the time of data collection, 24 outpatient drug treatment programmes were being implemented under the Chilean national drug treatment programme for justice-involved youth in the Metropolitan Region in Chile. Eighteen programmes accepted the invitation to participate in the study, and the remaining six teams declined for internal reasons (e.g., an ongoing evaluation being implemented by the national drug treatment programme). The principal investigator presented the

study to the team at the workplace of each of the programmes. Several meetings were conducted in April 2015. After the treatment teams had agreed to participate, the team director was asked to indicate which professionals met the selection criteria. This procedure was followed because the teams comprised small groups of professionals, with just one or two professionals usually having direct contact with the youths' parents or guardians. Informed consent for interviews was obtained telephonically from each of the selected professionals (18 in total; 14 women, 4 men; 9 social workers, 5 psychologists and 4 others), all of whom agreed to participate.

Interviews and data collection

In-depth semi-structured interviews were conducted in May 2015 by the principal investigator, who has a bachelor's degree and a master's degree in psychology from the University of Chile. The study's aim and the interview outline were discussed with staff at the drug treatment department of the National Service for the Prevention and Rehabilitation of Drug and Alcohol Use (SENDA). The interview outline was assessed by two professionals who had formerly worked with youth within drug treatment programmes. Discussion topics covered the characteristics (structure and functionality) of juveniles' families, the role of families of justice-involved youth in the drug treatment process, interventions involving families, the outcomes of these interventions, barriers pertaining to the outcomes and what was required for more effective implementation of the programmes. In addition to providing their verbal agreement, the professionals provided written informed consent prior to being interviewed and received no payment for participating in the study. Professionals were interviewed in a private room at their workplace. The interviews, which were audio-recorded, lasted between 48 and 107 min. Saturation was reached by the 16th interview, with no new information obtained for the final two interviews (17 and 18).

Data analysis

The audio recordings were transcribed verbatim by trained interviewers, following the Jefferson transcription guidelines adapted for research in the social sciences (Bassi Follari, 2015). To ensure anonymity, the transcripts were assigned individual numbers prior to the data analysis. Audio files and full transcripts were encrypted before they were stored, and the transcripts were anonymised before they were imported into ATLAS.ti 7.5.16 (2012), a software programme used for qualitative data analysis. All analyses were conducted in Spanish using traditional content analysis (Helgevold & Moen, 2005). Thus, during the first coding cycle, codes were created and defined deductively (based on topics from the interview outline) and inductively (based on the interviewees' responses) (Saldaña, 2009). The first coding cycle was performed line by line by two independent coders (ML and MS), and each coded interview was reviewed. Before an interview was coded, newly emerging codes in all of the previous interviews were checked. The second coding cycle was performed in four steps by three independent coders (ML, MS and DM). Initially, the 265 first-cycle codes were organised according to the ten topics in the interview outline. Subsequently, 26 codes unrelated to the topics (youths' profiles and interventions) were identified. Next, subgroups of the first-cycle codes were formed based on affinities in content relating to each topic. Lastly, 42 s-cycle codes comprising these subgroups of first-cycle codes were created. All of the decisions taken at each step were discussed. A reliability rating was not used because the aim was to reach a consensus, discussing and clarifying each difference until the group members unanimously agreed on the appropriate use of codes (Harry, Sturges & Klingner, 2005). Four further steps were implemented involving the same three independent coders. Firstly, second-cycle codes related to the research question were selected. Secondly, the topics of the non-related second-cycle codes were identified (e.g., how professionals interact with the youths' families). Thirdly, the 29 selected second-cycle codes were grouped according to content affinity. Lastly, we formulated five themes relating to these groups of second-cycle codes, which were organized into three levels for a better understanding (Table 2): (a) at the individual level 'families where intervention was difficult, (b) at the systemic level 'tensions entailed in the programme design' and 'the lack of a professional support network', and (c) at the structural level 'problematic and dangerous contexts.' The fifth theme was related to intervention needs (a code tree is presented in Table A in the supplemental material). A summary of the results was shared with the participants and their team supervisors, who validated them. Themes, sub-themes, codes (first and second cycles) and quotations used in this article were translated into English by a professional translator, with guiding inputs from the first author.

Ethical considerations

This research was part of a wider study on family factors related to substance use disorders of justice-involved youth undergoing drug treatment. Ethical approval was obtained from seven research ethics committees because the public health system in the Metropolitan Region is divided into six geographical areas, each with its own committee. Moreover, one committee is divided into two sub-committees, respectively covering studies involving individuals below and above 18 years.

Results

Despite their different backgrounds, professionals working in drug treatment programmes for justice-involved youth encountered common difficulties when approaching families regarding the four themes, which were organized in three levels. There is also a fifth theme related to needs for improving interventions.

A. Barriers perceived at the individual level

Theme 1. Families whose intervention is difficult

Professionals most frequently mentioned difficulties regarding the families of justice-involved youth. The frequency of these references was related not only to this topic's occurrence in the interviews but also to the number of aspects related to family difficulties that they mentioned. Professionals identified barriers in the following two key areas.

a. Difficult families that do not adhere to the treatment. 'Family' activities or interventions were usually only attended by one family member. The respondents stated that male parental figures rarely participate in the juveniles' treatment, and those who do mostly view their role as providing for the family's living expenses while the mother (or female figure) is held responsible for the children's upbringing. Therefore, in most cases, the mothers attend the treatment, with grandmothers or aunts attending in their absence.

When the teams identify someone within the family who can fulfil the role of a responsible adult, they usually face resistance from these individuals regarding their participation in the programme. According to the professionals, the reasons they provide for non-participation are lack of time (too many daily working hours, including weekends), as well as job locations that are far away from the treatment site and from their own homes. The professionals also identified several other reasons why parents or adults may not want to engage in the process. They are not willing to attend the programme if their juvenile offspring is not attending it, or they may generally lack a commitment to being involved in the lives of their offspring. The professionals perceived resignation to the juveniles' situation amongst those parents or responsible adults who did attend the programme. Families often lack hope that their juvenile offspring can change because they have previously attempted unsuccessfully to stop using drugs.

In many cases, those teams that have designed interventions involving the families observed that the parents or responsible adults were not willing to make personal changes. They noted that these individuals usually do not perceive any association between their parental behaviour

Table 2
Themes according to individual, systemic, and structural levels.

Type of theme	Theme	Individual level	Systemic level	Structural level
Barriers	Families where intervention is difficult	- Families that do not adhere to the treatment - Problems related to weak parental roles		
	Program design		- Barriers related to the design and implementation of the programmes that hindered professionals' performance (e.g., not complete teams and high turnover rate)	
	Support network		- Barriers related to the network (e.g., lack of integration of the justice, social and health systems)	
	Problematic and dangerous context	- Influence of the parents' family context - Influence of juveniles' behaviour		- Influence of the neighbourhood context
Not barriers	Needs		- Working conditions, intervention design and public policy functioning	

and/or the family's functionality and the juvenile's behaviour. Consequently, they are not interested in facing, speaking or even thinking about their own problems (because the juveniles, and not they, are in treatment). This view was expressed by a male psychologist '…sometimes there are families that say "Well, if I'm not the sick person, that's him, you need to call him, he has to go, it's nothing to do with me"' (Interviewee 8: male, psychologist in the programme for 4 years).

b. Problems related to weak parental roles. The respondents identified ineffective or weak parenting skills within these families as barriers. Owing to these weak parenting skills, identifying priorities (or even possibilities) for intervening in these families was complicated. They frequently mentioned that the normative system is either polarised or ineffective. Families do not establish rules because they do not want to be like their own parents or they feel guilty about not being stay-at-home parents. Alternatively, if there are rules, then there are no consequences for breaking these rules. Further, parents rarely monitor their juvenile offspring because they do not know how to do so when they themselves are not at home. Few families demonstrating weak parental roles sustained routines in daily familial life, such as shared activities (e.g., eating times or outdoor activities) or assigned responsibilities at home (e.g., washing dishes and tidying bedrooms). Thus, juveniles usually not engage in activities at home.

Furthermore, according to the professionals, many parents or guardians externalise the responsibility of the juveniles' upbringing and its consequences for other family members. Many of them are not providing the protective function expected of them, as confirmed by their explicit claims that they are not responsible for what juvenile offspring do because they do not know what they are doing. Moreover, the respondents noted that these parents primarily attribute responsibility to the juveniles, arguing that they are the ones who have decided not to go to school and not to help out at home; they have themselves created all of the problems confronting them.

The professionals perceived many of these parents to be incompetent in terms of raising youth. They suggested that a possible reason was overwhelm prompted by an excessive number of tasks to be accomplished. This issue is particularly salient when the father (or male figure) is absent within the family, leading to a doubling of the maternal role (i.e., working to bring in money and raising the children). Another frequently cited reason is parents' or guardians' untreated mental health problems (i.e., drug use and depression).

Because of the above-mentioned problems, the professionals deemed that the roles of the adults within these families demonstrated poor functionality (or dysfunctionality) and were below the required social standards. In many cases, juveniles were compelled to assume parental roles, assuming a position of power within the family from an early age. Consequently, their parents were no longer able to control them.

> *[there are several parental difficulties] from the establishment of clear, [to] consolidated and consistent norms. For the parental unit to really work as a unit, there must be no disagreements . . . eh, that affection has nothing to do with the boundaries, boundaries don't cause any harm. [As well as other problems] Ranging from problem-solving with their child, imagining the child as a child, not as a partner, as support or as a friend, . . . many [children] assume the role of a parent… (Interviewee 18: female psychologist in the programme for a year and a half)*

B. Barriers perceived at the systemic level

Theme 2. Tensions entailed in the programme design

Professionals reported barriers in the design and implementation of the programmes that hindered their performance. Drug treatments are collectively designed by a team that includes a psychologist, a social worker, a rehabilitation specialist, a psychiatrist and an occupational therapist. However, the teams are often not complete, thus overburdening other team members. The respondents indicated that there is a high turnover rate amongst the professionals and that uncertainties relating

to employment (contracts for just one or two years) as well as complexities relating to the field and the target population make it difficult to find replacements. This situation creates frustration and causes burnout amongst the professionals.

The models or theories used to support interventions seem to be in tension with practice. One group of interviewed professionals could not identify a working model or theory, implying that they do what they learned to do during their professional training. However, another group that identified a theoretical framework stated that the theories were not adequate for working with these families, as they do not apply to all of the different types of families that they work with. Moreover, they do not integrate all of the important elements that extend beyond substance use disorder. For instance, when families live in a risky and vulnerable context, this reality exceeds the interventions, and many professionals reported acting according to common sense.

> *I have heard testimonies from mums who have locked their children in their rooms so they can't go out. And they say to me, "Sir, I don't know if I am doing the right thing". I told her, "look, you know, if I weren't a therapist and had a child like this, I would lock him up too". . . . because it is desperation if [the neighbourhood] is full of drugs. It's full [of them] and nobody does anything. (Interviewee 2: male social worker in the programme for 3 years)*

Professionals also face difficulties with respect to the overall system design. For example, insufficient sites for interventions entailing the provision of detoxification programmes for juveniles. They also experience difficulties associated with their specific programmes, such as the inability to adjust family interventions according to the families' available times. From the interviewees' responses, it appears that the programmes do not closely match the families' profiles. Some of them felt that the programme timings did not accommodate the families' situations, given their observations that not every family member is ready to change at the same time; a longer intervention period is required. Thus, even though all of the professionals supported change, they felt despondent and had limited expectations of change occurring within these families. They noted that they have had to adjust their expectations to "feasible" rather than "big" changes that seemed to be out of reach.

Theme 3. Lack of a professional support network

Given the complex profiles of families and juveniles, the teams need to coordinate with other programmes in the implementation of complementary interventions. However, the professionals perceived a lack of integration of the justice, social and health systems that apply different approaches for understanding and intervening in these families. Thus, they lacked support for their drug treatment interventions.

According to the respondents, professionals within other programmes are not prepared to receive and work with these families. This is a critical issue because these other programmes could potentially facilitate or constrain drug treatment programmes, because of inadequate services offered to these families (e.g., no drug treatment programmes targeting women) or non-adjustment of the intervention to the families' needs (e.g., insufficient time slots available for appointments within a depression treatment programme). Therefore, the teams need to invest time and effort in training other professionals working in other programmes to obtain a comprehensive understanding and to adjust their interventions according to these families' profiles.

> *We have the possibility of working with the health network . . . to refer the girls more than anything, and the mums for mental health cases, let's say, depression . . . The problem is that on many occasions, the family doesn't adhere to the treatment. . . . These mothers are the breadwinners; therefore it is difficult for them to leave their workplace to go to therapy. (Interviewee 9: female social worker in the programme for 5 years)*

Moreover, professionals were uncomfortable with the coercive judicial context. They believed that the link between drug treatment and the justice system, as perceived by the families, was not conducive to adherence to the treatment because the families viewed the treatment programmes as coercive interventions. In addition, professionals working within the justice system neither explain to the families how the drug treatment works nor do they provide any motivational intervention prior to sending juveniles for drug treatment.

C. Barriers perceived at the structural level

Theme 4. Problematic and dangerous context

The professionals perceived the families' context as constraining their involvement and as an obstacle to achieving better treatment outcomes. This context entails the next three sub-contexts.

a. Influence of the neighbourhood context. While the conditions and contexts of the family were not uniform, several of them lived in dangerous environments where drug use and crime are prevalent. On the one hand, these risky and vulnerable environments were viewed by the respondents as impoverished areas located at a distance from the city centre and thus complicate access to public services (i.e., health and social services). Such areas reflect high levels of socio-cultural deprivation and exclusion and a poor quality of life. On the other hand, these areas are more prone to micro-trafficking and criminal gangs that attract juveniles.

> *For example, here there are entire settlements that are immersed in coca paste . . . that are, let's say . . . that have become really a . . . a settlement of zombies, of . . . of people that, in every other house, traffic drugs; that is lucrative for them. And also how they use the . . . the boys as soldiers to sell the drugs, do you get me? It's a really perverse social circle, and that is what we work with'. (Interviewee 4: female social worker in the programme for 3 years)*

These environments not only make it difficult for parents to believe that their children can change but they also make professionals' interventions in the families' homes complex and dangerous.

b. Influence of the parents' family context. Professionals held that it is difficult to change the behavioural patterns of juveniles that are deeply rooted in the families of origin of their parents or of the guardians because they are repetitive, ultimately inducing the juveniles' drug use problem. There are various patterns, notably violent family relationships (i.e., physical punishments used to train children and/or physical violence between parents) that commonly occur, especially when the children are young. Thus, juveniles learn to react violently to problems, and parents try to avoid conflict with their children. A second pattern entails drug use amongst a significant proportion of adults. Further, some adults are also involved in criminal activities (robberies and micro-trafficking), and this pattern may be repeated across generations.

> *. . . the families, were adolescent -fathers or mothers-, very young. Eh, and their past is the same. They had a violent dad, an unconcerned mother. Ehm, they say that, that their past was the same. They also, since adolescence, were using drugs, stealing, and their parents were also very violent, not very affectionate, they didn't set any boundaries. . . . [It's] like a trans-generational thing'. (Interviewee 16: female psychologist in the programme for 2.5 years)*

Thus, parents either do not perceive their children's drug use and criminal activities as a problem (because these behaviours are normalised) or they are habituated (resigned) to these problems.

c. Influence of juveniles' behaviour. The professionals also felt that the complexity of the juveniles' profiles makes these children difficult to manage and creates stress for their parents. Thus, many adults are reluctant to continue to help or support their children. The professionals noted that juveniles' drug use and criminal activities have increased in the last several years. In addition, juveniles are using a new class of substances, benzodiazepines, that induce more violent reactions. Additionally, they are using drugs at earlier ages when they lack awareness of associated problems. Thus, juveniles are committing more violent crimes.

It's a problem [for parents] when they [the children] use alcohol, crack, coca paste, cocaine, and non-prescription drugs because this generates a lot of problems at a behavioural level; problems at a relationship level. The children spend a lot of time on the street. There are some that sleep all day and go out at night. . . . [The parents] are worried when their children are slim, when they have to go out and find them at night, when the children cut themselves. (Interviewee 6: female family counsellor in the programme for 9 years)

Moreover, problematic juveniles' profiles not only include drug use but also several other problems, such as physical and mental health problems, risky sexual behaviours, sexual abuse, school dropout and/or a history of major violations of children's rights not only within the family but also within the public system (schools and the health, social services and family justice systems). When juveniles lose all of their family support, they often end up living on the streets.

D. Themes not related to barriers

Theme 5. Intervention needs

Apart from the above discussed barriers, the professionals identified elements that could help them to achieve better results when working with justice-involved juveniles' families in three main areas: working conditions, intervention design and public policy functioning. Better working conditions entail the inclusion of all of the necessary resources (financial, human and material) and greater employment stability (i.e., a permanent employment contract). An improved intervention design entails a working model that is adjusted to fit families' profiles along with clear guidelines for family interventions, the design of which should take account of the professionals' experience. Moreover, the respondents felt that they lacked the necessary expertise and indicated a need for more specialised training as well as a system for training new professionals to fulfil the requirements of drug treatment programmes.

It's related to the structure of the teams; being able to have more stable human resources. . . . [It's like] the three main professional groups are being put on the stand, and the other professionals who offer complementary support [are not] stable. . . . [And we need to] receive more training in this area, the teams may have more tools. If the teams had more time to reflect . . . Because there are many things, many emergencies that we need to attend to. (Interviewee 15: female social worker working in the programme for 1 year)

More effective public policy implementation would entail the introduction of effective family interventions from the outset, better coordination amongst public programmes (on many occasions, they over-intervene or their interventions reflect contradictory perspectives). Moreover, the respondents felt that in general, the state should assume a more proactive role in the implementation of public policies (e.g., not outsourcing drug treatment programmes).

Discussion

In sum, we found that even though some professionals identified only justice-involved youth as their direct patients, several others declared that the families' involvement is critical when working with young people undergoing drug treatment. However, they perceived difficulties in four areas when attempting to approach these families and to develop any type of relation or intervention with them. In addition, they perceived a need to improve their current practices with these families.

A. Individual level

Although the professionals generally agreed on the importance of working with justice-involved youth's families and expressed their willingness to do so, their overall perception regarding these families was very negative, based on their belief that not much can be done with them. Additionally, because the families are not perceived as the main targets of their interventions, some professionals (and teams) do not attempt to involve and work with the families in the treatment process. Previous studies on implementing guidelines for drug use have found that professionals' personal values may lead to judgmental or moralising values that undermine the implementation of research-based intervention guidelines (Adams, 2008; Andraka-Christou & Capone, 2018; Lin, Lan, Li & Rou, 2018; Vorilhon et al., 2014). In the present study, the interviewed professionals presented a long list of deficits they perceived in the parents. This conveyed the impression that they did not feel prepared to undertake family interventions. This perception may also be indicative of a barrier to implementing any (new) guideline for integrating families within interventions focusing on justice-involved youth. In light of studies suggesting that the effective implementation of programme guidelines is associated with professionals' feelings of responsibility, confidence and self-efficacy (Harris & Yu, 2016; Ramos, Sebastian, Murphy, Oreskovich & Condon, 2017), one strategy for overcoming this barrier may be to enhance such attributes in health providers. Further, a training programme that addresses professionals' attitudes and subjective norms may be helpful for overcoming their negative perceptions about their patients (Choo, DeMayo & Sun, 2018; Friedmann et al., 2015).

B. Systemic level

The design of the national drug treatment programme also presents challenges for professionals. The guidelines do not include clinical guidance for working with families. Thus, the teams apply their own frameworks to determine what to do and how to do it. Some teams use models to incorporate families, but many of these teams do not know how to implement these models into practice, stating that 'models do not fit these families' profiles' (Padwa & Kaplan, 2018). Others do not use any models to address the family component (i.e., the professionals do not believe in models; Adams, 2008). It is noteworthy that a feasibility study on adapting a family intervention for young people misusing drugs showed that the concept of family was considered challenging, as this group of young people usually have families that do not conform to the traditional family composition of two parents and their children. Consequently, it may be difficult to implement the traditional systemic family approach that entails an entire nuclear family in such situations (Watson et al., 2017). Additionally, an incomplete team (e.g., one lacking a social worker or psychologist) creates a burden on the other team members who are non-experts in tasks related to the families. Moreover, the treatment of justice-involved youth with substance use disorders is a complex and demanding job that is associated with high levels of staff turnover within teams, as has been seen in other demanding intervention settings (Szerman et al., 2014). These difficulties also affect the professionals' perceptions about their abilities to work with this population. As noted by several participants, they had to lower their expectations about their patients and their families being able to change because these high personal expectations were not met in their daily practice. Researchers have demonstrated the importance of providing training on the use of models or guidelines and its effectiveness in overcoming these barriers (Adams, 2008; Andraka-Christou & Capone, 2018; Friedmann et al., 2015; Harris & Yu, 2016; Ramos et al., 2017).

The barriers identified by participants in this study related to the establishment of an efficient professional network with two principal objectives. On the one hand, participants sometimes did not know about or have access to the necessary complementary interventions to which they could refer their patients. Alternatively, even when such programmes existed, these were not prepared to receive patients undergoing substance use disorder treatment. The teams experienced this barrier as being overwhelming, because they felt compelled to implement such interventions by themselves, or assumed that there would be patients

with unmet needs who would impact on the interventions that professionals implement (e.g., a mother with a drug use problem but no treatment program to refer her to). On the other hand, participants felt that the contradictory aims and models, for instance of sanction delegates within the juvenile justice system, or the lack of knowledge and stigmatisation of this population from other teams also had a negative impact on their interventions. Previous studies have also shown that difficulties associated with the integration of programmes result from a lack of community resources and support as well as the ambiguity of interventions that involve different goals, stigmatisation, or exclusion due to failure to adherence to assessment criteria (Adams, 2008; Gust & McCormally, 2018; Ramos et al., 2017). These barriers may be overcome by developing supportive exchanges between agencies, providing training in service delivery and addressing the values and beliefs of the personnel implementing complementary interventions (Adams, 2008).

C. Structural level

A more complex barrier may relate to the families' environments or contexts, which cannot be changed by the teams; rather, they constitute the framework within which they implement treatment programmes. The professionals identified many factors that negatively influence their interventions. This context induced their negative feelings regarding their work, such as hopelessness, powerlessness and frustration. Previous studies have shown that negative feelings may contribute to conflicts that influence professionals' judgments and coping responses, making it difficult for them to decide how to treat their patients (Deans & Soar, 2005). Moreover, negative feelings may increase the risk of burnout (Schulte, Meier, Stirling & Berry, 2010). The current literature does not explore professionals' negative feelings relating to the contexts of their interventions. Nevertheless, the findings of studies on professionals engaged in highly demanding psychological and social interventions (e.g., those involving hospice care, trauma survivors and terminally ill patients) may prove valuable. An important finding of these studies is that self-care and burnout prevention strategies constitute a key pillar relating to professionals' mental health (Alkema, Linton & Davies, 2008; Azar, 2000; Killian, 2008; Riordan & Saltzer, 1992).

D. Perceived needs

Finally, the participants identified needs that were directly related to the difficulties they perceived in relation to their work with the youths' families. They requested more training because they felt that they lacked adequate skills for intervening in these families. Moreover, they indicated that an improved design of the treatment programme was required as it did not provide sufficient guidance. Further, to enhance support obtained through a professional network, they noted that improved coordination amongst programmes was needed. These perceived programme deficits do not just apply to these professionals. A systematic review of the reported attitudes of mental health professionals working with co-morbidity diagnoses showed that professionals had an almost universal perception of deficiencies in services and in vocational training programmes (Adams, 2008). A further finding is that professionals working in the fields of mental health, substance use disorder and dual diagnosis usually mention areas of improvement relating to the provision of further training, inter-agency arrangements, oversight and the need for smaller caseloads (Deans & Soar, 2005; McGovern, Xie, Segal, Siembab & Drake, 2006; Ramos et al., 2017; Schulte et al., 2010). Therefore, it seems that when working in demanding settings, professionals need ongoing training, close supervision and more effective inter-agency exchanges to address the complexity of these profiles and contexts and to avoid burnout and turnover within the teams.

Strengths and limitations of the study

This study is the first to seek to understand professionals' perceptions regarding the involvement of families within drug treatment programmes targeting justice-involved youth. It addresses a critical gap, given that no other assessments have previously been conducted in Chile since the inception of the national drug treatment programme. Additionally, professionals are key stakeholders whose involvement in the process of conceptualising improvements in the programme guidelines or design is essential. However, this study had some limitations. Although we aimed to recruit one professional per outpatient programme active in Chile's capital of Santiago for the study, six of the teams were unable to participate. However, because we covered all of the sectors within the city, the families' profiles and contexts may have been adequately represented within the sample. For comparative purposes, we included only outpatient programmes to maintain similar profiles of justice-involved youth attending the drug treatment programmes. Thus, detoxification, inpatient treatment and treatment for justice-involved youth in jail were excluded. Finally, it is noteworthy that the contexts and perceptions of outpatient teams in other parts of the country may differ from those of the teams located in the capital.

Practical implications of the study

Although this study was explorative, its findings may provide inputs relating to outpatient programmes for policymakers. Recommendations on elements to be incorporated in (national) clinical guidelines are as follows: (1) provision of a clear definition of the concept of 'family' (Watson et al., 2017) and clarification on whether or not the family must be included within specific interventions; (2) clear aims and interventions to be implemented with families; (3) strategies for promoting family adherence to the programmes, which is a complex issue, given the families' characteristics; and (4) specific interventions for addressing transgenerational behavioural patterns, as the professionals identified this issue as a complex one within interventions. The following recommendations relate to programme implementation. The first concerns planning and designing training programmes that address professionals' perceptions, attitudes and beliefs about these families in conjunction with addressing models and/or guidelines (Friedmann et al., 2015). This process should be of sufficient duration to enable professionals to translate theory into practice (Schulte et al., 2010). Additionally, funds and resources should be allocated for the implementation of a permanent system offering clinical support, self-care and burnout prevention to the teams, especially given the stressful contexts in which they work (Alkema et al., 2008; Killian, 2008). In addition, we recommend the development of a system that facilitates the integration of substance use disorder treatment programmes with other complementary programmes. This system could include not only training programmes for working with this population but it could also address the values and beliefs of staff about this specific population (Adams, 2008).

Conclusions

In general, professionals working in drug treatment programmes for justice-involved youth are receptive to the inclusion of (new) interventions targeting the parents or responsible adults within these youth-centred programmes. Moreover, several programmes have already developed different ways of approaching and working with the families. However, professionals evidenced a negative perception of these families their living contexts and of the intervention itself and reported that they did not receive support from other complementary programmes. These barriers induce feelings of hopelessness and pessimism amongst

professionals regarding the effectiveness of the current programmes. Efforts to innovate the treatment modalities aimed at improving the outcomes must therefore take into account professionals' perspectives not only to avail of their expertise but also because their current perspective could pose a barrier to the introduction of any programmatic changes.

Funding

This study was conducted as the doctoral study of the first author, who is being supported by a scholarship from the Chilean government. However, the sponsor played no role in any part of this study. No other funding was obtained for this research.

Declaration of Interests

None.

Acknowledgements

We would like to thank the National Service for the Prevention and Rehabilitation of Drug and Alcohol Use (SENDA) of the Chilean government for supporting this research as well as the programmes and institutions that agreed to participate in the study.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.drugpo.2020.102996.

References

Adams, M. W. (2008). Comorbidity of mental health and substance misuse problems: A review of workers' reported attitudes and perceptions. *J. Psychiatric and Mental Health Nursing, 15*(2), 101–108. 10.1111/j.1365-2850.2007.01210.x.

Alkema, K., Linton, J. M., & Davies, R. (2008). A study of the relationship between self-care, compassion satisfaction, compassion fatigue, and burnout among hospice professionals. *J. Social Work in End-of-Life and Palliative Care, 4*(2), 101–119. 10.1080/15524250802353934.

Andraka-Christou, B., & Capone, M. J. (2018). A qualitative study comparing physician-reported barriers to treating addiction using buprenorphine and extended-release naltrexone in U.S. office-based practices. *Int. J. of Drug Policy, 54*, 9–17. 10.1016/j.drugpo.2017.11.021.

Azar, S. T. (2000). Preventing burnout in professionals and paraprofessionals who work with child abuse and neglect cases: A cognitive behavioral approach to supervision. *J.Clinical Psychology, 56*(5), 643–663.

Bassi Follari, J. E. (2015). Gail Jefferson's transcription code: Adaptation for its use in social sciences research. *Quaderns de Psicologia, 17*(1), 39–62. 10.5565/rev/qpsicologia.1252.

Choo, E. K., DeMayo, R. F., & Sun, B. C. (2018). Is there a mismatch between policies to curtail physician opioid prescribing and what we know about changing physician behavior? *Int. J. Drug Policy, 56*, 54–55. 10.1016/j.drugpo.2018.03.002.

CONACE. (2004). *Drogas: Tratamiento y rehabilitación de niños, niñas y adolescentes. orientaciones técnicas desde una mirada comprensiva evolutiva*. Santiago de Chile: Gobierno de Chile: (Consejo Nacional para el Control de Estupefacientes, Ed.) Retrieved from http://www.vel.cl/enac/pdf/20758-1.pdf.

CONACE. (2008). *Niños, niñas y adolescentes: Tratamiento de drogas*. Santiago de Chile: Gobierno de Chile: (Consejo Nacional para el Control de estupefacientes, Ed.) Retrieved from http://www.bibliodrogas.gob.cl/biblioteca/documentos/TRATAMIENTO_CL_6028.pdf.

Corporación OPCIÓN, & UNICEF. (2009). *Conoce tus derechos. manual sobre la ley de responsabilidad penal de adolescentes*. Santiago: de Chile: UNICEF Chile Retrieved from http://www.unicef.cl/web/wp-content/uploads/doc_wp/Manual_LRPA_Web_c.pdf.

Deans, C., & Soar, R. (2005). Caring for clients with dual diagnosis in rural communities in Australia: The experience of mental health professionals. *J.Psychiatric and Mental Health Nursing, 12*(3), 268–274. 10.1111/j.1365-2850.2005.00830.x.

Friedmann, P. D., Wilson, D., Knudsen, H. K., Ducharme, L. J., Welsh, W. N., & Frisman, L. , … Vocci, F. J. (2015). Effect of an organizational linkage intervention on staff perceptions of medication-assisted treatment and referral intentions in community corrections. *Journal of Substance Abuse Treatment, 50*, 50–58. 10.1016/j.jsat.2014.10.001.

Gust, S. W., & McCormally, J. (2018). National Institute on Drug Abuse International Program: Improving opioid use disorder treatment through international research training. *Current Opinion in Psychiatry, 31*(4), 287–293. 10.1097/YCO.0000000000000426.

Harris, B. R., & Yu, J. (2016). Attitudes, perceptions and practice of alcohol and drug screening, brief intervention and referral to treatment: A case study of New York State primary care physicians and non-physician providers. *Public health, 139*, 70–78. 10.1016/j.puhe.2016.05.007.

Harry, B., Sturges, K. M., & Klingner, J. K. (2005). Mapping the process: An exemplar of process and challenge in grounded theory analysis. *Educational Researcher, 34*(2), 3–13. 10.3102/0013189X034002003.

Helgevold, N., & Moen, V. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277–1288. 10.1177/1049732305276687.

Hogue, A., Henderson, C. E., Becker, S. J., & Knight, D. K. (2018). Evidence base on outpatient behavioral treatments for adolescent substance use, 2014–2017: Outcomes, treatment delivery, and promising horizons. *J.Clinical Child and Adolescent Psychology, 47*(4), 499–526. 10.1080/15374416.2018.1466307.

Hogue, A., & Liddle, H. A. (2009). Family-based treatment for adolescent substance abuse: Controlled trials and new horizons in services research. *Journal of Family Therapy, 31*(2), 126–154. 10.1111/j.1467-6427.2009.00459.x.

Keaney, F., Gossop, M., Dimech, A., Guerrini, I., Butterworth, M., & Al-Hassani, H. (2011). Physical health problems among patients seeking treatment for substance use disorders: A comparison of drug dependent and alcohol dependent patients. *Journal of Substance Use, 16*(1), 27–37. 10.3109/14659890903580474.

Killian, K. D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology, 14*(2), 32–44. 10.1177/1534765608319083.

Kopak, A. M., Chen, A. C.-C., Haas, S. A., & Gillmore, M. R. (2012). The importance of family factors to protect against substance use related problems among Mexican heritage and White youth. *Drug and Alcohol Dependence, 124*(1–2), 34–41. 10.1016/j.drugalcdep.2011.12.004.

Lin, C., Lan, C.-. W., Li, L., & Rou, K. (2018). Service providers' adherence to methadone maintenance treatment protocol in China. *Int. J. Drug Policy, 56*, 1–5. 10.1016/j.drugpo.2018.02.018.

Lobato, M. (2008). *Equipos de tratamiento del consumo problemático de drogas de la red de salud: Percepciones, dificultades y desafíos ante la ley no 20.084 sobre responsabilidad penal adolescente*. Chile: Universidad de Retrieved from http://www.tesis.uchile.cl/tesis/uchile/2008/lobato_m/sources/lobato_m.pdf.

McGovern, M. P., Xie, H., Segal, S. R., Siembab, L., & Drake, R. E. (2006). Addiction treatment services and co-occurring disorders: Prevalence estimates, treatment practices, and barriers. *J. Substance Abuse Treatment, 31*(3), 267–275. 10.1016/j.jsat.2006.05.003.

Ministerio de Justicia. Ley N 20.084 que establece un sistema de responsabilidad de los adolescentes por infracción a la ley penal (2005). Santiago de Chile: Justicia Penal. Retrieved from file:///C:/Users/USUARIO/Downloads/LEY-20084_07-DIC-2005.pdf

Ministerio de Salud. Norma técnica No 85: Tratamiento integral de adolescentes infractores de ley con consumo problemático de alcohol-drogas y otros trastornos de salud mental., Pub. L. No. Resolución Exenta No 391 (2006). Retrieved from http://bibliodrogas.cl/biblioteca/documentos/TRATAMIENTO_CL_5449.PDF

Ministerio del Interior. (2005). *Ley no 20.000 que sanciona el tráfico ilícito de estupefacientes y sustancias sicotrópicas*. Santiago: Justicia penal Retrieved from https://www.leychile.cl/Navegar?idNorma=235507.

Padwa, H., & Kaplan, C. D. (2018). Translating science to practice: Lessons learned implementing evidence-based treatments in US substance use disorder treatment programs. *European Journal on Criminal Policy and Research, 24*(2), 171–182. 10.1007/s10610-017-9360-3.

Perry, A. E., Coulton, S., Glanville, J. M., Godfrey, C., Lunn, J., & McDougall, C. (2014). Interventions for drug-using offenders in the courts, secure establishments and the community. (Review). *Cochrane Database of Systematic Reviews*. 10.1002/14651858.CD005193.pub3.

Ramos, M. M., Sebastian, R. A., Murphy, M., Oreskovich, K., & Condon, T. P. (2017). Adolescent substance use: Assessing the knowledge, attitudes, and practices of a school-based health center workforce. *Substance Abuse, 38*(2), 230–236. 10.1080/08897077.2017.1287149.

Rigter, H., Henderson, C. E., Pelc, I., Tossmann, P., Phan, O., & Hendriks, V., … Rowe, C. L. (2013). Multidimensional family therapy lowers the rate of cannabis dependence in adolescents: A randomised controlled trial in Western European outpatient settings. *Drug and Alcohol Dependence, 130*(1–3), 85–93. 10.1016/j.drugalcdep.2012.10.013.

Riordan, R. J., & Saltzer, S. K. (1992). Burnout prevention among health care providers working with the terminally ill: A literature review. *OMEGA - J. Death and Dying, 25*(1), 17–24.

Saldaña, J. (2009). *The coding manual for qualitative researchers*. London: SAGE Publications Ltd Retrieved from http://www.iribresearch.ir/rm/book/The coding manual for qualitative researchers -Johnny_Saldaña-2009.pdf.

Schubert, C. A., Mulvey, E. P., & Glasheen, C. (2011). Influence of mental health and substance use problems and criminogenic risk on outcomes in serious juvenile offenders. *J. American Academy of Child Adolescent Psychiatry, 50*(9), 925–937. 10.1016/j.jaac.2011.06.006.

Schulte, S. J., Meier, P. S., Stirling, J., & Berry, M. (2010). Dual diagnosis competency among addiction treatment staff: Training levels, training needs and the link to retention. *European Addiction Research, 16*(2), 78–84. 10.1159/000277657.

Szerman, N., Vega, P., Grau-López, L., Barral, C., Basurte-Villamor, I., & Mesías, B. (2014). Dual diagnosis resource needs in Spain: A national survey of professionals. *J. Dual Diagnosis, 10*(2), 84–90. 10.1080/15504263.2014.906195.

UNODC. (2018a). *World drug report 2018*. Vienna: Drugs and age Retrieved from https://www.unodc.org/wdr2018.

UNODC. (2018b). *World drug report 2018*. Vienna: Executive summary, conclusions and policy implications Retrieved from https://www.unodc.org/wdr2018.

van der Pol, T. M., Hoeve, M., Noom, M. J., Stams, G. J. J. M., Doreleijers, T. A. H., & van Domburgh, L. , & Vermeiren, R. R. J. M. (2017). Research review: The effectiveness of multidimensional family therapy in treating adolescents with multiple behavior problems – a meta-analysis. *J. Child Psychology and Psychiatry and Allied Disciplines* Wiley/Blackwell (10.1111). 10.1111/jcpp.12685.

Vorilhon, P., Picard, V., Marty, L., Roussel, H. V., Llorca, P. M., & Laporte, C. (2014). Attitudes of family physicians towards adolescent cannabis users: A qualitative study in France. *Family Practice, 31*(5), 585–591. 10.1093/fampra/cmu030.

Watson, J., Toner, P., Day, E., Back, D., Brady, L. M., & Fairhurst, C. (2017). Youth social behaviour and network therapy (Y-SBNT): Adaptation of a family and social network intervention for young people who misuse alcohol and drugs - a randomised controlled feasibility trial. *Health Technology Assessment, 21*(15), 1–259. 10.3310/hta21150.

Young, D. W., Dembo, R., & Henderson, C. E. (2007). A national survey of substance abuse treatment for juvenile offenders. *J. Substance Abuse Treatment, 32*(3), 255–266. 10.1016/j.jsat.2006.12.018.