

# **Effective Interventions Unit**

## **Support for the Families of Drug Users: A review of the literature**

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## Executive Summary

It is now increasingly recognised that drug misuse affects the whole family including wider kin. There is a growing concern about the needs of families affected by drug use and the best ways of meeting those needs.

A literature search and review was conducted using standard bibliographic search procedures in order to:

- establish what is known about the support needs of families of drug users
- establish what is known about effective ways of addressing those needs
- examine whether, and how, family support groups and services link with other services
- examine whether involving families within the treatment or service offered to the drug user has beneficial effects upon the family and the drug user

Studies were typified as focussing on *needs* or experiences of families of drug users; *descriptive* studies outlining particular interventions or services; *evaluative* studies that assessed the impact of interventions or services; *policy/professional guidance* literature aimed at improving professional practice; and *grey* literature. Although 104 articles were found and reviewed, there was little literature that directly related to the needs of families of drug users or how those needs might best be met. There were few evaluation studies; of those, most were small scale and with results that were not generalisable.

Effects of drug use on family members include: depression; adjustment and behavioural disorder; deterioration in family relationships; increased likelihood of domestic violence; criminal behaviour; isolation; withdrawal; stigma; and concealment. Although some of these effects are reported in research on alcohol misuse, there may be important differences in experiences and needs relating to different substances as well as to poly-substance use.

'The family' is often treated as a single unit, although some studies have shown that different family members have different experiences and perceptions depending on their relationship to the drug user. A concern for the child is prominent, and the emotional and behavioural effects of parental drug use are documented. Some children play a caring role in their families. Other research focuses on parenting, although this is almost exclusively on mothers, whether or not they are drug users themselves. Isolation may be a barrier to seeking support and the families of drug users, especially grandparents, are a hidden population.

Ways of coping have been identified, such as toleration, engagement, withdrawal and concealment. No one style emerges as most appropriate as they may be related to different family members and change over time. However, coping styles may influence support sought or the nature of the service provided. Most interventions aim to change family dynamics, but there is little reflection in the studies reviewed about what family characteristics or types are important.

A range of supports are described in different studies, although evaluations of these are seldom generalisable. An exception is an evaluation of family skills training where parenting outcomes were improved amongst drug users themselves; however, no benefit was identified for children. Although some research identified significant improvement in a person's substance abuse problem and in other measures relating to the family, most improvement was

small, and sometimes there was none at all. However, support for parenting seemed to be rated highly by service users, and wraparound services (providing a range of care and support tailored to an individual family) similarly had some positive outcomes. Many services described support for family caregivers, though these were most commonly aimed at mothers or partners. Group or individual interventions may have beneficial effects in different areas of a caregiver's life.

There is almost a complete absence of documentation and research into family support groups. What there is suggests they might be effective in addressing some family issues, but research is descriptive rather than evaluative. Such issues relate to families being able to express their own needs and not having to be influenced by a professional discourse. The family focus of such groups balances out the priorities of intensive interventions, which tend to emphasise the needs of the user rather than the family. However, they may enable referral to other agencies as appropriate. The support needs of grandparents are little documented, although there may often continue to be a parenting role for both their children and grandchildren. Research identifies that their financial needs are not met.

The involvement of family members in treatment programmes has been shown, in some cases, to improve their effectiveness as regards positive outcomes for the substance user, sometimes even when the user is not directly involved in treatment, such as in Unilateral Family Therapy. Here improvements in drug abstinence and social functioning have been reported. There is less research on possible improvement in families themselves. Interventions where the primary focus was on support of the families per se were less common. This reflects the service based focus of many of the studies; it is possible that interventions which develop from family support groups may be oriented more around the family as a whole and less around the behaviour of the drug users, but they are not reported in the literature. Evaluations of unilateral interventions are rare, although such interventions do not directly involve the drug user. Al-Anon and Nar-Anon are both examples of such interventions; particular strengths may be the improvement of the well-being of the family member. Community Reinforcement Training may also demonstrate a positive effect on family members.

This review of the literature on support for families of drug users suggests that although there is a wide diversity of articles, these are most often descriptive pieces about service provision and development; most of the evaluation studies reviewed fall short of the established methodological criteria for establishing rigour. There was seldom a direct link between assessment of need and service provision, although that may have taken place at an informal level as part of service delivery.

- In terms of establishing what is known about the support needs of families of drug users, the review suggests that the diverse needs of all family members are not well documented, especially those of wide kin such as grandparents but also of siblings.
- In trying to establish what is known about effective ways of addressing those needs, this review suggests that the match between service provision and need is not always explicitly derived from a needs assessment that prioritises users' own views.
- The review could shed only limited light on whether or how family support groups and services link with other services, as while few articles reported on the work of family support groups, neither did they take a holistic view of the

range of services an individual or family may be accessing. However, some partnership working has been noted in the UK.

- In terms of whether involving families within the treatment or service offered to the drug user has beneficial effects upon the family and the drug user, the review suggests some beneficial effects upon the drug user and to a more limited extent upon the family.

## CHAPTER 1 INTRODUCTION

It is now increasingly recognised that drug misuse affects the whole family and wider kin. There is a growing concern about the needs of families affected by drug use and the best ways of meeting those needs. However, the needs of such families are not yet well known and the range of ways in which such needs are or can be met not yet well documented. Those who live with and look after drug users in their homes are a largely hidden group; isolation, shame, and guilt may all be common experiences. This literature review aims to draw together relevant research in this area in order to shed light on families' needs and how they can best be met. More specifically it seeks to:

- establish what is known about the support needs of families of drug users
- establish what is known about effective ways of addressing those needs
- examine whether, and how, family support groups and services link with other services
- examine whether involving families within the treatment or service offered to the drug user has beneficial effects upon the family and the drug user

A broad definition of family was used through the literature search, and included close relatives such as spouses, partners, children, siblings as well as other kin such as grandparents. Family support was taken to include services provided by the voluntary and statutory sectors as well as family support groups. A wide definition of drug misuse was also employed, including the misuse of both illegal and prescription drugs. In this report, substance misuse refers to both the misuse of drugs and alcohol; some literature from the alcohol field was pertinent to this review.

After a brief description of the methods used to identify and scope the literature, this review is then divided into three main substantive sections: the needs of families of drug users, support for families, and services more generally. In each of these sections the literature available is condensed in order to provide an assessment of what is currently known. A brief overview or mapping is complemented by more detailed discussion of key contributions identified in the literature search and scoping. The final part of the review offers a discussion and conclusion, including some recommendations for further research. Three appendices provide, firstly, a summary of the literature, secondly, the scoping of the studies retrieved, and thirdly, a methodological assessment of the evaluation studies and the criteria employed for that assessment. Where appropriate, the review makes reference to methodological issues when discussing research results in evaluation studies.

### Methods

Although the overall aim of the review was to focus on drug use, alcohol misuse often intersects with it. Accordingly, some literature on alcohol misuse was included, especially where families' needs were the main focus, or where support was described and evaluated. As the search of bibliographic databases progressed, a decision was made to widen the search a little further to include other vulnerable groups such as those affected by behavioural difficulties, AIDS/HIV or mental illness, as the searches were revealing little that directly addressed the issue of family support and drug use. Although the main focus was UK research, relevant literatures from other English language speaking countries were included, especially Australia and the USA where services that include families in some way seem to be a little more developed.

Standard bibliographic search techniques were used, including both medical and social science databases. A wider internet search using a search engine was conducted in order to identify projects and literatures not indexed elsewhere. Key words included items such as family support, family needs, relational specific terms, family services, drug use/misuse, alcohol use/misuse, substance use/misuse. 'Grey' literature was obtained wherever possible, for example, by directly contacting agencies themselves.

A total of 104 articles and chapters were identified, from the period 1990 to present (2002). Everything was indexed in a customised bibliographic database with tagged key words which described the type of study. The types identified after a preliminary review were studies focussing on *needs* or experiences of families of drug users; *descriptive* studies outlining particular interventions or services; *evaluative* studies that assessed the impact of interventions or services; *policy/professional guidance* literature aimed at improving professional practice; *grey* literature.

All articles were obtained in hard copy and 'scoped' in order to identify the type of support offered; type of service delivery; whether services met expressed need; and the focus of the evaluation, where appropriate. The scoping was conducted in order to address the main objectives of the review. A methodological assessment of all the evaluation studies was carried out, focussing on their aims and objectives; the research design; the methods used in terms of validity, reliability, generalisability; and sources of bias. The results of the review are now presented under the three main themes of needs, support and services.

## CHAPTER 2 NEEDS OF FAMILIES OF DRUG USERS

This section considers the needs of families of drug users as identified in the literature obtained. An overview is provided of the field, followed by a more detailed appraisal of relevant areas.

### Mapping of the literature

The relatively limited extent of the literature on drug misuse in families indicates that drug use has yet to be fully established as a family problem with researchers, funders or service providers. The existing literature is divided on the extent to which it is a problem *for* the family, or a problem *of* the family. Studies of the impact of drug use on families tend towards the former, examining how drug use affects the well-being of family members, alters family dynamics and changes caring roles. Studies of the relationships between the user and their family tend more towards the latter, examining the way family structure or behaviour patterns can produce and sustain drug use, and also what alterations in family members' behaviour may contribute to reducing drug use. Later on, in the sections on Support and Services, it will become apparent that problems exist with the latter perspective. Placing emphasis on the family's role can make its members feel stigmatised as responsible for the drug use. A balanced perspective would maintain its focus on family well-being, of which the successful treatment of the user is an important, but not an absolutely dominant, component. There is a tension, then, between the need to establish drug misuse as a problem for families and its treatment as a family problem.

In viewing drug misuse as a family problem, the question becomes, for whom? Studies have examined the differential effect of drug misuse on family members, depending on their role and position in the family, their gender, their relationship to the user, and, in addition, the effect on family dynamics as a whole. Family type and form were less closely examined in the literature, and this is important at a time when social change has led to increasing family diversity. Those studies that did look at family type mainly examined lone parent households. Ethnicity was also only rarely considered as contributing to a diversity of needs.

There is also a time dimension to be considered. In addition to family form and family process, needs and risks vary depending on the stage in the life course an individual is at. Here the literature diverges in the way it approaches the life stages of childhood and adolescence. With childhood, drug use is examined in terms of its danger to child development, for instance, its impact on later educational performance. Adolescence, however, is studied as a 'problem stage', in terms of adolescents being likely to be involved in drug use, and the effect this has on their parents and siblings. This is in line with the general societal view of adolescence as a risk taking, problem time within the life course. It is necessary to challenge this perception: adolescents are certainly at risk of starting drug use, but are also vulnerable to the effects of sibling or parental drug use at a time of transition and change.

Research on families and substance misuse is better established in the alcohol field. Comparing both types of study in the course of this review, it became apparent that different substances could be associated with very different impacts on the family and could elicit a different response from services. This seems to be due to three factors: the moral and social connotations of the substance user's behaviour, mood and physical health; the effect of the substance on the user; and the social contexts associated with the substance use. For this reason care must be taken when applying results of alcohol studies to work with drug users

and differences in the needs of families affected by one or other substance, or polysubstance use, should be recognised and explicitly researched. In the case of polysubstance use, more research is needed on the perceptions of family members about which substance is the more problematic for them. Nonetheless, some lessons can be drawn from the alcohol field in relation to family support.

It is important to investigate the ways in which support needs are defined by researchers and providers, as this may often be implicit rather than explicit (see also Services section on what family members themselves consider important outcomes of interventions). Few studies focussed directly on eliciting families' own views of what their needs were, being more influenced by the points of contact between families and services. This suggests a need for more basic research into the experiences of families affected by drug use.

Gender was present as an issue, though it was seldom made explicit in studies. There is a common assumption throughout the literature that 'family' means 'parent' and 'parent' means 'mother.' This applies both to situations when the parent is the drug user, and where the child is the drug user. In each case, the service user is presumed to be the mother. In part this is due to mothers being more likely to contact services, but it is apparent that the needs of fathers affected by drug use are often rendered invisible by this assumption. This is reflected both in the focus of research and in the organisation of services.

There appears to be little reflection upon the studies about what family characteristics or types are being treated as central and important. It is important to have some idea of whether the same or similar relationship contexts are being studied, especially as many interventions seek to change family dynamics. Certainly, some family types are characterised as implicated in drug use, especially intergenerational transmission (for example, those with absent fathers). As noted above, much emphasis is on children's needs, or on the support needs of the drug user in their parenting role. The 'family' is therefore conceptualised as both a problem and a solution. The focus is most likely to be on those with a caring role within the family, usually women.

Support needs are described in various ways across diverse studies. Certain commonalities regularly appear, such as: a focus on children or women within the family context; the need to support parenting; the effects of different types of substance misuse; and issues around isolation. Yet there is no systematic assessment of need or even frequent reflection on the implicit values in such assessments. There is certainly very little emphasis in the available literature on the needs of different family members, on the family's needs as separate from those of the substance user, and on how needs map onto and are reflected within actual or proposed service provision or support networks.

## **Findings**

### **Impact on family life and family dynamics**

Drug misuse by a family member has an impact on all family members associated with them. Research details the psychological and social disturbance both within the family and in relations with others outside the family. Effects on the family include: increased stress; depression; adjustment and behavioural disorders; deterioration of family relationships; increased likelihood of domestic violence. Springer et al. (1992) identified problems for children in families affected by substance misuse relating to social withdrawal, responsibilities of having to care for siblings and parents, psychological and psychosomatic disturbance and poor educational performance.

According to Velleman et al (1993), short-term negative effects included feeling: lonely; isolated; tired; drained; unsupported; anxious; depressed; suicidal; guilty; tearful; apprehensive; worried; fearful; tense and confused. Longer-term effects included major changes in physical health such as shingles, ulcers, raised blood pressure and/or psychological health including anorexia, depression, panic attacks and 'nervous breakdown'. Relatives also reported the effects that the drug user's behaviour had on their own behaviour, including: increases in appetite-related behaviours such as: drug use; alcohol use; eating; tobacco consumption. Relatives also described the negative impacts of drug use on the relationship they had with the drug user, their social life and finances. They were also uncertain about how to understand or make sense of the problem and how to behave towards the drug user.

When considering the impact of drug use and associated needs, care must be taken in not assuming the family is undifferentiated or that the needs of all members are the same. 'The family' is often treated as a single unit, but some studies have illustrated how individuals' experiences and perceptions depend on their relationships with the drug user. Velleman et al. (op.cit) reported differences between parents' and partners' experiences of the drug user's behaviour. Partners reported more: physical violence; mood changes; threatening behaviour; pressure for money and damage to property. Parents reported more: lying; manipulation and self-neglect by drug user. Parents were generally more shocked and surprised by the drug use itself than were partners. Common views that relatives held of the drug user were: a sense of hurt; reduction in love/affection for user; embarrassment by/bitterness towards user and feeling of having been let down. However, many also described the user in positive terms, such as gentleness, consideration, caring and sensitivity. This indicates the existence of different needs according to the relationship the family member has with the drug user.

In a later work, Orford et al (1998) indicate that different responses by family members were adopted depending on the family role that they filled. Support is likely to be most effective when tailored to the role the individual has within the family. It should be borne in mind that there is a difference between role and position within the family. Position is the place the individual has in the family as defined by those outside it and usually by those inside it as well: for instance, the parent is always the adult with *de jure* caring responsibilities as defined in part by the legal context, and the assumptions made by services. Role refers to the actual functions and *de facto* responsibilities the individual takes on. In many families, and in particular those affected by drug misuse, these are not the same. For instance, grandparents may have taken on a parenting role with their grandchildren, due to the parent or parents being unable or unwilling to parent. Children can and do adopt parenting responsibilities for younger siblings, and even for parents themselves. This can have a profound effect (see later discussion of the parentified child). The evidence indicates that services often overlook this divergence between role and position when assessing needs of families. This can be a problem since it means that support is not always properly targeted on the individual with the greatest *de facto* responsibilities. Greater awareness of this would be useful in ensuring the effective targeting of support resources.

## Children

Dore et al (1996) described interventions for children aged 7-11 years (latency age) from drug-involved families. They looked at the effect of parental drug use on children such as the risk to their mental health and the range of negative

emotions that children experience as a result of the drug use: helplessness; lack of control over life; low self-esteem; guilt; shame; isolation; feelings that parental drug use is their own fault. These emotions can cause harmful behaviours in children from drug-involved families: social withdrawal; aggressive behaviour; attention deficiency; hyperactivity; poor performance at school; higher risk of teen pregnancy; drug and alcohol consumption; dropping out of school and delinquent behaviour. They recommend that these children need: their social competence promoted; their interpersonal skills strengthened and social isolation decreased; their self-esteem increased by learning that they are not different and to learn new skills/problem solving strategies for dealing with difficult situations.

Markowitz (1993) describes the needs of children of substance using parents and identifies similar emotional responses of the children to parental drug use to Dore (op.cit). Markowitz puts forward the view that the ability of substance using parents to empathise with, relate to and validate the feelings of their children is likely to be impaired to some degree by their drug use. There may also be inconsistency in the parent's behaviour due to the effect of the drugs. She suggests that the children of drug users can feel a range of emotions including: confusion; guilt; anger; helplessness, shame and humiliation if their parents behave inappropriately or lose self-control. They typically have very low self-esteem, feeling that they are to blame for parents' substance use and that they themselves are flawed.

Children who respond to parental drug use by taking over some aspects of the parenting role can be at greater risk than those who do not. Bekir et al (1993) describe how adult family members, under the strain of their own drug use problems, abandon or abrogate their responsibilities as parents and spouses. In these circumstances another family member has to step in and take over some of their responsibilities. It is often a child who does this. They present two types of response on the part of the child: rebelling, that is, becoming withdrawn and presenting behavioural problems; and rescuing, that is, adopting a parental role with mother and siblings. The 'parentified child' was evident in the majority of families in their study.

Apart from the strain this role reversal places directly on the child, it would appear to store up problems for the future. Drug users in Bekir's study who responded to their father's drug use by becoming parentified children themselves developed problems on becoming parents, and were likely to abandon or withdraw from parenting responsibilities. Bekir's group were all drug users themselves, so it is possible that their withdrawal from parenting was caused by the stresses of drug use rather than simply their personal family history. It is clear, however, that in these situations there is a risk that the child's own personal development will be sacrificed to the maintenance of the family. It is particularly vital, if drug use risk and other problems are not to be passed along generationally, that children are supported if they do have to take up parenting roles. Furthermore, drug using parents need to be supported in their own parenting so that they do not abandon the parenting role.

### **Effect of different substances**

Drug and alcohol misuse cannot always be appropriately grouped together as 'substance misuse.' Each involve different dynamics within the family, and different relationships to services (although of course these may also be combined in any one family). Different types of drugs involve different stresses and demands on family members as well. Families of illegal drug users often have to cope with stealing by the drug user, whereas this is not reported by families of

alcohol users or users of prescription drugs. The studies reviewed were suggestive of some interesting differences between the needs and attitudes of families affected by alcohol or drug use. Relatives of tranquillizer users were more ambivalent about the drug use than relatives of illegal drug users, who were more explicit in their condemnation. Across the studies, families tended to want to deal with alcohol misuse within the family, whereas they were more ready to involve formal services in the case of drug misuse. It is likely that sociological reasons partly explain this: alcohol misuse is more likely than drug misuse to occur in middle class families. There are intersecting issues, one being that alcohol can be obtained legally and getting hold of it does not require contact with a criminal subculture. The definition of alcohol as a family problem may also increase the likelihood of interventions, focussing on the whole family, when contact with services is made. Professional interventions for those affected by illegal drug use are much more likely to focus directly on the drug user.

Orford et al (1992) noted that relatives drew distinctions between ways of coping with different forms of drug use. Relatives of people addicted to tranquillisers experienced fewer problems than those associated with illegal drug use: for instance none reported stealing by the user, being pressurised into giving the money, or the user disappearing, all of which were reported by significant proportions of relatives of users of illegal drugs. Other stresses became more salient for them, such as the addict withdrawing from family life, or not being interested in sex.

As well as families reacting differently, Feig (1998) notes differences in agencies' views of the effect of different drugs. She states that substance misuse treatment services view addiction to crack cocaine in similar terms to addiction to alcohol or heroin, the treatment and recovery process being similar for all. However child welfare services, being focused on children, view crack as being more dangerous than other substances, because of social factors including its expense and the effort in acquiring it, which takes up parents' time and resources, the fact that women are more likely to use it than for instance heroin, and the criminal culture associated with it. A gender difference is apparent here: drug use by mothers is often considered more problematic than drug use by fathers. Caseworkers react much more strongly to individual incidents of crack use than chronic alcohol misuse and are much more likely to recommend the removal of a child from his or her family in those cases.

## **Gender**

Responses to drug use in the family are heavily influenced by gender. Women relatives appear to be more likely to seek support than men, and there was generally more emphasis on their support needs as family carers than men or fathers in the literature reviewed. The majority (70%) of callers to the ADFAM Helpline are female, although younger men seem to be more likely to seek help than men in general (Marshall 1993). Mothers constituted 33% of callers to the ADFAM helpline, compared to fathers at 6% (ADFAM 1998). Mothers seem more ready to contact services, and service providers are geared towards dealing with mothers, a chicken and egg situation that does little to promote the involvement of fathers and other male relatives. Marshall implies that mothers are likely to conceal their child's drug use from fathers, a point which may militate against recognition of and meeting the whole family's needs. However, fathers and male carers can become involved, particularly if publicity materials are aimed at them. Interventions can be targeted, for instance through workplace drug education sessions (Flemen 2001).

Family substance misuse is taken mostly to be maternal substance use (Colby and Murrell (1998) and Tracy and Farkas (1994)). There is very little research on the impact of paternal substance use on children, service response, support and coping, or on the differential impact maternal and paternal substance use may have on the child and on other family members. One of the few studies to examine paternal influences was Bekir et al (1993), in the context of absent fathers. None considered the impact of paternal substance use on caring, both reflecting and reinforcing the gendered nature of care and caring within the home and beyond.

### **Ethnicity**

Among ethnic minority families affected by drug use there is a low level of awareness of services, and a general lack of staff from ethnic minorities working in services (Flemen 2001). An important concern is diversity: linguistic; religious; generational and national. There are drug use problems which predominate in some ethnic groups, for instance the misuse of tranquillisers by South Asian parents. General Practitioners (GPs) are important points of contact for members of ethnic minorities, who tend to rely on them more than on specialised services.

### **Rural Communities**

Drug use is a problem in both urban and rural communities, although there is a greater reluctance to accept that it is a problem in rural areas (Flemen 2001). People living in rural areas have particular difficulties accessing services. In rural areas public transport is often very inadequate. Families may have concerns about receiving drugs-related services from people locally in their community, because of problems of confidentiality. Concealment of drug use (see below) may be much more difficult.

### **AIDS**

AIDS is associated with injecting drug use - users of heroin and other injected drugs are at high risk of AIDS. Land and Harangody (1990) examine a support group for partners of people with AIDS. They note that the bulk of people actively looking for support in giving care for AIDS sufferers are gay men whose partners have AIDS. The implication is that carers of people with AIDS who have been infected through injecting drug use may be more reluctant to seek service support for their own caring needs.

### **Family responses, coping and concealment**

Orford et al (1992) created a typology of ways of coping with family drug use, based on their research. They separated coping styles into eight forms: emotional; inaction; avoidance; tolerance; control; support for the user; confrontation; and independence. The most effective forms of coping, according to the authors, were confrontation and support for the user. Coping styles, feelings and perceptions go together; and families often use a combination of different ways of coping. In the light of this there are a number of suggestions for counselling family members. Since ways of coping, feelings, and perceptions are all linked, counselling can start to encourage relatives to talk about their actions, their feelings and their thoughts regarding the drug user. Advice about the various ways families have coped with drug use could be given, with the counsellor and the relative discussing the merits of different coping styles.

In a following study (Orford et al 1998) these types of coping were tested. They were then reclassified into three categories: toleration; engagement and withdrawal. Each coping style has different effects on both the family member and the drug user, and the style adopted by the family member depended very much on their role in the family. They found that older teenage children were more likely to withdraw, but it is likely given the findings from the literature on roles and positions that children taking on a parenting role would not be in a position to do this. Colleagues tended to tolerate. Parents and partners fluctuated between all three. This suggests that certain family members' coping strategies may mean that they are least likely to express their needs, or seek external support.

One response to drug use is concealment. It is often used by a relative as a way of maintaining the family unit and protecting the drug user. Those providing support for a drug using brother or sister often describe how they help their sibling conceal drug use from their parents (Marshall 1993). This is partly to protect the parents, who are perceived as not being able to cope; and also to protect the user from the parents overreacting and worsening the situation. This concealment worsens the isolation of the supporting relative within the family, and may mean that other support does not reach them.

### **Approaching services and support groups**

There is a point at which the relative feels they have to ask for help. Reaching it is often a difficult process. Marshall (1993) reports that many family members try to cope on their own for a long time before they look for help, and feel ashamed when they do. Seeking help outside of the family is often taken as an admission that the family has failed in its primary function of caring for its members. When that point is reached, help is sought for the substance user and the family's ability to provide support for them, rather than support for the direct needs of families themselves.

## CHAPTER 3 SUPPORT

This section reviews the support for families of drug users described in the literature. Again, an initial overview is provided as context for the subsequent detailed consideration of key contributions from the literature.

### Mapping of the literature

As was noted in the previous section, different family members have different needs that have to be addressed. However, family support is usually taken to mean 'parent support'. Support for families should include support for parents, siblings, the extended family and important friends of the user. It is apparent from the literature that in order to reach all family members a variety of different approaches have to be used. Some of these are outlined below. However, the aims and methods of support services can be contradictory. For instance, child welfare services prioritise the protection of children, which may mean removing the child from his or her parents. Family preservation services prioritise keeping the family together to support the drug user. There is a separation in the literature and in support services between concern for the family and concern for the drug user.

In the previous section on Needs it was noted that studies diverged between considering drug use as a problem of the family or a problem for the family. Here, support services diverge between those that support the family as an instrument of drug prevention policy, in educating and intervening with the user, and those that start from the viewpoint that family members need support in their own right. The latter are best exemplified by the support groups organised by families themselves. Attitudes vary: some professionals appear to stigmatise the family as being responsible for the drug use, and one of the attractions of family support groups for their members is that they seek explicitly to counter this. The interface between professional and peer support and how this relates to the expressed needs of service users should be more thoroughly explored by further research.

Family support groups are a common form of support for families. They are widespread throughout Scotland and the rest of the UK and provide support at a local and national level, as documented in the grey literature. However, there is relatively little research about them. Since they are mostly voluntary there is little funding available for research into best practice, effectiveness and the development of the groups over time, but some is available in the grey literature. What there is suggests they are effective in addressing some of the issues outlined above. Their family focus balances out the priorities of intensive interventions, which mainly prioritise the needs of the user rather than the family. They are able to address stigmatising of the family members.

In the section on Needs, drug use was shown to have an impact on family dynamics. One of the changes drug use brings is to the roles carried out by family members, such as drug using parents ceasing to play a parenting role. Few services explicitly address this aspect of drug use in families. Those that do (described below) aim to generate 'role recovery' among drug using parents. In doing so they are particularly valuable as they combine both drug prevention and family preservation services, crossing the divide between user-oriented and family-oriented support.

Since much emphasis in the literature is on family members as carers and on parenting roles, there is an implicit gender dimension to support services. The

most likely point of contact with a family is either a mother or female partner, whether or not they are a drug user. Although this is partly for practical reasons, it places greater responsibility on one family member, and means that little support is provided for fathers and male partners. The grey literature details ways in which male family members could be targeted for involvement and support but there are no reports of existing support services which do this.

The grey literature generally places more emphasis than the academic literature on providing support for wider kin, beyond the nuclear family. Mainly this means grandparents, who are usually the carers of first resort. However other relatives, such as aunts and uncles, may become involved as carers. Some family support groups address this by restricting themselves to specific groups of carers, such as grandparents. More practical problems for grandparents and other kin as carers are the extent of financial support for them and the difficulty of accessing it. One study noted that financial benefits given to parents for their children was often not passed onto grandparents who were the actual carers. Hence it is important to ensure that social security benefits and other financial aid does go to the person in the caring role, whatever their position in the family, and that these carers have the information and advice necessary to receive their full entitlement.

## **Findings**

### **Support for 'At-Risk' Families**

Olsen (1995) examined 'Project Connect', a community-based programme in the USA which aims to support families dealing with substance use by reducing the risk of child maltreatment, encouraging family preservation and increasing effective response to the families' needs. She found a significant decline in risks concerning family housing, parent mental health, knowledge of childcare and substance use. However, adult conflict and client co-operation scores increased. This could be due to the fact that conflict, or reported conflict, may increase, as people break free from coercive personal relationships. 62% of parents' substance use problems improved but for 21% the problem got worse, whilst for 17% the problem stayed the same. Although children involved in the project and those who were not were placed in care at similar rates, an increased number of children who were involved in the project were returned home and in a shorter period of time than the other children. The study involved intervention and control groups with pre and post intervention comparisons. The small sample size, however, limits generalisability.

Mumm, Olsen and Allen (1998) looked further at 'Project Connect' to consider implications for generalist social work practice. They described the 'generalist perspective' as being concerned both with individual troubles and the social problems that contribute to these. The generalist perspective aims to intervene at multiple levels: individual; family; community; organisational and policy. They raise issues regarding the tensions between the different systems that substance-abusing parents are involved with. Child welfare systems aim to protect children and assure their safety whilst substance use treatment providers focus on recovery, which can be slow and full of relapses. In common with Adams (1999) they point out that the negative attitudes and discrimination towards substance-abusing parents that exists in policy, and that are held by some professionals, can affect service delivery.

Whipple & Wilson (1996) evaluated a parent education and support programme for families at risk of physical child abuse. The 'Family Growth Center' runs a range of programs including respite care, support groups for parents and parent and child education and support programs teaching cognitive, affective and

behavioural skills. Programme resources included: parent manuals; parent handbooks; videotapes and family logs. Trained specialists staffed the childcare and programs were run by paraprofessionals (such as a family services co-ordinator) and social workers. Parental stress decreased significantly among parents with both low and high programme involvement.

Ray et al (1998) evaluated a 'wraparound' service model employed in the "Breakthrough for Families Project" for 28 families affected by substance use and adolescents at risk of abuse or neglect. Wraparound services are tailored to each family, and emphasise the family's existing strengths, rather than its problems. They are intended to coordinate service delivery in situations where a family has multiple needs, and previously would have had to make its own patchwork solution by engaging individually with a variety of statutory and voluntary services. Parents showed improvement in three measures of family functioning according to the Olson Family Instruments battery: Family Cohesion, Family Adaptability and Family Strengths. These scales aim to measure how the family works together. Adolescent's ratings on the same instruments improved little, although they felt there had been improvements in family functioning. The study gave scanty methodological detail, although it was notable for including a narrative/ethnographic component, and revising the use of standardised instruments to emphasise a qualitative component. The findings are unlikely to be generalisable, and no control group was used.

### **Family Preservation Services**

One form of support takes the shape of family preservation services. These are used as part of family prevention strategies for a variety of problems, including drug use. Family preservation services focus on the family and its social network. They coordinate both practical support for the family, for instance care, housing and transport, with clinical interventions to build psychosocial skills and improve family dynamics. Pecora et al (1992) evaluated a home based family preservation service in the USA. The service used behaviourally oriented training, clinical services, concrete services, and advocacy. It was found that it gave parents both the skills and resources to create a better home environment. The study has a small control group and a reasonable sample size. However generalisability was limited because of differences in the way the service operated in different cities. Since they employ a coordinated approach to the family, and include its wider social support structure, family preservation services are suited to tackling drug use in families, which requires both practical measures and measures which support the family. However, more evaluations are required.

Potocky & McDonald (1996) looked at the effectiveness of a community-based family preservation service for the mothers of drug-exposed infants by standardised measures and interviews. The programme, in particular the support group and interaction group services, was found to be of some value in avoiding child placement as 19 of 27 children remained with their families. In interviews, mothers said they felt that the programme was beneficial but felt overwhelmed by the number of different professionals visiting. Mothers were only willing to have an average of 1.7 hours per week involvement with the programme, which may have impacted on its effectiveness. There was no proven impact on a child's well being, indicating that having family preservation as an end in itself is limited. The study had a small sample size and no control group, but did include interviews with participants.

The Bridges Program, described by Gruber, Fleetwood and Herring (2001), is a home-based substance misuse recovery service for substance abusing parents and their families in the USA. It combines family preservation and substance

misuse recovery. Interestingly it focuses on helping parents regain their role within the family. It addresses four areas: individual actions and cognitions; individual recovery actions; family actions and cognitions and family recovery actions. The authors present two case studies to highlight the efficacy of the intervention model and the overall positive impact of the continuing care service on these families. There is no evaluation, but the programme indicates that family preservation and drug misuse services can be effectively combined; and that role recovery is a useful focus for interventions with drug using parents. It may be that role recovery methods could be applied to other family members, such as children in a parenting role. This program attempts, then, to blur the boundary between concerns about the drug user and concerns about the family. Again, rigorous evaluation is required.

## **Children**

Markowitz (1993) suggests that children affected by drug use require at least two basic types of treatment: being given the information that growing up in a chemically dependent home creates an at-risk situation and basic education about chemical dependencies to reduce shame. Such children can often benefit from group interventions as these can reduce isolation and provide peer support and reassurance they are not alone in their experiences. Self-help groups such as Alateen and Narateen can be useful. In treatment children of substance-misusers are considered to need: an atmosphere of trust; an understanding of common characteristics/behaviours of parents who misuse drugs; substance use education; suggestions for coping strategies; reassurance that they are not responsible for the substance misuse; reassurance that it is normal to feel angry sometimes and to be shown understanding about the conflicting range of emotions the child may feel about the parent. Emshoff and Price (1999) in their literature review of seven prevention and intervention programmes for children of alcoholics note several features that they should contain. These are: education and information provision; help to enhance coping and social competence skills; provision of an emotional outlet and social support; and providing positive activities for the participants that exclude alcohol and other drugs, such as sports, or Outward Bound programmes.

## **Support for Family Caregivers**

Many services described support for family caregivers. Group interventions appear to help more with social support; individual interventions with psychological issues. Toseland et al (1990) compared individual and group interventions for caregivers, using a control group. Each intervention offered: validation of care giving experiences; encouragement and praise; reassurance about coping; and support for managing difficult situations. It was found that both types of intervention were beneficial. The individual intervention was more problem oriented, and participants discussed a wider range of personal issues. The group participants reported more extensive positive developments in both formal and informal support. The study used a quasi-experimental design and effectively used triangulation of methods to confirm its findings. It had a high reliability and validity, and it is likely to be generalisable. The findings indicate that group or individual interventions will have beneficial effects in different areas of the caregiver's life; so for instance those that need more formal and informal supports may be best served by group support. Screening might be effective in allocating individuals to group or individual interventions based on their assessed need.

Support is often reliant on the caregiver changing his or her own response to the substance misuse. Meyers & Smith (1997) examined Community Reinforcement

Family Training (CRAFT), a treatment that teaches the partners of problem drinkers how to use behavioural principles to reduce drinking, encourage their partner to seek treatment and to reduce stress for themselves. The key elements of CRAFT are: the understanding that responsibility for the problem belongs to the drinker, although a partner can help through behaviour; motivation for the non-drinking partner; communication training; the use of positive reinforcement; ceasing to unwittingly 'support' partner's drinking by actions such as calling in sick for them or cleaning up the consequences of their drinking. It included reinforcers for the partner such as: improving their own social life, activities and work life away from the drinker to reduce stress and improve well-being. Like many interventions for families of substance misusers, this was 'treatment reliant' – support was offered on the expectation that the family member would play a direct role in treatment for the user, although this might also bring direct benefits to themselves also.

Copello et al (2000) looked at a treatment package to be delivered by primary care health professionals in the UK to help the families of people with drug and alcohol problems. This study developed from the work of Orford et al (1998) on families' responses to drug use and the coping styles they employ. An intervention manual based on the stress-coping health model was produced, and professionals were trained in a five-step system to help the family member. The approach could be tailored to the specific circumstances of the family member. They found that there were significant reductions in two types of unproductive coping, 'tolerant-inactive' and 'engaged', although the anticipated significant increase in withdrawal coping was not supported. It was not clear from the study why an increase in withdrawal coping was an aim, as it is not always regarded as a negative response. Orford et al, (1998) report that withdrawal was associated with greater independence on the part of the family member and reduced stress. Copello et al (op.cit) found significant decreases for psychological and physical health symptoms. Health workers' confidence in working with these families increased as a result of using the package. The authors concluded that primary health care practitioners – GPs, Practice Nurses and Health Visitors – could be trained to work with families of substance misusers. There was no control group for the relatives and the sample size was small. The professionals involved were self-selected and generalisability is limited.

### **Family Support Groups**

As mentioned earlier, most of the research on family support groups comes from the grey literature.

### **Development of family support groups**

Research in family support groups was commissioned by Parents Against Drug Abuse (PADA) and was carried out by Kenny (2000). He investigated the working of community based family drug misuse support groups in the UK. He contacted 179 in all, of which 152 took part in the research. He found that 92% of local parent groups were started following a parent's own experience with substance misuse by a relative, usually a child. These groups have greater longevity than many community groups. 79% had been in existence for more than 3 years whereas most community groups do not last more than one year. 78% of local groups worked with similar groups: larger or better established groups were able to support smaller or newer ones. Funding was variable; slightly under one half had received some sort of funding. Sources varied, including Health Authorities, Drug Action Teams, and Community Safety Partnerships. The European Social Fund was an important source of finance for Scottish groups. Support and supervision for volunteers was important for maintaining group functioning.

## **Facilitating family support groups**

Facilitator-led support groups were described by Flemen (2001) as having several advantages: the facilitator can be more detached, can motivate the group, and the group can work in a constructive way. The facilitator can keep a balance between sharing and focussing on problems; some people prefer to have a designated leader and group members are kept free from organisational/administrative tasks. The facilitator can also enable group members to discover strengths and to recognise and respond to their own needs and as well as those of the facilitator. The disadvantages of facilitator-led support groups were that poor facilitation may deskill or disempower group members, and members may have concerns about confidentiality.

Land and Harangody (1990) describe the development of a support group for partners of people with AIDS, using a mutual support facilitated model. The purpose of the group is to reduce stress and enhance functioning. They discuss different options for the creation, composition and functioning of the group, and the different stages in the group's development. A group can be on-going or run for a finite period of time, it can have a closed or open membership. The group should be mediated by a facilitator who aims to help members manage stress by recognising feelings; gaining insight into their situation; developing relaxation techniques and reframing problems. Agendas should be allowed to evolve weekly. The group moves through various stages: the initial phase (sharing information about coping; cohesion); a stage when group begins to become like a family; and finally termination when group ends. The authors recommend that the service should be evaluated after termination.

The role of the facilitator is particularly important, both in maintaining the group and in screening potential members. Group cohesion and the sense of the group as an almost familial unit are reported as vital to its success. Land and Harangody (op.cit) note that cultural issues are important and people who are involved in substance misuse may require their own group because of the specific nature of their difficulties. Understanding group development provides an important window into the processes of support and therefore on who may be best supported through such groups. However, such understanding may also suggest who may be excluded from such networks, through reluctance to become involved or through attrition over time.

## **Benefits and functioning of family support groups**

Marshall (1993) notes some of the benefits of joining a self-help group. These are: empowerment; members being able to develop ownership of the issue and discuss it outside of a professional discourse; development of organisational and social skills as a result of running the group; reassurance about the commonality of their experiences; and a source of support outside an institutional or professional context, since some people are nervous of professionals. The group dispenses with the need for professional involvement. She also describes some potential problems: anxiety can be increased if people hear about problems worse than their own, and if the group dwells too much on negative accounts it can be disheartening. A group by its nature is not anonymous: the anonymity of a telephone helpline may be preferable, as may be the informal nature of a befriending network. Individual counselling can provide more focused response and advice, but one-to-one counselling was said to be less widespread than other interventions, although it can meet the need of families who wish face-to-face, individual contact. It will be important to ensure systematic evaluation of family support groups, both in terms of process and outcome and in terms of links with

other services. Most work is descriptive at this stage of the development of the field.

One of the most important functions of family support groups is as providers of information (Kenny 2000). While 97% offer advice and information about illegal substances, slightly less (90%) have information on misuse of prescribed drugs, and less again (70%) have information on misuse of legal substances, including alcohol, and are willing to actively seek out information required by parents. Since polysubstance misuse is common it may be advisable for groups to have access to information about all three categories. Groups also carry information about other matters of concern to families – including health, legal issues, and welfare. They are sensitive to the wider context of drug use in the family: 92% of groups say their work also involves discussing general family and neighbourhood problems that result from drug use.

Nearly all offer an information service about drugs in the form of a helpline. The advantages of telephone helplines were reported as being: accessible; anonymous; less expensive for service providers; not needing childcare/transport. The disadvantages were that they are mainly useful for crisis information, they require access to a telephone (which may exclude those on low incomes) and lengthy calls can be expensive for users. Kenny reported that most local support groups used helplines. Flemen (2001) quoted Birmingham Parents for Prevention as having found in its evaluation of helpline services that there was a lack of publicity of phone numbers. 57% of callers to helplines found the number from the Yellow Pages. They did not always find the help they needed first time. 22% had to contact six agencies before finding the right one.

Kenny (op.cit) reported that 89% of local groups have regular support group meetings (Kenny 2000). Most of these allow parents, grandparents, other members of the family, and friends to attend. 10% restrict themselves to families affected by use of a certain substance, or to a specific group like grandparents. Some groups take the view that parents have different needs depending on their circumstances, and so offer more than one support group, for instance having one for 'new parents,' parents who have only recently found out about their child's drug use; another for those whose children were long term users and who have a chaotic life; and another for those who were in a position to move on.

A large part of the work of groups was providing ongoing emotional support through each point of the user's 'drug career.' This included rehabilitation periods. Statutory agencies would not necessarily sustain their involvement for that long. Since they are in contact with families over a sustained period, these groups are aware of gaps in service provision, which would make them a useful focus for research aiming to identify unmet need. One important function of family groups was to emphasise to parents and family members the importance of their own health and needs, which also have to be recognised alongside those of the user. Practical support included transport, important for maintaining family members contact with the user when they are in prison or residential treatment. Other support included baby-sitting and social outings.

Hill (2001) looked at a peer support group run by and for mothers of sexually abused children in York in the UK. He used a small number of qualitative interviews to research the women's views. He found that the women were very positive about the group, saying that it had helped them where family, friends and professional support could not. They expressed the following good points about the group: finding others who shared similar experiences; the group was non-judgemental; the value of being able to express feelings; the group had

indirectly helped children by better equipping the mother to be able to listen to children and understand their behaviour; and attendance was flexible. This study was primarily a process evaluation involving a small number of users; limited information on the methods and analysis were provided in the article.

Family support programmes were examined by Lightburn & Kemp (1994), who described valuable approaches and best practice from the USA. They define 'family support' programmes as: neighbourhood-based programs providing comprehensive services to families to develop parental competencies and address the developmental needs of children through support, activities and education. They advocate particular key elements of effective programmes: a developmental, family-centred approach; a comprehensive range of individualised services; concrete; supportive; educational and clinical; a commitment to participation and empowerment; having strong connections to neighbourhood and community; using highly flexible staff and programme structure and a flexible, non-stigmatising service. Although not specifically concerned with drug misuse and not evaluated, there are some useful pointers to how family support programmes in Britain might be structured, although further evaluation would be required.

Most support groups focus on parents with children who are drug users (Flemen 2001). In many instances, it may be the children that are affected by parental or sibling drug use. It is hard to gauge how extensive this problem is, since parental drug use is unrecorded unless statutory services such as police and social work have become involved. Lifeline and ADFAM have developed resources for children with drug or alcohol using parents. Local agencies might be advised to follow suit, but again, process and outcome evaluation would be essential.

### **Support group involvement with agencies**

Groups were aware of the limitations of the support they could offer and would refer people on to other agencies. In their work, groups formed contacts with local statutory and voluntary organisations. Kenny (2000) reports that some have become involved in partnerships with other agencies to provide joint services or projects. Scottish groups are usually represented on the working groups of local Drug Action Teams, although are not full members. Less are represented on Drug Reference Groups, although some are involved in strategic planning in their local areas. Some groups were involved in training for professionals. 98% had participated in community-based training, such as with tenant groups, parents and young people. In Scotland groups were especially likely to train in partnership with other professionals (two thirds said they did this).

### **Support for members of the extended family**

Although there was little literature on wider kin, Lewis and Williams (1994) studied a family support group for African-American grandparents who had taken on parenting of their grandchildren. Their children were often unable to parent because they were drug addicted, in gaol, or deceased. Grandparents found themselves continuing in a parenting role even if the 'parenting crisis' had passed. Financial support from the US Department of Social Security (DSS) was extremely limited; and social security money given to parents for their children was seldom passed on to the grandparent when they were in a parenting role. Referrals of grandparents to a kinship and resources service by the DSS was found to be helpful, where case managers could help with long term planning. However financial support was inadequate, with grandparents given less than a third of the money given to foster parents.

Hirshorn et al (2000) examined support for grandparents who were bringing up grandchildren due to parental substance use, in the form of a 2-year pilot community-based 'learning programme' for the grandparents of children whose parents misuse substances in Detroit, USA. The programme addressed several aspects of family and personal life. These included: family roles (exploration, disparity between expected and actual roles, and responses when roles unfulfilled); clarification of family role boundary ambiguity; learning assertiveness/self-management skills; creating a positive home environment (communication/praise to reduce unacceptable child behaviour, effective listening techniques and dealing with anger); developing support networks; setting personal goals; and expanding personal horizons (opportunities for: employment; retirement; education; self-development and accessing resources).

The aim was for the intervention to improve three areas for grandparent carers: their self-management (purposeful behaviour employed in the development or use of resources, both personal and material, to achieve goals); reduction of role boundary ambiguity (the blurring of understanding of family roles due to taking on the role of raising the grandchild not usually accorded to a grandparent) and improvement in their personal well-being. They found mixed, though generally positive results, with some aspects of grandparents' lives improving more than others. In the second year, grandparents' skills improved, although in the first year their personal lives deteriorated. Boundary ambiguity was reduced in both years, and in year one there was an increase in emotional well-being. However, Hirshorn's study had some problems with validity, as the pre and post intervention methods were different, and there is limited generalisability because of the small sample size. However, it was one of the few to focus on extended family members.

### **Support using the education system**

The education system is a focus of many programmes seeking to intervene with children of drug users. Dore et al (1999) evaluated a psycho-educational curriculum for use in schools with children in families affected by substance use in low-income areas. This was a randomised control trial, although variable school attendance affected participation rates. Although validated measures were used, some children had difficulty, thus limiting both validity and reliability. The only statistically significant change found was reduction in physical attacks on others, although positive changes in the children were noted with regard to: locus of control; social acceptance; self-worth; reduced restlessness/attention-seeking behaviour in classroom; completing more assignments and improved relations with peers. Interestingly, no changes at all were found in levels of loneliness and social isolation, suggesting that different types of intervention and support would be necessary in order to do this. In their study, Gross and McCaul (1992) evaluated a 13 week psycho-educational intervention with young people aged 11-18 years aimed at providing social support and enhancing the drug resistance skills of children of substance misusers. The intervention included: information; brief advice and informal counselling and the 'Life Skills Training Curriculum'. However, this intervention was found to be unsuccessful in causing statistically significant changes in any of the intended areas: depression, self-esteem, behavioural problems, or drug use. The intervention was delivered differently at different sites and this raises questions as to its generalisability and points to the need for further process evaluation. There were also problems with attrition and some bias in the sample itself.

Interventions based in the education system may be limited in their effectiveness, although in both studies quoted above there were limitations in both the

implementation and evaluation of the programme. Interventions based in the education system require the children to be in attendance, and low attendance is a common problem for children with drug using parents. Dore et al also noted difficulties many children had with reading and understanding parts of the intervention curriculum. Therefore, interventions must begin with support for children's attendance at school and enhancement of their reading and comprehension skills; and possibly extend beyond the school environment because of isolation at home. However, thorough process and outcome evaluations are required.

## CHAPTER 4 SERVICES

This section reports on the literature focussing on services and interventions more widely, and the involvement of families in those. An overview is provided as well as specific details of relevant research.

### Mapping of the literature

As in the literature reviewed in the previous two sections, the tensions between a focus on treatment for the drug user and the needs of the wider family are also evident in the literature concentrating on services and interventions. In many intervention studies, involvement of the family member in therapy is evaluated according to the effect it has on the drug user rather than on the family member. This is limiting from two perspectives. The first is that the maintenance of participation in treatment will be facilitated if it is shown to have a positive impact for family members. The second is that programmes which have a positive impact for family members should be developed in their own right. Family members ideally should be fully involved in evaluation.

The involvement of family members in treatment programmes has been shown to improve their effectiveness as regards positive outcomes for the drug or alcohol user. In general, the majority of interventions have as their primary aim of encouraging the family to alter the behaviour of the drug user, and these include interventions with children. Interventions with the primary aim of support for families *per se* were less common. This reflects the service based focus of many of the studies; it is possible that interventions which develop from family support groups may be oriented more around the family as a whole and less around the behaviour of the drug user, but they are not reported in the literature.

How outcomes in service interventions are measured is an important question, given that there seems to be a divergence between the assumptions of evaluators and the priorities of service users. Pharis and Levin (1991) evaluated an intensive intervention of mothers at high risk of parenting problems. Some of the aspects of the programme that the mothers ranked as most important were 'gave you a person to talk to who really care about you'; 'helped you to learn more about how children develop'; 'helped you give your children a better start in life than you had.' One of those that was ranked as least important was 'helped you get along better with your husband/boyfriend.' Yet, in other studies, marital or relationship satisfaction is used as a key outcome measure. For evaluations of a programme's effectiveness to be relevant to service users it is important that it takes account of what they consider to be important, especially as to what relationships need to be strengthened and what dynamics need to be changed.

Evaluations of intensive interventions are more common than those of low-level interventions. This might be in part for methodological reasons. Intensive interventions are more amenable to commonly used methods and commonly held assumptions about methodology in the field of drug use studies. These are that: the population to be studied is static, enclosed and clearly defined; it can be accessed over an extended period to allow for before and after comparisons; there is scope for multiple methods to be used. It is important that more studies of low-level interventions are produced so that their efficacy can be compared to more intensive interventions. It is important that such studies include the views and experiences of service users.

## Findings

### Involving family members in planning

ADFAM is a UK organisation working with and for the families of drug users. Its service users are families and friends of drug users and workers linked to drug services for the family. 'Engaging experts', the report for ADFAM written by Brown (2001), looked at ways of involving service users in ADFAM, in terms of planning, development and implementation of services. ADFAM currently involves service users through a range of activities including: asking users for feedback; sending questionnaires on how to improve services to Helpline callers; obtaining feedback from participants on courses and recipients of consultancy services of the Prison Project; having service users sitting on the Prison Project Advisory Group and community consultation such as 'Families in Focus', a series of UK wide meetings asking services users what they need.

A lack of resources, both financial and in terms of time, was identified as the main barrier to involving service users. Issues of confidentiality, lack of knowledge of services provided and that service users may not wish to be involved (due to it being too emotionally painful or to them feeling exhausted from their experiences) were also identified as barriers to involvement. Several organisations around the UK were identified as having examples of good practice in involving service users. These included efforts by: a pilot project by the Somerset Drug Action Team; the Prison Reform Trust; the Children and Youth Project at West Sussex Voluntary Organisations Group; Imagine London; the IMPACT helpline run by the Scarborough Alcohol and Drugs Abuse Centre; Involvement Task Group (Sheffield); the Glasgow Association for Family Support Groups and the Scottish Drugs Forum.

### Involving family members in treatment

Flemen (2001) looked at making services for families affected by drugs as inclusive as possible. He described the approaches to working with families as ranging from the family member being only a recipient of the service, to them as being a contributor to the service. Family members as service providers fall into three categories: informal (education through one-off drugs awareness); semi-formal (more extensive education/training and can go on to deliver peer-education, telephone support etc); and formal (family members who are professionals).

A four-tiered model of family service provision is described by Flemen (2001). Tier one is defined as being most widely used and accessible services, often a first point of contact for families with low risk of harm. This includes: one-off drugs awareness sessions; telephone helplines; work by police, social services, schools and GPs. These agencies carry out brief interventions and can refer on to other agencies. Tier two services are more structured interventions where drug use is more significant. Services may be accessed directly or by referral. These include: structured drugs awareness programmes; parenting skills courses; support groups; structured counselling provision. Tier three services are more specialised interventions where drug use is very significant or there is a high-risk of problems developing. These include: individual counselling and psychotherapy; infectious disease advice; substitute prescribing or detoxification; family assessment and therapy. Finally, tier four services are highly specialised, work with the most complex cases, and involve intensive collaboration across agencies. These include residential interventions and services that place children into care. This may be a useful typology, and helps to identify ways to promote both user engagement and partnership working across sectors.

## Outcomes of family interventions

Higgins et al (1994) evaluated the effect of the participation of significant others in a behavioural treatment package for cocaine users. They found a positive effect on cocaine abstinence, although their study used a small sample with limited methodological details being provided. Positive impacts are recorded even where the user is not directly involved in the treatment programme, as in the case of Unilateral Family Therapy (Thomas et al 1987, 1990). Romijn et al (1992) examined the outcomes for 18 families entering two therapy programmes in Holland, one in Amsterdam and the other in Arnhem, and the relationship between family functioning and success. The programmes involved therapists trained in methods described in Stanton and Todd (1982). These involved families in treatment and employed two treatment strategies, entitled 'diversion' and 'compression'. These are designed to counter two family factors related to drug use by a child. These are that one parent (usually the mother) has a strong relationship with the drug using child, while the relationship between the two parents is weak. They found that most families experienced improvement in drug abstinence and social functioning one year after the start of therapy. The relationship between the parents was strengthened, although interestingly the relationship between mother and drug using child was also strengthened, with more positive communication between the two following therapy. Success in treatment for the drug user was particularly likely in families where communication had been poor or negative initially but had improved during treatment to become more positive and supporting. Their results corresponded with other findings from the literature, although there was no control group comparison in the study.

One study which examined outcomes for parents and children was conducted by Catalano et al (1999), who evaluated an experimental intervention with drug using parents, measuring the outcomes for both parents and their children. The drug users were methadone maintained. The intervention group had this treatment supplemented with family skills training and home based care management services. Parenting outcomes were good, with parents who had been through the intervention reporting lower domestic conflict, less drug use and better problem solving skills in drug use situations, though not in non-drug related situations. However, with children the only statistically significant change favoured the control group, who had better social involvement with their parents at 6-month follow up. There were non-statistically significant differences in the prevalence of smoking and drinking. It can be seen then that a positive result for the drug user does not necessarily translate into a positive outcome for other family members. The study had a randomised experimental design with reliable and valid measures, and the results have some generalisability.

Support for parents of adolescents involved in drug use is documented in Henricson and Roker (2000). Two programmes were identified. The Purdue Brief Family Therapy Model attempts to redefine drug use as a family problem, re-establishing parental influence over the child. It aims to: reduce the family's opposition to drug treatment; establish drug use as being an issue for the whole family; restore parental influence in the family; end damaging cycles of behaviour in the family; evaluate the 'interpersonal function' of the drug use; put into practice strategies which will change that interpersonal functioning; and make available assertiveness training for the drug using child and siblings to resist pressure to use drugs. The Training in Parenting Skills education programme seeks to educate family members in skills with which to end the adolescent's drug use. It provided education in: the development of drug addiction; the extent to which parents were and could assume responsibility for it; the importance of communications and conflict resolution; and the course of recovery for both child

and family. They were successful because they helped to create a supportive environment in the family, and used emotional ties to motivate the drug user and the family member to change their behaviour. The therapy model had greater success (54.6% success rate) than the education model (37.5%).

Involving family members in treatment is not a one way street. For instance, Dore et al (1996) describe the Children of Alcoholic Families programme, a school based intervention to support children with alcoholic parents. The authors note that school based programmes are useful, because they allow easy access to children from substance misusing homes, without being dependent on whether the parents are themselves seeking treatment. However, this raises questions about how to assure privacy, particularly as school is sometimes the only avenue of escape or respite for children, and obviously such programmes do not reach non-attenders.

### **Unilateral interventions and support networks**

Unilateral interventions are those that do not directly involve the drug user. They have their own value as they do not have to correspond to the drug user being involved in treatment or being at a specific stage in their treatment. Furthermore, whereas bilateral interventions tend to focus on helping the family member to change the drug user's behaviour, unilateral interventions may have two further objectives: to change and enhance the relationship between user and relative; and to help the relative limit the effect of the drug use on themselves. Evaluations of unilateral interventions with families of drug users are rare.

Al-Anon is a unilateral support network. It, and its drug equivalent, Nar-Anon, focus on the last two objectives, on the grounds that the drug user has to take responsibility for their own behaviour. They emphasise 'loving detachment.' Reflecting this, research indicates that Al-Anon's particular strengths, according to some studies, was in improving the well-being of the family member. Keinz et al (1995) researched 64 female and 14 male members of Al-Anon and found that being in Al-Anon for longer was significantly correlated with improvements for non-drinkers in: overall self-esteem; self-satisfaction, marital adjustment; behaviour, physical self, personal self and family self. However, using a small, self-selecting sample limited the study's generalisability. Self-selection reduces the sample's representativeness of the total population reached by Al-Anon.

Community Reinforcement Training (CRT) is a USA-based intervention with family members and significant others (FSOs) of drug users (Kirby et al 1999). It was developed from a previous unilateral intervention with partners of alcoholics. The study compared CRT, a series of individual counselling sessions, with a series of group counselling sessions. Both interventions reduced the number of self-reported problems of family members, particularly relating to areas of finance and health. They showed a positive and statistically significant impact upon pre- and post-treatment scores in family members' mood states, social functioning and family functioning. Family members assigned to the CRT intervention did better on three of the five outcomes measured than those in the group intervention. They stayed in treatment longer; were more likely to complete treatment and the drug user was more likely to enter treatment. More drug users entered treatment with the CRT intervention than Nar-Anon, but this finding may not be valid as Nar-Anon specifically does not focus on initiating treatment entry of the drug user. The samples were not randomised and numbers recruited were small. There was no control group, and results cannot be generalised.

Gibbons & Thorpe (1989) looked at "Home-Start", a British voluntary home-visiting and befriending service for disadvantaged and/or vulnerable families with

young children. The study compared higher and lower needs families to see if higher needs families could benefit as much as lower needs. It found that the service was able to help higher needs families: 86% saw their volunteer at least weekly; they reported receiving more general help and the same amount of domestic help as lower needs families; and 50% reported being very satisfied with the service. Volunteers felt that they were well matched with the high needs families and were equally able to provide a good service for families with both levels of needs. However the study was limited: only one branch of Home-Start was studied, the sample size was small, and there would be limited generalisability.

### **Improving service uptake**

Marsh et al (2000) evaluated a programme design to increase access to treatments for substance abusing women, by means of providing practical assistance. They found that transport, outreach and child-care services increased access and uptake of treatments. It was associated with reduced drug use. Marsh et al used a quasi-experimental design which had a low likelihood of bias. Practical assistance to mothers who use drugs is important in improving their uptake of services. There is no research on whether assistance to fathers would also be helpful. Similarly, there is no research on how service uptake may be improved for family support services more generally.

Ray et al (1998) found that the 'wraparound service' for families affected by substance misuse and adolescents at risk of abuse or neglect had little effect on adolescent's well-being. However their school attendance increased from 50% at intake to 60% at termination; living at home from 64% to 88% and 88% reported school problems at intake compared to 33% at termination. One intervention, then, may improve access to other services or provision, and produce positive outcomes beyond the main aims of the intervention.

Flemen (2001) highlights the importance of making interventions accessible. Factors to consider are: venues should be accessible (by public transport) and 'neutral'; using home visits and childcare provision. Special efforts should be made to reach all groups and types of families and family members including: people living in rural areas; people from ethnic minorities; fathers and male carers; step-parents, divorced and lone parents; lesbian and gay parents; and foster and adoptive parents.

It is likely that services geared towards giving practical assistance to drug using mothers with children would be ideal for providing treatment or support specifically targeted at their children, as well as themselves. As mentioned previously, improving children's participation in education is a prerequisite for effective interventions based in the education system. Development of wraparound services aimed at meeting the diverse needs of family members across different settings may be one way forward. Informal and formal support can then be balanced to meet changing needs.

## CHAPTER 5 CONCLUSION

This review of the literature on support for families of drug users suggests that although there is a wide diversity of articles, these are most often descriptive pieces about service provision and development: most of the evaluation studies reviewed fall short of the established methodological criteria for ensuring rigour. There was seldom a direct link between assessment of need and service provision, although that may have taken place at an informal level as part of service delivery. There is clearly a need for interventions of all kinds to be evaluated systematically, in order that further developments to provision can be based on sound evidence.

In terms of establishing what is known about the support needs of families of drug users, the review suggests that the diverse needs of all family members are not well documented, especially those of wider kin such as grandparents but also of siblings.

Research with grandparents in a parenting role is very limited. What research there is indicates that they amount to a significant 'hidden' population of carers for children affected by drug misuse, and that they enjoy only limited support from service providers. Much focus is on children and on parents, but even here needs are not often directly assessed from the viewpoint of family members themselves. This leads to a tendency to report professionally defined needs which may or may not correspond with user defined needs.

Issues relating to isolation and concealment were raised in a number of articles, suggesting that support and service provision will have to be very flexible in order to reach these excluded groups. The needs of parents (by default this usually means mothers) are considered, with support for parenting skills identified as relevant. However, again the views of mothers themselves are seldom elicited prior to the service intervention, although may form part of the delivery and evaluation process. The needs of children, who are reported as being harmed in several ways if living in a family affected by drug misuse, are considered in some of the literature; here the issues outlined above are supplemented by concerns about behaviour including poor school performance.

In trying to establish what is known about effective ways of addressing those needs, this review suggests that the match between service provision and need is not always explicitly derived from a needs assessment that prioritises users' own views. Services may be geared primarily to meet the needs of the drug user, where the family is conceptualised as supporting or hindering that primary concern. Few studies report directly on interventions aimed at other family members' needs and how they may interact with the effects of drug use on the family.

The evaluation studies reviewed often fell short of the rigour required for effective evaluation. Where an effect was reported on either a family member or on a drug user, this was often small, and sometimes not in the expected direction. Studies were seldom generalisable, and process evaluations rarely carried out. This means that little is known about the nature of the intervention; and effects were often considered in individual ways using psychological measures. Issues around family dynamics and family functioning were seldom addressed, and when they were, service users did not necessarily prioritise the same items and the service providers/evaluators.

Most studies use individualised psychological scales to measure outcome success despite the fact that some programmes claim to be explicitly family oriented. This limits investigation of family processes, since the scales are usually used as before and after measures: process evaluation was in general limited. Furthermore, reflecting the focus of most of the programmes, assessment is made of the outcome for the drug user, not the family as a whole. It is harder to get a picture of the different effect of interventions/support on individual non-drug using family members, or the family as a whole. Generally low-level interventions or services are under-evaluated. Evaluations tend to be of intensive interventions. There are few evaluations of, for instance, telephone helplines, and none of websites or online advisory services.

None of the studies explicitly evaluate resource effectiveness, compare different programs for cost-effectiveness, or address resource issues more generally (a partial exception is New et al 1998). It is important to see how much intervention and support is effective, and whether the apparently more expensive intensive interventions work better. Decisions about provision are increasingly based on perceived value for money. Intensive interventions are more likely to be closely evaluated because they are more amenable to the application of evaluation methods, especially specific pre and post intervention measures relating to clearly defined outcomes. It is possible that resources are more likely to go to them because they are open to this kind of evaluation, with the impact of low level or less formal programmes being missed because it is harder to measure and evaluate.

The review could shed only limited light on whether or how family support groups and services link with other services, as few articles reported on the work of family support groups, neither did they take a holistic view of the range of services an individual or family may be accessing. Although family support groups do exist and some have been described, there is very limited evidence of their effectiveness, development and the extent to which they may become embedded in a network of service contacts. Importantly, this should be highlighted as an area of further investigation, where local level groups can be researched in their local contexts. The results of such research can feed into a national picture of both availability, processes and effectiveness.

In terms of whether involving families within the treatment or service offered to the drug user has beneficial effects upon the family and the drug user, the review outlines how some studies report beneficial effects upon the drug user and, to a more limited extent, upon the family. However, this may only be on some family members and not across all dimensions measured. There is little evidence of long term effects because of limitations in the research itself.

The review has also suggested that the different ways in which substance misuse is viewed by different agencies, and by families themselves, may be important to investigate further. They will clearly affect provision and uptake of services, and may help explain differences across different substances and indeed different settings. There seemed to be some distinctions between attitudes towards and interventions within families affected by alcohol misuse and drug misuse, notwithstanding the importance of the interaction between the two. Relatedly, illegal drug use and the misuse of prescription drugs may also produce different effects and needs in families; although there is some recognition of this, there is little systematic research. Poly drug use may also be important in this context.

The taken for granted assumptions about families and caring responsibilities are played out in much of the literature in an unreflective way. This means much more focus seems to be placed on women as mothers or partners, whether or not

they are themselves drug users. The route into family support is therefore most often through women, or sometimes children especially if they are in a carer's role. While no doubt reflecting the everyday realities of caring responsibilities in most families affected by substance use, it also means that the family related needs of men, as fathers in particular, are under-researched, as are the needs of grandparents or siblings. Future work should perhaps challenge, as well as work with, the existing gendered division of caring work within and beyond families.

There is a tension running through much of the research reviewed, implicitly rather than explicitly. This relates to the relationship between the drug user and the wider family, the interrelationship between their needs and those of the wider family and their different roles in the support or treatment provided. If the main focus of intervention is on the drug user, the role of the family may be conceptualised in a particular way and vice versa. The complexity of these interrelationships between drug related and wider needs will be evident in service development and delivery; a more explicit analysis of that complexity at the point of needs assessment and service development will help to produce more reflective practice, revealing and, hopefully, resolving some these inherent tensions.

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