

Addiction and the family: is it time for services to take notice of the evidence?

Over the last few years, there have been important advances in our knowledge of the potential role of families and wider social networks in the course of addiction problems. Evidence comes from both theoretical studies aiming to develop a clear and detailed understanding of the experiences of those people who are close to and affected by someone with an addiction problem, and from applied clinical studies evaluating a number of treatments involving families and, in some cases, wider social networks. In addition, comprehensive reviews of the alcohol treatment literature (e.g. Miller & Wilbourne 2002) suggest that treatments that incorporate a social component are among the most efficacious. In this context, families are seen as important stakeholders that can both aid the process of change and benefit from improvement of the addiction problem. We argue that an increased emphasis on the role of families and wider social networks in routine service provision can: (i) assist in getting clients to treatment and maintain engagement in treatment; (ii) improve both substance-related outcomes and family functioning, and (iii) lead to the reduction of impacts and harm for family members and others affected, including children.

The work of Barber & Crisp (1995) and Miller *et al.* (1999) suggests that working directly with those who are concerned about someone's addiction in cases where the user of substances has not come forward for help (or is indeed resistant to it) can lead to positive outcomes for those people concerned and, in many cases, to the engagement of the user in treatment. These types of approaches are sometimes described as 'unilateral' to indicate the fact that change can be achieved for the user of substances while working directly with other members of the user's social environment. A recent study among outpatient substance abusers has also shown that social support at intake was a positive predictor of retention in treatment (Dobkin *et al.* 2002).

Further evidence of the influence of the social environment in supporting either continued problem drinking or abstinence emerged from Project MATCH in the form of what the investigators reported as the 'largest matching difference observed in the trial' at the 3 year follow-up assessment (Project MATCH Research Group 1998). The results showed that those participants who had networks supportive of drinking at baseline and later engaged

actively in self-help groups supportive of abstinence following Twelve-step Facilitation Therapy achieved better drinking outcomes.

In addition to those already mentioned, there are a number of other social and family-based treatments with proven efficacy, such as Community Reinforcement Training (e.g. Smith *et al.* 2001), Behavioural Marital Therapy (O'Farrell 1993) and Unilateral Family Therapy (Thomas & Ager 1993). It has also been shown that involving significant people in treatment can improve outcomes (e.g. Higgins & Budney 1994; Epstein & McCrady 1998). An intervention developed from social approaches of proven efficacy is currently being compared with Motivational Enhancement Therapy in a multi-centre alcohol treatment trial (UKATT Research Group 2001). The intervention, termed Social Behaviour and Network Therapy (Copello *et al.* 2002), starts with the person with a drinking problem but proceeds by identifying family members and friends supportive of the user's efforts to change and engaging them in the treatment process whenever and as much as possible.

With regard to family harm, results from studies focused on families show that reductions in the stress-related psychological symptoms experienced by family members affected by addiction problems (e.g. anxiety, depression, worry) can also be achieved (Moos *et al.* 1990; Copello *et al.* 2000; Halford *et al.* 2001).

Evidence is therefore growing to support the view that families and social networks can be influential, yet a paradox is evident when we look at addiction services. Despite the accumulating evidence for the important role of families, on the whole service delivery remains focused on the individual drinker or drug user, with families and other members of the user's social network playing a very peripheral role, if any. Where available, services for families and couples are highly specialized and based on those models with the least evidence for effectiveness. With very few exceptions, help for those concerned about the user is reactive, poorly thought out and marginal.

A recent study confirms this view. As part of a national survey conducted in the USA (Fals-Stewart & Birchler 2001), programme administrators from 398 randomly selected community-based addiction services were interviewed. The authors set out to establish the extent to which one form of family intervention, Behav-

joural Couples Therapy (BCT), was used in routine addiction practice. Results showed that none of the services surveyed used BCT, despite the documented robust evidence of the effectiveness of this approach. Only 27% of services provided some form of couples-based programmes, with less than 5% offering some form of behaviourally oriented couples therapy but not BCT. A possible conclusion from this survey is that a small proportion of services offer approaches that involve significant others, and where this is the case the choice of treatment is not guided by the evidence base (a problem admittedly not confined to family treatments).

Fals-Stewart & Birchler (2001) reported a number of barriers given by programme managers as to why it is difficult to incorporate an evidence-based family treatment such as BCT into routine service provision. The two most commonly reported barriers were that the treatment was 'too intensive' and 'not typically employed as an adjunct to other services, but rather as a stand alone intervention' (Fals-Stewart & Birchler 2001, p. 279). The argument about intensity is an important one, and there is a need to develop less intensive family interventions that can achieve the same positive outcomes. The second one is rather more puzzling, given that in most studies of BCT substance-related outcomes are at least as good as those achieved through individual-based treatments and hence the family intervention alone should be sufficient.

To our knowledge, no similar survey has been conducted in the UK but one could predict that if undertaken, a survey would confirm low application of family approaches in routine addiction practice. The authors of the present paper conducted a recent survey within one of the largest non-statutory providers of alcohol services in the UK. During a 2 day period we monitored all contacts across a range of community alcohol services to establish whether family members affected by alcohol problems were seen in routine practice. Out of 174 client contacts, family members were seen as clients in their own right in only five cases (2.8%), and family members were involved in couple interventions in a further three cases (1.7%).

Given the developing evidence, the lack of family interventions and family involvement within routine service provision needs to be considered, particularly in our current climate of clinical governance and the need to deliver evidence-based treatments.

We propose that one of the most significant barriers to family involvement in routine addiction treatment results from the commonly held notion among service providers that family members are 'adjuncts' and are not central to addiction treatment services. Given the fact that most services operate with limited resources, substance-user-focused treatments are prioritized over

family-focused services. In fact, the language used by some agencies to describe concerned others—for example, 'third parties'—illustrates the attribution of a less important role. If services are to involve family members in the treatment process, therefore taking full account of the current evidence, we suggest that three issues need to be considered by both service providers and commissioners.

Firstly, models of alcohol and drug problems need to place the role of the social environment as central and as important as that played by individual factors (e.g. Rachlin 1997; Orford 2001). Over the years, the social environment has played a very minor role in addiction theories that have in the main focused on individual factors (e.g. neuroadaptation, motivation and self-efficacy). Once the social environment becomes central to the understanding of addiction problems, it is possible to incorporate a wider view of addiction into training as well as service planning and provision.

Secondly, the base of treatment needs to be broadened to see the family as a legitimate unit for intervention, as illustrated by the range of approaches already discussed. This means that in addition to the user of substances, any family member or concerned and affected individual can become the focus of help, either within a family-based intervention or as a client in their own right. Specific approaches can be drawn from the developing evidence on social interventions. In addition, attempts should be made wherever possible to incorporate the role of the social environment in formulations about the presenting addiction problem.

Finally, both commissioners and service providers need to pay more attention to, and recognize that there are, a broader set of positive outcomes in addition to reductions in substance use. In this context, the potential reduction of social costs associated with the impact of addictions on other family members are important (e.g. substance-related family violence), as is the reduction of costs associated with resource use through additional health and welfare service demands made by affected family members.

An alternative to our current services would involve altering the focus of treatment from the individual to the social context within which the addictive behaviour takes place, hence placing an increased emphasis on the family. Drawing from current evidence, focusing on the family as a unit and following a careful and thorough assessment of each case, such services could tap into a whole range of potential points of intervention. Attempts could aim to maximize early detection and engagement and a range of positive outcomes for both users and concerned and affected others within the same treatment agency. Such services need to be flexible and equally accessible to both users and those affected by the substance use. Staff need

to be familiar with a range of family and individual treatment strategies. The family unit can provide a point of engagement even before the substance user is fully motivated to change, as illustrated by 'unilateral' approaches. If the user becomes engaged in treatment, family interventions could then follow with the option to continue to work 'unilaterally' with those network members able and willing to continue to provide positive support for change, even in cases where the user withdraws from treatment. Attention to the social environment can also help to minimize or eliminate the influence of social networks supportive of continued substance use, which were shown to be influential by the results of Project MATCH (Project MATCH Research Group 1998). Finally, the special needs of the most vulnerable family members (i.e. young children) could be monitored and addressed while working with the family unit.

It is important to recognize that there are a number of ethical issues that need to be taken into account when working in this way. In cases of family violence or abuse, strategies will need to be developed to respond effectively to these very difficult problems, and treatment providers need to be aware of the impact that interventions may have in the broader context. On the other hand, an awareness of the wider context can aid detection and hence intervention in order to reduce the potential harm associated with these problems.

Finally, it could be argued that our proposal fails to take into account the burden of care that addiction treatment services already experience. While fully recognizing this burden, our proposal is for a change of focus to take into account and, where necessary, involve the social environment. This may not lead to additional contact time in most cases but to different ways of formulating and treating addiction problems.

Our proposal is one way of attempting to incorporate current evidence on family interventions into addiction service provision. What we propose is that in our current drive to develop evidence-based services, family involvement in routine service provision to those with alcohol and drug problems needs to be given serious consideration.

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REFERENCES

- Barber, J. G. & Crisp, B. R. (1995) The 'pressures to change' approach to working with the partners of heavy drinkers. *Addiction*, **90**, 269–276.
- Copello, A., Orford, J., Hodgson, R., Tober, G. & Barrett, C. on behalf of the UKATT Research Team (2002) Social behaviour and network therapy: key principles and early experiences. *Addictive Behaviors*, **27**, 345–366.
- Copello, A., Templeton, L., Krishnan, M., Orford, J. & Velleman, R. (2000) A treatment package to improve primary care services for relatives of people with alcohol and drug problems. *Addiction Research*, **8**, 471–484.
- Dobkin, P., De Civita, M., Paraherakis, A. & Gill, K. (2002) The role of functional support in treatment retention and outcomes among out-patient adult substance abusers. *Addiction*, **97**, 347–356.
- Epstein, E. & McCrady, B. (1998) Behavioural couples treatment of alcohol and drug use disorders: current status and innovations. *Clinical Psychology Review*, **18**, 689–711.
- Fals-Stewart, W. & Birchler, G. (2001) A national survey of the use of couples therapy in substance abuse treatment. *Journal of Substance Abuse Treatment*, **20**, 277–283.
- Halford, W., Price, J., Kelly, A., Bourma, R. & Young, R. (2001) Helping the female partners of men abusing alcohol: a comparison of three treatments. *Addiction*, **96**, 1497–1508.
- Higgins, S. & Budney, A. (1994) Participation of significant other in out-patient behavioural treatment predicts greater cocaine abstinence. *American Journal of Drug and Alcohol Abuse*, **20**, 47–56.
- Miller, W. R., Meyers, R. J. & Tonigan, J. S. (1999) Engaging the unmotivated in treatment for alcohol problems: a comparison of three strategies for intervention through family members. *Journal of Consulting and Clinical Psychology*, **67**, 688–697.
- Miller, W. & Wilbourne, P. (2002) Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders. *Addiction*, **97**, 265–277.
- Moos, R., Finney, J. & Cronkite, R. (1990) *Alcoholism Treatment: Context, Process and Outcome*. New York: Oxford University Press.
- O'Farrell, T. (1993) A behavioural marital therapy couples group program for alcoholics and their spouses. In: O'Farrell, T., ed. *Treating Alcohol Problems: Marital and Family Interventions*, pp. 170–209. New York: Guilford Press.
- Orford, J. (2001) *Excessive Appetites: a Psychological View of Addictions*, 2nd edn. New York: John Wiley & Sons.
- Project MATCH Research Group (1998) Matching patients with alcohol disorders to treatments: clinical implications from Project MATCH. *Journal of Mental Health*, **7**, 589–602.
- Rachlin, H. (1997) Four teleological theories of addiction. *Psychonomic Bulletin and Review*, **4**, 462–473.
- Smith, J., Meyers, R. & Miller, W. (2001) The community reinforcement approach to the treatment of substance use disorders. *American Journal of Addictions*, **10**, 52–59.
- Thomas, C. & Ager, R. (1993) Unilateral family therapy with spouses of uncooperative alcohol abusers. In: O'Farrell, T., ed. *Treating Alcohol Problems: Marital and Family Interventions*, pp. 3–33. New York: Guilford Press.
- UKATT Research Team (2001) United Kingdom alcohol treatment trial: hypotheses, design and methods. *Alcohol and Alcoholism*, **36**, 11–21.