Identifying the role of families within Treatment

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A Report Prepared for Adfam by

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Executive Summary

- Large numbers of families in the United Kingdom are affected by the behaviour of substance misusers in significant ways. In England alone, more than 1.5 million people may be affected by a family member who is a regular user of Class A drugs.

- Strengthening family support for those who use drugs can have positive benefits for treatment outcomes. However, some affective relationships, for example where the parties to the relationship are themselves involved in harmful substance use, can make rehabilitation more difficult. It is crucial therefore that family based therapeutic interventions are carefully targeted following an appropriate assessment of the supportive relationships that may or may not be available.

- Family members of drug users, and people in affective relationships with these users, are currently underserved by the current treatment strategy. Very few agencies are directly concerned with the wellbeing of carers and family members or their direct involvement in treatment plans. Moreover, there is a general lack of awareness of the effects of a person's substance misuse on their families by both the general public and professionals.

- To date, the scientific research has mostly concentrated on adolescent substance misusers and the role families can play in education, harm avoidance and treatment effectiveness. Resources have mostly been targeted at substance misuse affected families with children in younger age groups (especially infants and under fives). More research needs to be conducted into the effectiveness of positive family involvement in the care and treatment of adult substance misusers, especially those involved in the criminal justice system; looked after children in the care of local authorities; and children with no formal family support (e.g. unaccompanied asylum seeking minors).

- The needs of family members, carers and significant others who are willing and able to help in the treatment process must be adequately addressed and included in any treatment or support plan.

Introduction

In June 2005, Public Health Minister Caroline Flint welcomed the launch of a new treatment strategy by the National Treatment Agency which aims to focus on the service user's journey through the treatment process. 'This strategy', said the minister, 'is vital in helping to provide a life away from drugs for the user and a new future for families, friends and communities affected by the impact of drug addiction'.[1] The welcome emphasis on the family and community impact of substance misuse in drug prevention and treatment initiatives in the United Kingdom provides the context for this report which offers a synthesis of existing findings in relation to treatment effectiveness and the role of families from a variety of different national settings and experiences.

Drug and alcohol misuse can have a devastating affect not only on the lives of the individuals concerned, but also on those who live with or who maintain a close relationship with a problematic user of alcohol and/or narcotics. Home Office figures estimate the number of problematic Class A drug users in England at between 281,125 and 506,025. Adfam calculates that on average three family members are affected by another member's problem drug use, which would give figures of between 843,375 and 1,518,075 for this category of substance misuse in England alone. In the United Kingdom, 250,000 to 350,000 children of problematic drug users require specific support and attention; the equivalent of about one child for every problem drug user (ACMD, 2003). The burden of dealing with drug misuse is likely to fall on the user's family, a problem that may be compounded by feelings of shame and guilt (Usher, et al 2005; Velleman and Templeton, 2003; Sims, 2002). However, those who work in the field of drug treatment and prevention increasingly consider the family to be a key resource in harm avoidance and treatment effectiveness strategies.

This report will explore the possibilities of improving treatment results and long term rehabilitation through increased support for families of those involved in drug and

[1] National Treatment Agency press release, June 30 June 2005, 'New drug treatment effectiveness strategy launched: focus on the service user's journey'.

alcohol misuse. A highly synthetic review of the literature in the field was conducted in 2006. This review confirms the importance of the role of the family in the lives of drug users and suggests that families can be extremely valuable in ensuring successful treatment, but the situation often needs to be mediated and families – in addition to the individual drug user – require substantial support during the treatment phase and beyond. Moreover, approaches to closely involving the family in drug treatment must consider individual situations and circumstances, such as stigma, cultural sensitivities and whether there are other drug users in the family.

The literature review is followed by an analysis of the results of personal interviews conducted with representatives of treatment agencies, as well as the results of a questionnaire distributed amongst the same group. Participants were selected based on researching relevant organisations in public directories and on the internet and subsequently by snowballing existing participants. The sensitive nature of the research, and issues of confidentiality amongst service users, made this selection process both sensitive and effective. In addition, a focus group was conducted with the Loughborough-based support project *Snowdrops Family Drug Support*, which aims to provide support for families and carers of people affected by drug use. The core of this research was carried out between March and May 2007. Again, the importance of the family in successful drug treatment is highlighted through this research, but it also reveals a high level of complexity due to the substantially different circumstances of individual drug users and their families.

Literature Review

The family is increasingly considered to be a key resource in harm avoidance and treatment effectiveness strategies. Some approaches to understanding drug misuse assert that, because drug misuse problems may originate within the family and because the negative impact is most felt by family members, the family unit is ideally placed to explore the problems of a drug user and to be in a position to help change their environment and provide a valuable support network.

Most of the treatment options available have traditionally focused on the individual client. However, both within the scientific literature and among an increasing number of treatment centres and support services, there is recognition that family members can make a valuable contribution to positive treatment outcomes. However, coping with a family member's substance misuse can have an extremely negative impact upon families, and on individual family members' mental and physical health.

Much of the literature reviewed here sees the family as a resource for the drug dependent subject. However, other studies stress the importance of the well-being of the family as a whole and tend to see the drug misuse of individual family members as but one symptom of a greater underlying problem. This literature review is designed to reflect the bias of the literature towards particular age groups, relationships, and 'at risk' groups; as a consequence there exist overlaps between different categories of analysis as well as gaps in terms of the evidence base.

Preventing Substance Misuse in Adolescents

Much of the literature written about families and drug misuse is centred on the theme of family interventions as a means of preventing problematic adolescent drug use, which is a large and recognised problem in many contemporary societies. When parents were questioned about their greatest fears, most concern focussed on the risks posed by drugs and alcohol for their children (21%) in the United Kingdom

regardless of age, income or job status, with some variation by location. Parents in Scotland were most concerned about the issue of drugs (34%), whilst those in London were least concerned about the threat of drugs (11%) (NFPI, 2001a). Black and minority ethnic (BME) families were also concerned about alcohol and drugs, though slightly less so (on average 16%), and unlike the parents in the mainstream survey it was not the most pressing concern raised (NFPI, 2001b). Parents' fears about drugs may be well founded, as children are increasingly likely to be offered alcohol and drugs (35.5% of 11-15 years olds have been offered drugs), with "relatively high" levels of substance consumption by 12-17 year olds, with one in four classified as 'frequent drinkers' (NFPI, 2001a).

Family factors have been shown to hold the most potential to prevent or increase the risk of adolescent drug misuse (Vakalahi, 2001; Liddle, 2004). Positive family attributes include strong parent-child relationships; supervision of and positive disciplining of the children; anti-drug misuse attitudes held by the parents[2]; family support of and advocacy on behalf of their children (Kumpfer, 2003; Winters, 1999, Usher, 2005). Children from single parent families and less advantaged socioeconomic backgrounds are more likely to misuse substances (Usher, 2005).

Individual traits linked to abstinence in adolescence include setting and being driven by future goals, involvement in religion and success in school - all of which may also be shaped by family background (Winters, 1999). Social cognitive theory asserts that individual behaviour is based on role models, so family members can act as positive role models to their children, reinforcing good forms of adolescent behaviour. By the same token, a negative parent-child relationship could have the opposite effect—resulting in the adolescent joining a substance abusing peer group, for example (Vakalahi, 2001). Parents and siblings have been found to contribute both to the promotion of substance misuse and to its cessation and/or treatment (Vakalahi, 2001).

[2] The converse is also true—children with parents that misuse substances are more likely to follow their parents' behaviour. For example children whose parents drink heavily are three times more likely to develop such drinking habits themselves (NFPI, 2001a). Similar cross generational patterns of drug use have been identified in the findings documented in *Hidden Harm* (ACMD, 2003).

The perception that family background and affective relationships can be major factors in an individual's involvement with substance misuse has informed various prevention and treatment programmes. The Strengthening Families programme, originally developed in Salt Lake City, Utah, and which has since been extended to a variety of US, Australian and European cities with different ethnic populations, is based on the programme designer's belief that:

> Because 'substance abuse' is a 'family disease' of lifestyle, including both genetic and family environmental causes, effective family strengthening prevention programs should be included in all comprehensive substance abuse prevention activities (Kumpfer et al., 2003:1759).

The developer of the Strengthening Families programme, which uses a behavioural/cognitive family training approach, claims that substance misuse is but one of variety of anti-social behavioural activities that can be corrected or even eliminated over the course of 14 sessions involving both parents and children in the 6-10 age range. Various retention incentives may be included, such as family meals, activities, transport and childcare facilities (Kumpfer, 2003). The US National Institute on Drug Abuse (NIDA) found that the Strengthening Families programme has generated positive outcomes, although in the online article which described the programme, the examples given were anecdotal (NIDA, 1997). Given the significant cost of the programmes which seem to be marketed at local faith and community groups, no evidence appears to exist which could verify the cost effectiveness of the programme as against alternative forms of intervention or therapy.

Another programme, Focus on Families, based in Seattle in Washington State was aimed at families recruited from two of the city's methadone clinics. This programme relied on house visits to provide 'coaching' for life skills. Parents needed to be willing to attend twice weekly 90 minute training sessions for the first four months; children also attended 12 of the sessions to improve communication skills 'and to deal with the never ending crises in the lives of addicted parents'. At the 12 month interval the programme's findings indicated that parents recruited to the Focus on Families project significantly reduced their drug use compared to the control group (NIDA, 1997). However, given the relatively small size of the sample and the likelihood that

volunteers to a harm reduction programme will be more motivated to reduce their drug use than substance users in general, more research would be needed to confirm that positive outcomes were exclusively the result of this particular programme.

Societal Factors Affecting Adolescents

While the role of the family is considered to be vital in much of the drug treatment and prevention effectiveness literature, other wider societal factors are also seen as relevant in the case of adolescents in particular. One commentator argues that in order to really protect young people from the risks of substance misuse, some initiatives should be relevant to - and targeted at - the entire population, whilst others need to be aimed specifically at 'at risk' groups within the population (Vimpani, 2005). This is necessary because a child's environment is affected by close interactions with peers, school, church and neighbourhood, as well as more distant interactions such as culture, laws, policies and levels of equality in the child's society (Vimpani, 2005). Thus possible types of intervention would need to be broad enough to include community nurses and health visitors assisting young parents, action to enhance literacy levels, and initiatives to increase community cohesiveness and safety (Vimpani, 2005). However, there is little in the literature about the role of broader social policies in preventing substance misuse, and this finding is not confined to the United Kingdom.

Family Involvement in Treatment

The way that family members react to and attempt to deal with a relative's substance misuse will have different impacts upon the service user and their chances of recovery (Copello, A. and Orford, 2002; De Civita, Dobkin & Robertson, 2000). Family members may engage directly with the problem to deal with it and urge the user to cease substance misuse, or they may tolerate the drug use. If family members completely withdraw contact from the person using substances, the risk to

the family member (and to younger family members in particular) is greatly increased—indeed family relationships may even be destroyed (Usher, et al 2005; Velleman and Templeton, 2003). Behavioural couples therapy and family-based interventions were all associated with significantly improved outcomes during treatment, but there is very limited follow-up data and no evidence of long-term benefit (National Collaborating Centre for Mental Health, 2007: 178).

According to the NICE guidelines on drug misuse and psychosocial interventions:

5.4.1.1
Staff should discuss with people who misuse drugs whether to involve their families and carers in their assessment and treatment plans. However, staff should ensure that the service user's right to confidentiality is respected.

5.4.1.2
Staff should ask families and carers about, and discuss concerns regarding, the impact of drug misuse on themselves and other family members, including children. Staff should also offer family members and carers an assessment of their personal, social and mental health needs and provide information and advice on the impact of drug misuse on service users, families and carers.

Any attempts to involve families and close members of social networks in treatment need to be informed by the complexity of the issue and the way that different family relationships are constructed. Some research suggests that mothers of drug users are more likely to be involved in the treatment plan of a son or daughter (Kidorf et al, 2005). However, if parents themselves are problematic substance users or involved in criminal activity, grandparents may become the (often unrecognised) primary carers for their grandchildren (Family Rights Group, 2001, Grandparents Plus, 2005, The Grandparents Association, 2005).

An important idea involved in family therapy is the central importance of family relationships and family resilience (Velleman, 2007; Vimpani, 2005; Usher, 2005; Velleman and Templeton, 2003). ‘Resilience’ is a key concept as it:

> provides a context by which families can be viewed as confronting and managing disruptive experiences, buffering stress, effectively reorganizing and moving forward with their lives. It emphasises the value that family interactions have on affecting immediate and long-term adaptation for family members as individuals and the family as a whole (Gruber, et al 2004: 1384).

Because the role of the family is identified as key in drug misuse (although evidence tends to refer specifically to adolescents – see Kumpfer, 2003; Winters, 1999; Vakalahi, 2001), an array of treatment options offer scope for the family and other social networks to become involved in treatment. Findings show that for adolescent clients at least, both engagement with and retention in family-based therapies is higher than those found in ‘standard’ treatments. They have also been shown to produce increased rates of treatment success:

> in clinical trials in which they are compared with alternative interventions, in the majority of studies, family-based treatments produce superior and stable outcomes with significant decreases on target symptoms of alcohol and drug abuse, and related problems such as delinquency, school and family problems, and affiliation with substance abusing peers (Liddle, 2004:76)

The family can become involved in a client’s treatment in a number of ways. Clients may be involved in a residential therapeutic community, or involvement may be structured around group therapy, chores and supervision. Family involvement in this type of programme is typically limited to cases where the substance misusing referral is an adolescent.[3] Also the increased rate of treatment success would appear to be measured from a very low base with one study finding that only 10-20% of adolescents complete such programmes (Winters, 1999).

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[3] Although ‘adolescent centred’ treatment programmes appear to be the norm, the service offered by Clouds in the United Kingdom offers a ‘Brief Residential Family Programme’ that accepts clients and their families of all ages. However due to the high cost of the treatment and the lack of an ‘open door’ referral process, this type of programme is likely to be funded by public agencies only in exceptional circumstances. There would also appear to be no independent evaluation studies of the centre’s effectiveness in long term rehabilitation.

Family involvement may also take the form of family therapy (National Collaborating Centre for Mental Health, 2007). Much has been written about this therapeutic method which takes a variety of forms. The majority are based on cognitive and behavioural psychology techniques to address observable family relationship problems and establish more effective and positive ways of acting and relating. This approach is premised on the idea that substance misuse is due, at least in part, to pre-existing family problems. If this can be addressed, treatment will be more successful than if the client is treated alone and then just returned to the same, potentially negative, family environment. 'Family' therapy may include just one family member, an entire family, an extended family or even friends and neighbours (social networks).

There is evidence from the UK Alcohol Adult Treatment Trial that social network involvement 'can play a central part in the resolution of addiction problems' (Copello, 2005). Social behaviour and network theory (SBNT) combines elements of relapse prevention, community reinforcement, network therapy, and family member intervention (Marlatt and Gordon, 1985; Meyers et al. 1996; Galanter, 1999; Copello et al, 2000 cited in Copello, 2005). However, critics point to a bias towards the needs of substance misusers who are identified as the 'focal' while those linked to them through family and social ties are seen as 'network members' whose role is meant to be essentially supportive. Such an approach may risk marginalising or ignoring the support needs of those affected by another's substance dependency, unless the needs of other network members are specifically addressed (Soyez and Broekaert, 2005). An Edinburgh University study reveals that the benefits of family support groups appears confined to the grey literature where findings are not typically subject to the validation of scientific peer review and tend to be descriptive rather than evaluative. The same report found that 'the diverse needs of all family members are not well documented, especially those of wide kin such as grandparents but also of siblings'. Endorsing the work of Copello and colleagues, the reviewers noted that 'involving families within the treatment or service offered to the drug user' appeared to have 'some beneficial effects upon the drug user and to a more limited extent upon the family' (Bancroft et al. 2005).

Some family involvement in therapy may be more practical in emphasis. In one study, opiate-addicted patients who had to advance to a certain level of treatment after missing earlier level requirements were asked to bring in a ‘drug-free significant other’ to help them in the creation of a ‘drug-free’ social network. The creation of this network was seen as useful in addressing the fact that once treated, clients may have little or no non-drug related social life on which to rely and so become involved in substance misuse again (Kidorf, et al 2005).

The involvement of a non-relationship-specified ‘other’ was in recognition of the fact that whilst work with spouses had been shown to have some success, not all drug misusers would have a spouse or suitable partner. Clients’ significant others (the largest percentage of which were clients’ mothers—29%) went to weekly meeting as planned and reported back on non-drug involved outings each week. The results were promising, though strong conclusions cannot be reached as the ‘significant other’ component was just one part of a three step plan, including medication-timing based incentives. Some risks may be associated with such a scheme. Those unable to recruit a ‘drug-free significant other’ may be disheartened and withdraw from treatment, though this did not occur within this sample. Also the authors raised concerns that this method could strain relationships and that was why the focus was on present actions, rather than on the past. Patients and their significant others were also engaged in counselling and suitability rating beforehand (Kidorf, et al 2005).

While family involvement in therapy can be extremely beneficial in exploring a client’s genetic and environmental background, in some cases it will not be suitable for families in which people have suffered abuse, violence or extreme instability (Cavacuiti, 2004). Those leading family therapy need to be aware that young people may have been abused and that girls in particular are more likely to have experienced sexual or physical abuse or severe rejection by their family (Usher, et al 2005; Winters, 1999). However, the role of gender in treatment effectiveness has not yet been fully explored.

Families of substance misusers of any age may be involved in ‘continuing care’ at home. This kind of intervention has been seen as vital in recovery:

> As a supplemental or complementary service to primary treatment, aftercare/continuing care often stands alone as the determining experience for recovery or relapse (Gruber, et al 2004:1380).

Again, the role of the family here is premised on the idea that for substance misusers of all ages, family involvement can be seen to extend the benefits of therapy or treatment into the client's 'real world', making it easier, and in some cases, making changes, in order to help them avoid relapsing into substance misuse. Continuing care aims to help the client rebuild their life via "restoration of the individual as a productive worker, citizen and family member" (Gruber, et al 2004:1381). Involvement of the family is relevant because it is the family that can be the environment in which the problem develops, as well as the place most affected by the client's substance misuse. Home visitation interventions (such as the US-based Bridges programme) can help professionals to understand the client's home environment and provide the best scope to change the client's 'real world', as well as act to assist the entire family and their underlying problems rather than the client alone (Gruber, et al 2004).Though home visits for aftercare can be seen as an expensive option, parents seem to find them useful in overcoming time, childcare and transportation issues that can make parents with drug problems reluctant to submit to treatment (Gruber, et al 2004).

Family Involvement in Treatment Effectiveness for Different Age and Relationship Groups

Family involvement in treatment may be of particular value for young and adolescent drug users. Studies show that drug agencies in a variety of national settings regard this age group as requiring specific interventions due to their developmental needs, possible abuse issues, and their role in family life (Usher, et al 2005).

Parents who Misuse Substances

As the Advisory Committee on the Misuse of Drugs declares: "Parental problem drug use can and does cause serious harm to children at every age from conception to adulthood"(ACMD, 2003:1).

For young children whose parents misuse substances, it is of vital importance that they are given an outlet for expressing fears and concerns about their parents (ACMD, 2003; Hogan, 2003). In a Dublin-based study on opiate using parents and their children, 40% of the parents asked said their children had witnessed them taking drugs at some point. 70% felt that their children probably did know about their drug dependency despite the fact that most of the parents had tried to conceal their drug-taking and the majority had attempted to keep the subject of drugs taboo in the family. The parents, often fearful of having their children removed by social services or of being arrested for drug-related crime, had tried to hide the issue from their children and, at times, from the authorities that could have provided help. By talking to the children of drug users, researchers concluded that this concealment of the issue was problematic. Children realised that something was wrong, or were explicitly aware of their parents drug use, but felt because of the taboo and, in some cases, specific instructions not to tell anyone, that they could not voice their fears to their parents or seek reassurance elsewhere. Thus it was concluded that:

> Intervention programmes should be offered to support effective family communication about parental drug dependence…children and parents could benefit from a risk-reduction approach to parenting (Hogan, 2003:113).

Parents need to be helped to understand how their strategies impact on their children. The author asserted that children need direct support, but programmes aiming to do this must tackle the likely low uptake due to parents' fears of negative disclosure.

Age as a Factor

The age of an adult client may have some bearing on the role that their family and friends have to play in assisting or hindering treatment and recovery. In a study of adults in a managed care program in the United States, it was found that those in the 'older adults' category (55-77) were less likely to have used drugs five years after treatment due partly to the fact that they had less friends or family that encouraged drug use: 8% compared to 17% of 'younger adults' (18-39) and 'middle-aged adults'

(40-54) (Satre, et al 2004). This calls attention to the fact that family and friends, as well as representing possible sources of support, can also hinder or actively discourage recovery from substance misuse.

Treatment Considerations for Couples

There is little in the literature that is specifically about treatment for couples. One US study that does address the issue raises the fact that much of the previous work on couples has focused on co-dependency, despite the fact that drug users are disproportionately likely to form a relationship with another drug user to form a 'concordant' couple. The study found that such concordant couples tend to influence each other's substance misuse, often falling into the same pattern of use.

The difference between co-dependent couples and concordant couples in treatment is important due to the way that they interact in relation to substance misuse.

> In couples in which only one partner is a substance user, relationship satisfaction and stability is associated with decreased drug use both in terms of the amount of a drug used and the frequency of its use. In couples in which both partners manifest 'drug abuse', relationship satisfaction and stability is associated with increased drug use (Cavacuiti, 2004:650).

Another study, however, found a link between increased alcohol misuse and negativity in the relationship, so the evidence is not conclusive (Cavacuiti, 2004).

The treatment implications for couples in which one or more partners is a substance misuser would indicate that families and couples engaged in drug use can be highly "enmeshed" and so resistant to treatment. Domestic violence may be an issue, as it can be triggered by drug use (Cavacuiti, 2004). Trying to support a partner in their battle with substance misuse while trying to cut down or cease one's own usage could conceivably create a huge strain, both on the individual and on the relationship. This means that couples are likely to divorce in the first three to five years after treatment, due to different paces of recovery, or feelings that they have grown apart (Cavacuiti, 2004).

Drug Use in Prisons and among Ex-Prisoners

Drug use by prisoners and those with criminal convictions is far higher than among the general population. Approximately 55% of people arrested are problematic substance users and 80% report some drug use (Whitehouse and Copello, 2005). For a variety of reasons those leaving prison are at a greater risk of relapsing into drug misuse, and further research into at home continuing care for ex-offenders is seen as important in order to develop successful harm avoidance strategies for this client group (Gruber, et al 2004; ACMD, 2004).

Families with relatives in prison report feeling upset and let down by the prison service in its response to the substance use of inmates. Relatives and partners report incidences of drug dealing in visitors' centres and a lack of input in helping the user to stop using substances. This problem is compounded by the fact that some prisoners, especially those with long sentences, actually begin their substance misuse during their period of incarceration (Whitehouse and Copello, 2005).

A UK-based study found some examples of good practice among agencies working with families in a number of British prisons. The measures used included training and information (for prisoners, staff and family members), support groups, workshops and telephone support for visitors, which sometimes involved users. Some establishments held semi-therapeutic family therapy with specially trained staff. Telephone support, workshops and referral services to other specialist agencies such as Adfam were also on offer in parts of the country. The range of such provision varied widely due to limited funding and the fact that work with families is non mandatory. However, a dedicated family member was seen as hugely positive in supporting the work of the general drug treatment and misuse prevention strategy in all prisons (Whitehouse and Copello, 2005).

There may be particular language and gender problems that make it harder for prisons to engage effectively with family members from the BME communities (Whitehouse and Copello, 2005). This is an important area of consideration as BME

communities are overrepresented in the prison population (Home Office, 2004) and recent research found that visible minority adult male and female prisoners had 'significantly worse' responses compared to non-visible white prisoners to the question "Do you feel your drug or alcohol programmes will help you on release?" (HMIP, 2005:63).

Family Involvement in Treatment Effectiveness: The Impact on Family Members

The impact of dealing with a family member's drug problem has not been discussed or researched to any significant extent in the literature on the substance using client, or on drugs prevention in general. There is evidence, however, that families already are, and always have been, involved in trying to cope with family member's drug use even if they receive no help or constructive input in doing so (Sims, 2002).

The impact of coping with a family member's drug problem can have extremely negative effects on close relatives (Sims, 2002). One report examined the impact of a family member's drug taking on close relatives in three diverse contexts—in the South West UK, among urban slum dwellers in Mexico City and rural and urban Aboriginal populations in Australia. They found that, despite some small cultural differences such as religion or community cohesion, family members tended to cope with the problem of a relative's drug use in remarkably similar ways.

> They are uncertain how best to respond, they are unsure if it is 'their fault', they do not know where to go for help, and often whatever they try to do seems not to make life any easier. The results of these and other uncertainties are that family members commonly develop problems in their own right, often developing high levels of physical and psychological symptoms (Velleman and Templeton, 2003:108).

The Alcohol, Drugs and the Family research team behind these findings was explicitly concerned with the welfare of the families of drug users, rather than with the users themselves. They rejected the notion contained in some family therapies that one member's drug misuse is a 'symptom' of a deeper family problem and saw, instead, the involved family members as fundamentally similar to non-drug affected

families, except that these families are constantly faced with both the challenge and the social stigma of having a substance misuser in their midst. The ADF team's interventions were aimed at helping the non-drug using family members to cope better, although positive improvements in family relations might also have a beneficial impact on the drug user too.

In the ADF project intervention, family members could either have five sessions with a healthcare provider, or one session and a take-home manual. The focus was on helping the family member to obtain information and build a support network, discussing different ways of coping and, if necessary, obtaining referral to other relevant services. "Such intervention is successful in enabling relatives to cope better (as demonstrated both qualitatively and by significant changes on the Coping Questionnaire) and in reducing the levels of problems and symptoms reported by family members" (Velleman and Templeton, 2003:110).

The research that does exist from Australia, the United States and the United Kingdom demonstrates that a level of dissatisfaction exists in families about the services open to them when they are dealing with a family member's drug problem (Usher, et al 2005; Liddle, 2004; Sims, 2002).

> Families in England affected by problems with drugs and alcohol continue to be, at best, condescended to or, at worst, actively excluded (Sims, 2002:2).

In the UK in 2003, it was estimated that only around 14 services offering interventions specifically on behalf of family members existed (Velleman and Templeton, 2003). There may be a gap in services for families with teenage children as compared to services for under-elevens and under-fives, with research showing that families from all ethnic and social backgrounds are most concerned for their children during the teenage years, particularly in relation to drugs. It is also worth noting that in relation to a wide range of family issues, almost half of parents asked did not want more information provided, perhaps due to feelings that they are being bombarded by information that at times may be conflicting or judgemental. BME families, however, were more open to receiving more information (NFPI, 2001a; NFPI, 2001b).

Healthcare professionals have been encouraged by one researcher to consider the way in which they engage with the families of substance misusers—who may fear blame and judgement to the extent that they avoid seeking support (Usher, et al 2005). Because many family members feel anger, shame, hurt, embarrassment, guilt, confusion and despair, they often do not seek support early enough - if at all (Velleman, 2007). Therapy and treatment that emphasise the strengths of a family, rather than the problems, can help to depict the crisis in a more “manageable light” (Usher, et al 2005:213).

Who Should Work With Families?

There is no doubt that families of drug users are extremely affected by their family members’ drug use, and that families can represent a valuable resource in assisting drug users. Who, in terms of agencies or professionals, is best placed to engage families in treatment and to support them in their involvement?

The interventions examined here contain a range of possibilities. Some rely on the use of healthcare professionals, particularly nurses. One Australian study concluded that “Community nurses are ideally positioned to identify and assist vulnerable young people, and are well-situated to provide support to their parents and families” (Usher, et al 2005:213). In the UK, maternity units and specialist drug agencies are involved with pregnant drug users, and a high level of liaison between agencies was found (ACMD, 2003).

There is evidence that professionals, in healthcare and therapy, need more training on how to engage with successful family-involved methods (Liddle, 2004; Velleman and Templeton, 2003). As discussed below, training can also boost professionals’ recognition that such services are part of their job role (Velleman and Templeton, 2003). In the United Kingdom, the Royal College of General Practitioners has recently launched an accredited Certificate in the Management of Drug Misuse with learning outcomes linked to the Drug and Alcohol National Standards (DANOS) and

the National Enhanced Service Framework with plans for the e-modules to be made available to nurses and pharmacists working in the drug treatment field. In addition the Substance Misuse Management in General Practice network coordinates the work of GPs involved in community based drug treatment and works to disseminate best practice with bodies such as the National Treatment Agency and the Substance Misuse Advisory Service (SMMGP, 2005).

The National Clinical Practice Guideline Number 51 suggests several interventions at the family and community level (National Collaborating Centre for Mental Health, 2007: 193):

- The 5-Step intervention seeks to help families and carers in their own right, independent of relatives who misuse drugs. It focuses on three key areas: stress experienced by relatives, their coping responses and the social support available to them.
- Community reinforcement and family training is a manualised treatment programme that includes training in domestic violence precautions, motivational strategies, positive reinforcement training for carers and their significant other, and communication training. The primary aim of the treatment appears to be encouraging the person who misuses drugs to enter treatment.
- Self-help support groups consist of families and carers of people who misuse drugs. The groups should meet regularly to provide help and support for one another.
- Guided self-help is provided in the form of a self-help manual (for example, based on the 5-Step intervention) offered by a professional, who provides a brief introduction to the main sections of the manual and encourages the families and/or carers of people who misuse drugs to work through it in their own time at home.

For other approaches, especially those involving family work, social services are deemed more suitable. The Bridges home visitation intervention project developed in the USA by Gruber et al (2004) is delivered by a substance abuse specialist and a Masters level social worker holding substance abuse qualifications. The relevance of social services work with children of parents with problematic drug use is

demonstrated by the fact that 70% of social service agencies surveyed had specific substance use qualified staff. However, only 43% provided specific services for substance abusing parents and their children, and liaison with GPs was relatively infrequent. Few Drug Action Teams have yet turned their attention to services for children at specific risk of drug misuse (ACMD, 2003). The need to train staff in dealing with problematic drug use was highlighted by consideration of 290 cases of childcare concerns in London. 34% involved drug or alcohol misuse on the part of the parents, and these included many of the cases involving the most severe abuse or neglect. Most of the social workers involved were relatively newly qualified with little or no specific training in the area of substance misuse (ACMD, 2003).

To help children of substance using parents, it has been recommended that all specialist drug and alcohol services should contribute in assessing the needs of the children involved (ACMD, 2003). However, some treatment centres such as Narcotics Anonymous have been shown to be ill-equipped to deal with family issues (Satre, et al 2004). Few service providers, such as children's charities, are currently providing services specifically aimed at the children of drug users (ACMD, 2003, Department of Health, 2005).

The UK-based Alcohol, Drugs and the Family project developed a family member-centred intervention approach designed to be delivered by General Practitioners, Nurses or Health Visitors in a Primary Care setting. The researchers here found that training to provide such services meant staff were more likely to feel that it was a legitimate part of their role, and were more confident in performing that role (Velleman and Templeton, 2003).

Families may, for reasons of stress, shame and other problems, be reluctant to participate in treatment of any kind. However, one study demonstrated that if "specialized and culturally responsive family-based engagement procedure[s]" were used, 92% of families could be successful engaged in treatment initiatives, compared to a rate of 42% at a community clinic approached in the usual way, and retention was also shown to be higher (Liddle and Dakof, cited in Liddle, 2004:79).

A report by Adfam, a charity supporting family members coping with a relative's substance use, found that families who had experience of helping a family member to overcome substance misuse problems were keen to assist others. "Evidence shows that the peer based approach to education can prove effective in discussing subjects – like drugs and alcohol – which many perceive as 'difficult'" (Sims, 2002:4). Thus families themselves could offer support and advice to other families in a potentially non-judgemental and flexible forum.

The Adfam report also found that in order for the issue of substance misuse to be tackled, it needs to lose its stigma in the media and in wider society in order for families to be able to share their feelings and problems and receive the support they need.

Challenges, Pressures and Opportunities of Involving Family Members in Drug Treatment

The families and carers of drug users are often central to assisting and supporting the drug user in their day-to-day activities, yet there is relatively little support offered to families and carers. Family members may be unfamiliar with possible support services and, moreover, hide the family member's condition from the community, because of the shame and stigma attached to it.

The research carried out for this report provides an important starting point to understanding the multifaceted challenges associated with providing effective support to family members. This section of the report will present the results of interviews and questionnaires completed with representatives of treatment agencies as well as research results of a focus group conducted with family members and carers of drug users.

Research Methodology

Six treatment agencies participated in the research and generously shared their time and experience. The research was conducted in the Leicester area between March and May 2007. Because of limited resources the research had to be framed in a case study approach and conducted in one location. Leicester, a medium to large city in the English East Midlands, will provide a reasonable representation of the situation in the UK, but specific situations will undoubtedly vary depending on local circumstances. Table 1 provides an overview over the participating agencies and their main areas of activity.

Table 1: Participating Treatment Agencies.

Treatment Agency	Areas of Activity and Services Offered
Snowdrops Family and Carers Support	• Provides help, advice and information to people living with or affected by someone else's drug use throughout Leicester, Leicestershire and Rutland. • Support can be provided by telephone, home visits or within support groups facilitated by an experienced Parent Support Worker.
Leicestershire Community Projects Trust (LCPT)	• The LCPT is an independent voluntary organisation committed to serving the community. • It aims to reduce harm caused to individuals and communities by drug & alcohol misuse through services that are beneficial, accessible and non-discriminatory. • The LCPT runs services to help tackle substance use in the Leicester, Leicestershire and Rutland areas. Within these projects, it offers needle exchanges, outreach work, structured day care services, complementary therapies and help with access to residential rehabilitation for people within the Leicestershire and Rutland area.
Leicester Drug and Alcohol Action Team (DAAT)	• DAAT works in partnership with others to help people to resist drug misuse, support communities with drug related issues, find treatment for those in need and help stop the supply of illegal drugs. • The Leicester DAAT is responsible for overseeing the delivery of the National Drugs Strategy within Leicester.
Rainer Leicester Mentoring	• Rainer Leicester Mentoring provides a one-to-one mentoring service to vulnerable young people in Leicestershire, aged 13 to 18, who are affected by their own or parental substance misuse.
Addaction Leicestershire	• Addaction Leicestershire provides assessments for those in police custody and those referred by the police themselves. It also offers advice and information about drugs and substances, about local drug services, referrals and, where appropriate, liaises with probation officers. It also provides supervision to clients from their arrest to their sentencing, or until they are suitably placed with those providing appropriate treatment.
The Alcohol Advice Centre	• Provides help and advice to people affected by, or having concerns about, alcohol use.

Personal interviews conducted with representatives of the treatment agencies listed in Table 1. In addition, questionnaires were distributed amongst the same group. Participants were selected based on researching relevant organisations in public directories and on the internet and subsequently by snowballing existing participants.

The sensitive nature of the research and issues of confidentiality amongst service users made this selection process both sensitive and effective.

Specific services offered by the agencies include one-on-one mentoring and advice to young people whose parents have drug misuse issues. This includes the training of mentors in drug and alcohol support. The agencies also provide a network and referral service to a wide range of other agencies, including those involved directly in drug treatment or more general forms of support such as unemployment and housing services. In addition, medical services such as blood tests for drug users and their partners and more specific tests for sexual diseases (especially for those individuals working in the sex industry) are offered. Some agencies worked closely with pharmacies and one had its own nurse. It should be noted that only one organisation offered support to carers in the form of mentoring support. Because most of the agencies included in the survey were not working with family members and carers in an official capacity, the time their staff spent, if any, with this group remains undocumented.

Focus group research was conducted with the only agency specifically providing services to family members and carers of drug users, *Snowdrops Family and Carers Support*. This research method is used to utilise group dynamics and discussion for collecting qualitative data, which is less likely to emerge in individual interviews. Given the relative lack of formal engagement with carers and families, only this one organisation was a suitable partner in conducting focus group research. Consequently only one focus group with eight participants was conducted. The groups included six females and two males, all of who were ethnically white British.

In addition to conducting interviews and questionnaires with staff members of treatment agencies and the focus group research, requests for interviews and questionnaire research were made to General Practitioners (GPs) in the area. However, the requests received a very limited response. This part of the research should therefore not be considered comprehensive, but rather a “snapshot” of individual physicians' experiences. Moreover, no GP included in this survey worked directly with families or carers.

Challenges in Supporting Carers

Most agencies included in this research stated that drug users were their priority, though some suggested that they referred family members and carers to *Snowdrops Family and Carers Support*, an organisation primarily focusing on carers. Given the evidence in the literature that family members are directly and often very negatively affected by another family member's drug use (see e.g. Sims, 2002) but at the same time are important support factors in treatment outcomes, services to family members are underrepresented in the current structure of service providers.

Treatment agencies rarely have the capacity to support carers and focus on drug users at the same time. Financial and other resources are limited and thus services are often not extended to family members and carers by the treatment agencies. The vital, supportive and continuous care that family members and other carers can potentially provide to a drug user is thus not supported nor fully utilised. Moreover, according to one interviewee, the quality of services provided to carers and family members of drug users is geographically uneven and differs widely across the UK:

> Existing support for carers nationwide is very patchy. In some areas it is very good, but in others there is little or no support available. Leicester, Leicestershire and Rutland – the areas that I cover is poorly provided for. I am the only dedicated worker for families of drug users whereas other areas i.e. Derby, Chesterfield, Nottingham have teams of workers and volunteers. I feel that it very much depends on where the local Daats place carers services on their list of priorities as to how much funding and support is made available. [Interviewee, Treatment Agency].

Reports by focus group participants confirm a general lack of support for families of drug users from both the voluntary sector as well as local government. There was also general agreement that there is only ineffective or a complete lack of communication between treatment agencies on one side and drug users as well as their carers on the other. One of the participants provided an example of what s/he considered an inefficiency in the structure of drug treatment agencies:

> I was being thrown around from agency to agency for nearly 12 years until I stumbled onto snowdrops myself by accident - nobody before that even mentioned or seemed to know about them. [Participant, Focus Group].

Carers suggested that the most effective support they received was provided by *Snowdrops Family and Carers Support*, which is a voluntary sector organisation specifically focusing on carers of drug users within families.

Caring for a family member affected by drug use is generally a demanding task that often leads to exhaustion of the carer and disrupts his or her life as well as that of other family members and dependents. As one treatment agency staff explains:

> Many of the issues facing families affected by drug and alcohol misuse often include a great deal of stress which can then lead to both physical and psychological health problems. Initial effects when a family becomes aware that a loved one may have a drug problem include fear, worry, confusion, guilt, loneliness and anxiety. I find that often by the time families come forward for support, they can be emotionally and physically exhausted. Most also tell me that they didn't know where to go for support. [Interviewee, Treatment Agency].

Family - Carer Relationships

Carers and family members provide a range of support to relatives involved in substance misuse. The individual forms of support provided by carers and family members obviously differ greatly, as the discussions by focus group participants indicated. Care provided often goes far beyond emotional support. Carers implied that part of the struggle was helping the drug user cope with day-to-day activities related to their condition. This form of support included ensuring that the drug user attended appointments on time, ensuring that users knew where to go and who to speak to for appointments, and financially supporting the user in an attempt to prevent them committing crimes. The carers stated that they had to accompany the drug user to see local authorities for benefit claims and general advice, because the user was incapable of completing such tasks independently.

Perhaps most importantly, however, carers provide a (usually safe) place to live and and a place to call home for the drug users. This is a significant contribution to providing opportunities to overcome a drug habit or addiction and to prevent crimes that may be committed in support of drug use.

The behaviour of the drug user and that of a carer or family member are closely linked, but such linkages are often not recognised until the substance misuse has progressed to relatively advanced stage. An example that one staff member of a treatment agency cited was the experience of a mother of a drug user. When she started installing boundaries on her son, both realised the seriousness of the situation as obvious conflicts arose. Their relationship had been fundamentally altered by that point. Such situations often cause direct conflict within the family or a gradual or sudden deterioration of relationships between individual family members. Likewise, situations such as the example above can also lead to a complete breakdown of relationships and subsequently irreversible damage to the family. The mutual relationship between the behaviour of a drug user and his or her family needs to be considered by treatment agencies as it will certainly affect the outcomes of any rehabilitation efforts. It also shows that close involvement of, and support for, carers and family members is vital to the success of drug treatment.

The presence of a drug user fundamentally alters family dynamics in myriad and profound ways. Focus group participants suggested that as a carer they have to be prepared to detach themselves from their role as a spouse or parent of a drug user and instead focus on helping the user as an 'addict'. This kind of detachment often caused considerable emotional strains on carers, as it became increasingly difficult to view the user as their son or daughter, for example. Carers suggested that negative sentiments towards the drug user in the family are not uncommon, as one carer suggested, it is a feeling of just wanting the user to ‘leave and drown’. Such feelings are, however, not a reflection of a lack of concern by the carers. Rather, they underscore how profoundly difficult and deeply troubling the situation is for many carers. As one carer stated, ‘you become very low in yourself and want to run away from yourself - it breaks your family up’. Another carer stated that they had to get a restraining order against their family member because of their behaviour.

The long term effects are equally profound for families who lived with a drug user, as one participant suggested:

> You live for years with drugs and it takes its toll. Even when it’s over you get used to hiding your jewellery and suspecting the person in your family. [Participant, Focus Group].

Similarly, not only the relationship between user and a carer experiences severe pressure: the relationships between other family members are also affected, often putting considerable strain on the relationships between spouses or between parents and (non-drug using) children, as well as between siblings. The case of one mother illustrates this point. She said that it took years for her partner to understand the position as a carer, and their relationship suffered as a result of this. The strain on the relationship between family members is exacerbated by the fact that caring for a drug addict is a permanent task, twenty-four hours a day and seven days a week.

Inevitably other family members, especially spouses and siblings, felt that they were to some extent being left out due to the carer's attention on the drug user. One participant suggested that siblings of her son had suffered nightmares over his behaviour. Drug users can potentially hallucinate and generally not be in control of their behaviour, causing psychological insecurity and uncertainty for other family members. According to one carer, the atmosphere of tension and uncertainty in the home led to physical violence between family members. Another carer stated that the drug user's siblings (i.e. non drug users) viewed their parents as 'stupid' for 'putting up' with the actions of the drug user, and the situation resulted in 'other young lives being destroyed'. The support for family members and carers of drug users by treatment agencies was considered inadequate, especially in light of the severe consequences for entire families. The experiences of participants in the focus group confirm the findings in the literature that family members are generally dissatisfied by the support they receive from service providers (see Usher et al, 2005; Liddle, 2004; Sims, 2002).

Stigma and Cultural Sensitivity

Drug misuse is a highly stigmatised issue, as noted by Velleman and Templeton (2003). This view was supported by treatment agency staff in Leicester.

> Many people don't come forward as they feel ashamed, thinking that they must be bad parents and that they must have failed somehow for their child to end up taking drugs. [Interviewee, Treatment Agency].

However, representatives of the treatment agencies included in this research noted that the level of stigmatisation varied considerably amongst various groups and was culturally influenced. Staff from treatment agencies felt that there was a high level of stigma amongst the South Asian community, as doctors were more likely to know drug and alcohol users' parents. This would prevent these users from approaching a medical doctor in the first place and keeping the issue secret. A lack of effective cross-cultural communication was identified as an issue in reaching specific communities by one staff member of a treatment agency.

> I have difficulty in reaching out to ethnic groups as the carers are afraid to come forward for help and support due to the issues being taboo as you have said, and also the cultural differences. We used to have an Asian development worker who used to work with this minority group of carers who could speak several of the languages and he was very successful. However, his funding finished and he was not replaced. This has left a huge gap in services particularly as Leicester has a high number of ethnic minorities. My feeling is that we need to provide specific workers who understand the cultural difficulties and can speak the languages. [Interviewee, Treatment Agency].

There was also a high level of stigma amongst middle class families, as having a drug user in the family would usually be regarded as being dysfunctional as a family and would be viewed poorly in terms of social status. This stigmatisation of drug use poses particular challenges to treatment agencies, as it is either difficult to utilise the support of carers and family members or as consultations and other support have to be provided most confidentially, which may limit a user's access to services. There is a considerable need for public information to reduce the stigma attached to drug misuse as well as to make family members aware of the challenges and realities that the drug user is facing on a daily basis.

Authorities

Interaction with local authorities was regarded a challenge by both focus group participants and representatives of treatment agencies. For example, the housing department at Leicester City Council was criticised by one treatment agency staff member for its lack of interest in the consequences of drug misuse. Consequently,

the provision of adequate housing became a point of great contention as a result of a bureaucratic and non pragmatic approach by the department.

As mentioned above, carers would often accompany drug users on visits to local authorities. Focus group participants suggested that local government officials were rather uncooperative and uncompromising. Local authorities also lacked the expertise and commitment to help and to respond to specific needs of drug users. Carers and drug users were regularly referred to other offices or institutions by local authorities, who were unable or unwilling to respond to requests made. For carers this often became an endless trail of bureaucracy with little or no results. One focus group participant expressed her critique on the system of public sevice provision as follows: 'There was a lot of ticking boxes by people who are just interested in keeping to their own little departments.'

The role of General Practitioners

In addition to considerable challenges that drug users and their carers face in accessing public services by local authorities, the role of GPs was considered important as doctors were for many drug users the first point of contact when seeking assistance. At the same time, GPs were generally viewed negatively in the interviews with treatment agency staff. One staff member described them as ‘awful’ although s/he had some positive experiences with doctors as well. In many cases, it was suggested, doctors were unable to provide sensitive advice or care for patients involved in substance misuse. Moreover, some simply did not consider drug addiction an illness but an emotional state and consequently did not see any need to get involved. One of the major challenges arising from this situation is that drug users are discouraged from seeking formal support from public services and treatment agencies if the first contact with “the system” is through a GP, who – as is frequently the case - provides little or no support.

There was a general antipathy towards GPs by focus group participants, although occasional positive experiences with GPs who take a serious interest in the situation of drug users and their families was reported by one carer. At the same time carers

recognised that GPs were often the first ones to be contacted when seeking support and the role of GPs was thus considered to be very important. However, the shame and embarrassment felt by individuals was a barrier to taking the step of seeking support from GPs.

Focus group participants also felt that GPs did either not take the issue of drug use or addiction and the associated challenges faced by carers seriously, or treated it as a side issue. It was also suggested that the approach by GPs was reflective of wider societal attitudes towards drug use and addiction, which is often not regarded an illness and frequently considered the sole responsibility of drug users themselves. According to one carer this attitude was especially acute in pharmacies as well as amongst GPs and was reflective of a general lack of understanding of the issues faced by drug users.

As noted above, responses from GPs to interview requests and questionnaires were very limited. It is therefore not possible to analyse results from this part of the research in any meaningful way, other than “snapshot” accounts of individual physicians. Moreover, no GP included in this survey worked directly with families or carers. The support system for families or carers in the Leicester area was considered adequate by GPs and they referred family members or carers to organisations providing service in the area. At the same time, two physicians stated that GPs should not be dealing with issues of substance misuse at all because the resources were not available in the healthcare system. The perception of GPs by representatives of treatment agencies and within the focus group, as well as the (limited) response by GPs, suggests that the relationship between GPs and drug users and their families is rather challenging for both sides. This trend supports the view expressed in the literature that GPs (and other professionals) need additional specific training related to substance misuse (see Liddle, 2004; Velleman and Templeton, 2003).

Conclusion

The families of drug users are directly and often very negatively affected by relative's drug use. They may also represent an extremely valuable resource in increasing treatment effectiveness, although it is important to consider specific family circumstances as these vary substantially and will directly affect a family's (or individual family members') ability to provide support for the drug user. There is a need for improved support services for family members of drug users, as these are currently very limited and geographically unevenly distributed.

There can be considerable benefits to having family members involved as carers of people involved in substance misuse. Active involvement of family members in the care and treatment of drug users may prevent the breakdown of important family relationships and improve the long-term success of treatment. In addition, greater openness about issues of drug use in a family will help prevent the issue from being taboo. At the same time, this report has documented many of the concerns, issues and pressures experienced by the families and carers of drug users. Family members - on average about three people per drug user - are directly affected and experience many forms of hardship including, but not limited to, financial and social problems and issues of physical and psychological health. The relationship between carers and drug user is often complicated and challenging, a situation that is often exacerbated by the considerable stigma attached to the issue of substance misuse.

The few support services specifically available for the families and carers of drug users are difficult to access and largely unknown, even to other governmental and non-governmental organisations working in the field of drug use and prevention. General practitioners are generally considered to work in isolation from the larger network of service providers and there is an overall need for more information on the subject. As mentioned above, service provision is also geographically unevenly distributed. In this context, one representative of a treatment agency suggested:

> I feel that government funding should be allocated to a dedicated national organisation such as 'Adfam' who could then ensure that all areas nationally

> receive a fair allocation of funding and support in which to provide equal service provision. [Interviewee, Treatment Agency].

In summary, there is a great need for improved support services for the families and carers of drug users. Family members are directly affected by somebody else's drug use and also provide a potential resource in securing effective treatment. Support provided to family members helps the families and the user to lead an independent, healthy and productive life. At the same time, this research conducted in one mid-sized UK city provides important findings, but not conclusive results that can be applied across the UK. Resources should therefore be made available to fund pilot projects for improved support for family members of drug users as well as more research.

Recommendations

- This study has confirmed the general findings in the scientific literature that families can often be a useful resource for individuals affected by substance misuse. Concerned family members identify the need for support from specialist services and agencies as being crucial if the substance misuser is to make lasting positive changes to their relationship with drugs and/or alcohol and those around them.

- There is an apparent lack of awareness of the impact that substance misuse has on family members and carers of drug users, both by the general public and professionals. There is thus a need for more information to increase awareness.

- Our analysis also highlights the need for more evaluation research designed to measure successful outcomes of family interventions in the support and treatment of substance misusers in the United Kingdom. Such a study or studies would need to take into account the many different types of family and affective relationships in which substance misuse is found, and to focus sufficient attention on higher risk groups, and on family members with particular support needs.

- Extending the 'multi component' approach developed by the UK Home Office's Blueprint programme for drug education into the field of drug treatment and therapy would allow UK drug treatment agencies and professionals to develop an evidence base with which to compare the experience of family based interventions elsewhere (such as the USA and Australia).

- Where substance misusers are subject to custodial sentences, support for the offender tends to be concentrated on the individual prisoner and in preventing the supply of drugs into jails rather than on the family as a whole. By involving families in tackling their relative's harmful substance abuse while in custody or on probation the prison and probation services would be working to improve

the likelihood of ex-offenders avoiding harmful drug use while in custody and after release. The ex-offender, the family and the wider community are all likely to benefit from lower re-offending rates where successful treatment programmes have been completed while in custody.

- The needs and capacities of those coping with the substance misuse of a family member or a loved one can often go unnoticed by services or agencies when the focus is on individual rehabilitation and treatment. Those directly affected by another's drug use deserve to have their voices heard and their needs addressed. As Adfam reminds us:

Not every family can be supportive. Drugs can devastate family relationships… it is important that you look after yourself as well as the rest of the family.

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