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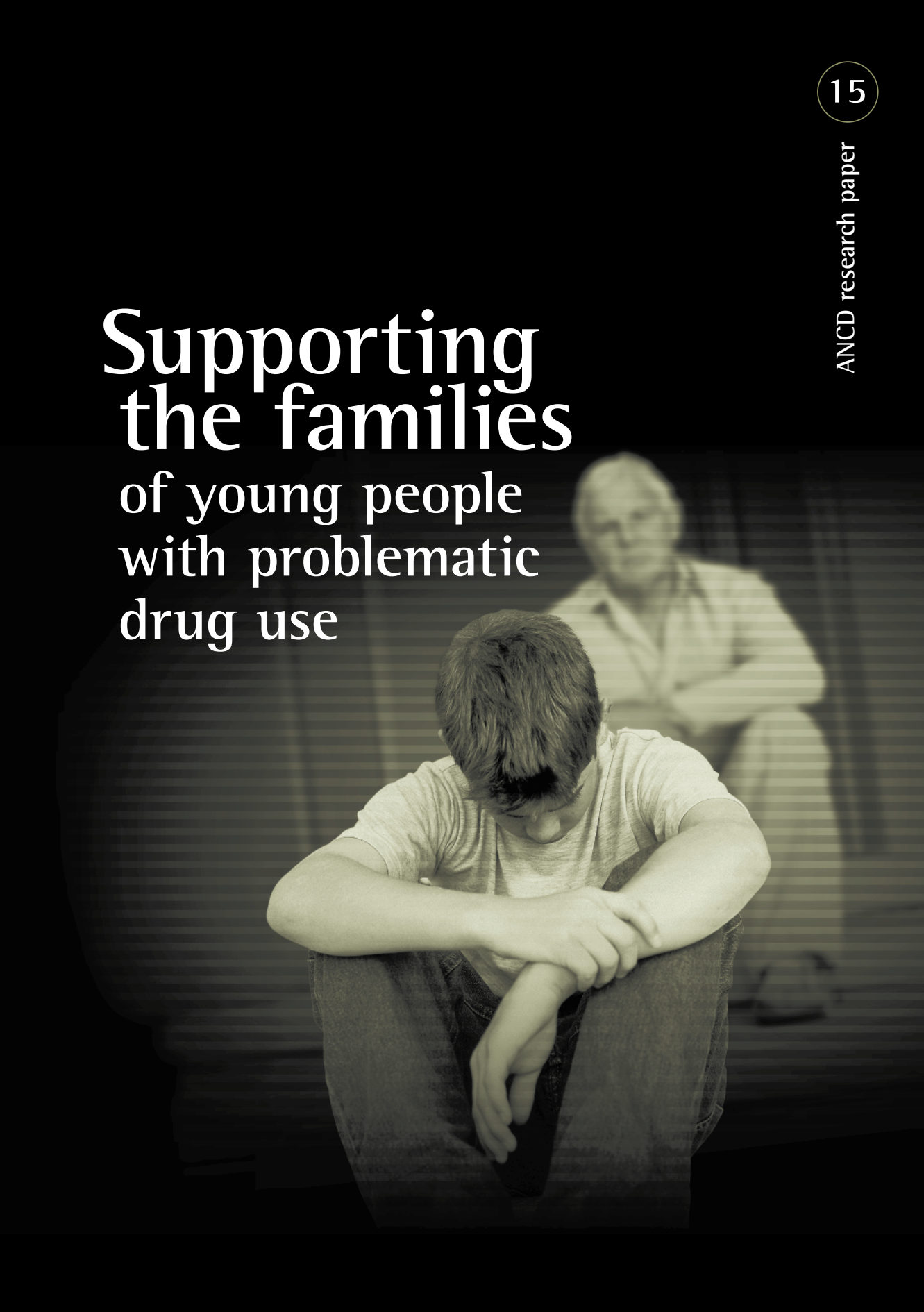
ANCD research paper

Supporting the families

of young people with problematic drug use



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ANCD research paper

Supporting the families of young people with problematic drug use

investigating support options

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A report prepared for the
Australian National Council on Drugs, January 2008

Published by the Australian National Council on Drugs
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Email: ancd@ancd.org.au
Website: www.ancd.org.au

National Library of Australia Cataloguing-in-Publication entry

Supporting the families of young people with problematic drug use: investigating support options / authors, Sally Frye ... [et al.].

Canberra: Australian National Council on Drugs, 2008.

9781877018183 (pbk)

ANCD research paper; 15

Bibliography

Parents of drug addicts — Services for — Australia
Drug addicts — Family relationships

Frye, Sally

362.29130994

Editor: Julie Stokes
Design: Starkis Design
Printer: New Millennium Print

Acknowledgement:

This work has been supported by funding from the Australian Government Department of Health and Ageing.

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Acknowledgements

There are many different approaches and strategies used by families who have to manage a situation where there is a young family member with a substance misuse problem. In this report we are enormously grateful to the many organisations who so willingly shared their experiences with us. It is clear that there are no easy answers to managing such a complex problem. What is clear from the reports we have read and people we have consulted is that families are in great need of support.

The authors of this report would like to thank the many people who provided us with information which helped to bring together the present report on current issues and practices in Australia. In particular, we would like to acknowledge the help of Professor John Toumbourou, Dr Stefan Gruenert, Tony Trimingham and Vanessa Winchester, amongst others.

We would also like to thank the members of the Australian National Council on Drugs for giving us the opportunity to write this companion report and Denise Gilchrist in particular for her encouragement and support throughout the project.

The content of this report was submitted to and examined by external reviewers prior to publication.

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Executive summary and conclusions

This report investigates the support needs of families who have, as a family member, a young person who is misusing substances. For the purposes of this report, a young person is defined as being between 12 and 25 years of age. As this age range spans several significant developmental periods, we will break this range down wherever possible. This project was commissioned by the Australian National Council on Drugs, which has identified drug use within the context of the family as a priority area. Our report complements a recently completed project examining opportunities to lessen the impact on children of harmful drug use by parents or carers, *Drug Use in the Family: impacts and implications for children* (Dawe et al., 2007).

The current report begins with a review of the literature examining the prevalence of substance misuse amongst young people, thus providing an indication of the number of families affected by youth substance misuse in Australia and the type of substance misuse most commonly encountered. It is important to remember that tobacco is, in fact, the most widely used drug by young people, with approximately 16.9 per cent of young people aged 12–20 years reporting daily use (Australian Institute of Health and Welfare, 2005). However, as its use is associated with little immediate or short-term harm, it would appear to be largely overlooked by family members as a drug of concern. This report is directly concerned with the effect of substances on changes in behaviour and performance. As a consequence, our report does not focus on tobacco use per se, although the issues associated with cigarette smoking are significant and the health effects are well documented.

A significant proportion of family members may need support to cope with the impact of a young person's substance misuse on their day-to-day functioning. In particular, family members are most likely to encounter alcohol misuse by a young person, with at least one in five young people consuming alcohol on a weekly basis by middle adolescence. Further, approximately one-fifth of young people in the 16–17 age range report regular binge drinking. Cannabis and amphetamine-type substances are the next most frequently used drugs. Additional key points identified from the review of Chapter 1 are summarised below.

Key points

1. Accurately quantifying the number of families affected by the problematic substance use of a young person is a challenging task, particularly in defining a young person, a family and problematic substance use.
2. In Australia, national household and school surveys highlight that alcohol is the most widely used substance by young people with the exception of tobacco. High rates of binge drinking, 'at-risk' drinking and harmful drinking are reported across all surveys. These rates increase with age, with approximately 11 per cent of 15 year olds reporting recent binge drinking compared to 21 per cent of those aged 17 years. Of particular concern is the finding that approximately 13 per cent of young drinkers report drink-driving and 16 per cent report going to work or school under the influence of alcohol. The proportion of young people using substances other than alcohol is considerably lower. The most widely used illicit substance is cannabis, with recent use reported to be approximately 14 per cent for school age students. Recent use of amphetamines is reported by 4 per cent of students.
3. Specialist datasets, in addition to national and school surveys, indicate that there is a higher prevalence of problematic substance use by young people from minority and disenfranchised groups, such as same-sex attracted young people, and young offenders involved in the criminal justice system. In young Indigenous Australians, approximately one-quarter report alcohol use (27 per cent). Of these, approximately half (12 per cent of all surveyed) reported drinking to excess. As in other school surveys, alcohol use increased with age. By 17 years, 22 per cent of males and 17 per cent of females who reported drinking were doing so to excess.
4. It is reasonable to presume that many Australian families are routinely faced with the problem of binge drinking by a young family member. The use of cannabis and amphetamine-type drugs is less common in young people, and it is assumed that fewer families need to manage the consequences of this use.
5. International household surveys and other population estimates show a similar pattern of alcohol use and binge drinking in young people. Cannabis is the illicit drug most likely to be used, with 21.4 per cent of English 16–24 year olds reporting use of cannabis in the last year and 19 per cent of American high school students reporting recent use of cannabis.

Given that many Australian families are likely to encounter substance misuse by a young person, Chapter 2 reviews the literature examining the ways in which this substance misuse impacts on family functioning and the relationships between family members and the young person. The first key aspect identified from this review is that there is only a small research base examining this issue and many of the findings from this research are limited by methodological issues. The key points identified from this part of Chapter 2 follow.

Key points

6. The impact of problematic substance use has mainly been examined in the context of marital relationships. Research that has specifically investigated the impact on the broader family typically draws on heterogeneous samples of parents, siblings and children of substance misusers and makes assumptions of uniformity of experience rather than differences.
7. Many studies examining the impact of problematic substance use on *family members* focus on the experience of *mothers* as well as the experience of family members of young people who are currently engaged in treatment. Consequently, the range of events and impacts likely to be experienced by all family members of young problematic substance users has not been conclusively established.
8. Similarly, young substance misusers often present with co-morbid mental health issues; the impact of these separate, yet overlapping, issues on family functioning has not been systematically examined.
9. Cross-sectional designs that measure family functioning momentarily, at one point in time, are commonly employed in research examining the impact of problematic substance use by a young person so that the dynamic nature of substance misuse and a family's response to it cannot be adequately identified.
10. Much of the research relevant to this report has investigated the impact of substance misuse on family members in the United States, Canada and the United Kingdom, with a limited amount of information derived from Australian family members.

Notwithstanding these limitations, it is clear that substance misuse by a young person can have a significant impact on many aspects of family functioning. While the most widespread problematic substance used by young people is alcohol, there is little contemporary information on the needs of parents and carers in relation to this issue. The impact of illicit drug use is more clearly defined with a young person's substance misuse impacting negatively on the physical and psychological health of family members, relationships within the family, family finances and levels of social support.

Key points

11. The way in which families respond to the information that a young person has a substance misuse problem depends on a range of social and contextual factors. However, an important starting point to help manage the effects of such knowledge is to have access to accurate information about different substances, the consequences of substance use and the associated lifestyle, as well as information on issues of overdose, withdrawal, treatment and relapse.
12. When family members discover that a young person has problematic substance use, they experience a range of intense and overwhelming emotions that impact on all areas of family life. They need to receive ongoing support to help them better manage the impact of these emotions on their day-to-day functioning.
13. Families need to be provided with clear information about the impact of different types of substances on behaviour. Support should be provided to help them better cope with the behavioural disturbances associated with specific substance types.
14. Family members need support in managing the psychological and health implications of living with a young person with problematic substance use. Treatment services need to recognise the need for family members to receive support and counselling in their own right, regardless of the treatment status of the young person.
15. The needs of siblings of drug users are significant, yet they have been much overlooked by research and treatment providers. There is evidence that sibling drug use may increase the likelihood of initial use by another child, with factors such as availability and a family's positive attitudes to drug use playing a key role.
16. Problematic substance abuse by a young person creates enormous financial pressures within the family, *creating ambivalence and confusion about appropriate responses*. Parents need support to find ways of best meeting these demands.
17. The families of young people with substance misuse problems often make limited use of social support due to difficulties accessing and receiving that support and the stigma attached to drug use.

Given that a significant proportion of families encounter problematic substance misuse by young people, Chapter 3 describes how family members respond to the discovery of substance use and misuse. The problems associated with the initiation of substance use – in particular, alcohol – are highlighted. Attention is drawn to the guidelines proposed by Hayes and colleagues (2004) which suggest the following points.

Key points based on Hayes et al. (2004)

18. Adolescents are less likely to drink and less likely to engage in binge drinking if parents actively disapprove of this behaviour. Conversely, adolescents whose parents display a permissive attitude towards alcohol consumption tend to drink more.
19. Parents should delay the onset of alcohol use in young people as long as possible in order to avert the adverse impact of alcohol on adolescent body and brain development as well as to reduce the likelihood of high-risk alcohol use and abuse in adulthood.
20. Once adolescents have started experimenting with alcohol, enhanced parental monitoring is regarded as the most effective strategy in minimising the progression to harmful or risky levels of alcohol consumption.
21. Good parental monitoring requires that there is a strong parent–child relationship; and further, that the parents are able to adapt rules depending on differing situations and changes in maturity.

Research suggests that a family's response to substance misuse by a young person is determined by a complex interplay of factors. Consequently, the response of each family and of individual family members may be different. The factors that may influence a family's response include: the age of the young person; the quality or strength of their relationship with family members; any pre-existing stressors and prior strategies for dealing with them; the nature of the substance use itself (i.e. substance type, the extent of the misuse); and the family's familiarity with the substance. Other key points identified from this review are as follows.

Key points

22. Typical coping styles employed by family members of a young person engaged in problematic substance use are: putting up with it; trying to regain control; withdrawing and gaining independence; and seeking help and support. Families often use a combination of these approaches as they search to find an optimal strategy to respond to the young person's substance misuse.
23. Family members place significant emphasis on the importance of support from family and friends. Unfortunately, the support they receive is often perceived as inadequate or inappropriate for various reasons which, in turn, may inhibit seeking further support and lead to an increased sense of isolation.

Chapter 4 reviews the support and treatment options for family members of young substance misusers published in the research literature. Limited research has attended specifically to the needs of this group, with only two specific interventions located for supporting family members of young substance misusers. Additionally, a third intervention assisting family members to deal with alcohol misuse in adults is reviewed because of its relevance to supporting those family members of young people engaged in harmful alcohol consumption. Other key points identified from this review are detailed below.

Key points

24. Historically, support and treatment options for family members of a young person with problematic substance abuse have been limited, with family members mainly adopting a key role in engaging and retaining the young person in substance misuse treatment.
25. Two interventions have specifically targeted the support needs of family members of young substance misusers (the Behavioural Exchange Systems Training (BEST) program and the Parent Coping Skills Training program). Both programs are delivered in a time-limited group format and focus on modifying parental interactions with the young person as well as providing instruction in coping skills for the range of distressing emotions that frequently accompany the discovery of a young person's substance misuse.
26. It is striking that the literature review did not identify any empirically supported interventions for family members confronted with problematic alcohol misuse by a young person. However, a brief psychosocial treatment package with a step-wise approach to intervention was successful in improving the physical and psychological functioning of relatives of adults with alcohol misuse problems in a primary health care setting. This approach may be appropriate for supporting family members of young people who misuse alcohol.

An alternative model for meeting the support needs of family members of young substance abusers is through the provision of support that focuses more directly on changing the young person's substance use. This can occur by modifying the family system (family-based interventions) or the wider social environment in which the young person and their family function (multi-systemic/multi-dimensional family interventions).

Key points

27. Interventions based on family systems theory focus on changing the interaction patterns between family members that may permit, maintain or encourage problematic substance use. These interventions can be supplemented by cognitive behaviour therapy, focusing on contingency management training to reinforce reduced substance abuse, together with a range of other skills training (e.g. problem solving, communication and conflict resolution). Further, support strategies can be provided in this context to improve the psychosocial functioning of the family members themselves.
28. Multi-systemic and multi-dimensional family therapy interventions broaden the focus of intervention beyond the family to consider the influence of the wider social environment on a young person's problematic substance use. Individualised, comprehensive intervention strategies are implied.
29. There is good evidence that a family-based approach to the treatment of a young person with substance misuse can be effective. This approach is an intensive intervention and requires considerable resources and time. Nonetheless, such approaches are well validated and have been associated with significant cost savings in families with complex and multiple problems.
30. The suitability of these broader family-focused interventions for families depends on the specific needs of the young person and their family – specifically the profile of risk and resilience factors present.

Chapter 5 provides a snapshot of current levels of service provision offered by Australian alcohol and drug treatment providers to address the support needs of family members with a young person engaged in problematic substance misuse.

In parallel to the findings of Chapter 4, this review found that service provision most commonly focuses on the needs of the substance user, with less attention directed to the broader needs of family members in their own right.

Key points

31. Results of a telephone survey found that the majority of treatment providers do not provide any direct service for family members affected by the problematic substance use of a young person.
32. Of those providers who do provide a family-focused service, support options generally fall into three non-exclusive categories – brief counselling; ongoing counselling; and access to specific programs or groups.
33. Not all Australian alcohol and drug treatment providers are adequately resourced to deliver interventions to family members when they request treatment or support.
34. When treatment providers do offer services to family members, they are generally regarded as a stand-alone program or service that is dependent on resource/funding allocations. Family-based services are seldom regarded as an integrated component of the treatment provider's response to a young person's substance misuse problems.
35. Treatment providers report a limited capacity to evaluate the effectiveness of services and programs delivered to family members. Although the majority express a general belief that their programs are of value and are well received, there has been little systematic study of outcomes.
36. There appears to be only limited uptake by service providers of those programs that have received systematic evaluation within the research literature.
37. There appear to be a number of gaps in the provision of services to family members, such as the delivery of services to siblings of substance users and also in the delivery of family-based services for those young people who are experiencing difficulties with dual diagnosis.

A separate chapter is devoted to the support needs of grandparents who are increasingly required to assume the care and responsibility of grandchildren affected by the substance misuse problems of their parents.

Key points

38. Grandparents raising grandchildren experience multiple challenges as they attempt to provide stability of care for their grandchildren, often at the expense of their own quality of life. Yet despite this, many also experience a sense of satisfaction and purpose associated with their ability to provide stable care and protection. Seeing grandchildren develop into healthy adolescents and young adults is an immense source of satisfaction.
39. Children exposed to parental substance misuse have frequently experienced a range of life events that make them vulnerable to developing emotional and behavioural difficulties. This makes the parenting role assumed by grandparents even more complicated and challenging.
40. Child development outcomes and, in turn, the parenting experience may be influenced during the prenatal period from exposure to drugs and/or alcohol in utero. The consequences of in-utero exposure to alcohol are considered on a spectrum (Foetal Alcohol Spectrum Disorder) and may include physical and cognitive deficits.
41. Children who have experienced parental substance misuse and associated family problems may display a range of emotional and behavioural problems when they enter the care of their grandparents. This places greater demands on their carers and underscores the importance of providing specific support services for grandparents who take on this role.
42. A number of resources have been developed for grandparents raising grandchildren. To date, the impact of these resources on the developmental outcomes of grandchildren has not been systematically investigated.

The following principles of best practice are informed by the research outlined in this document and have application to the work of all service providers who may be required to support family members of young people with problematic substance misuse.

Principles of good practice

Good practice principles for organisations and/or funding bodies

1. Organisations and funding bodies need to recognise that families play a key role in a young person's life and that, whenever possible, families need to be considered. This would require that extended families are at least included in the assessment process whenever possible, and support provided for these family members.
2. Organisations and funding bodies should demonstrate their commitment to the value of this work by providing adequate staffing and resource support for family support interventions to be effectively implemented by clinicians.
3. Organisations need to develop mechanisms that adequately assess the support needs of family members of young people with substance misuse problems who present for treatment and deliver empirically sound support programs in response to their needs.
4. Organisations should provide support services to family members of young substance misusers regardless of the treatment status of the young person.
5. Organisations need to provide access to a range of treatment interventions that vary in intensity and duration in response to the presenting needs of each family.

Good practice principles for clinicians

1. Clinicians need to receive adequate training in assessment protocols for articulating the support needs of *all* family members of young substance misusers. Clinicians also need to be provided with training in a range of empirically sound treatment models for supporting *all* family members who have a young person with problematic substance misuse.
2. Clinicians should be provided with adequate time within their workload to enable the effective delivery of these additional services.
3. Clinicians should be provided with regular supervision to ensure that their work with families is in accordance with treatment protocols and in line with best practice principles.

Good practice principles for treatment content and format

1. No single intervention is appropriate for supporting family members of young people with problematic substance misuse.
2. A spectrum of support options should be available to family members of a young person with problematic substance misuse. Services might include:
    a. The provision of information on the nature and consequences of the use of different substances and guidance on processes for family members to minimise harmful substance use. This information may be delivered by self-help publications (e.g. the internet), support groups or in a brief psycho-social education format.
    b. The provision of brief interventions designed to provide information and direct assistance to family members as they negotiate and resolve critical issues in response to a young person initiating experimental use of alcohol or illicit drugs or when the young person moves into more problematic levels of use.
    c. Individual mental health interventions for those family members who are experiencing significant mental health issues, as a consequence of, or in addition to, the young person's substance misuse.
    d. Targeted support interventions for family members that directly address the functioning of family members themselves and attempt to modify interactions between the problematic substance user and broader family members.
    e. Family-based and multi-systemic/multi-dimensional family therapy for those young people with problematic behaviour across a number of functional domains.
3. Support services provided to family members should be subject to ongoing review to ensure that the dynamic nature of a young person's substance misuse and therefore the support needs of the family are considered and recognised.
4. Clinicians need to recognise the importance of developing a sound therapeutic alliance with each family in order to optimise levels of support uptake.
5. Support interventions need to be the subject of regular systematic evaluation to ensure their effectiveness in achieving stated aims and objectives.

Recommendations of the report

On the basis of the key points and literature reviewed we have developed a series of recommendations for consideration. These have been grouped as follows:

Recommendations regarding the importance of treatment options to support family members of a young person with problematic substance misuse

Recommendation 1: The importance of providing support to families who have a young person with substance misuse should be recognised within existing drug and alcohol services as well as supported in stand-alone programs.

Recommendation 2: Treatment services need to recognise the need for family members to receive treatment in their own right regardless of the treatment status of their young person. This point is particularly relevant given that a significant proportion of young substance misusers are not engaged in treatment.

Recommendation 3: Both government and non-government services need to be adequately resourced to deliver appropriate interventions to family members. Clinicians need to be supported by the provision of adequate models of practice, supervision, sufficient time and resources to ensure that interventions have a realistic chance of improving outcomes for family members and their young people with substance misuse problems.

Recommendation 4: There is no single model that can be adopted uniformly. Treatment providers need to strengthen their capacity to deliver a range of interventions in response to the identified needs of each family. The good practice principles identified within this report provide a benchmark for determining program content and the delivery format and, in turn, a starting point for the development of an agreed set of national guidelines in the provision of support services for families affected by the problematic substance use of a young person.

Recommendations for supporting family members with specific needs

Recommendation 5: Family members of marginalised young people require intensive family support in recognition of the high incidence and chronicity of substance misuse common to these groups.

Recommendation 6: Grandparents who have assumed a parenting role for their children's children as a consequence of parental substance misuse should have access to additional support structures to address the grandparents' own issues, both pre-existing and/or those that have evolved as a consequence of child placement.

Recommendation 7: There has been little research investigating the needs of grandparent carers, the circumstances under which children should be placed with grandparents, and the outcome for children raised by kin carers in Australia. This is a critical area of research that requires funding.

Recommendations for determining the impact of a young person's substance misuse on family members and their corresponding support needs

One of the key factors that has made it difficult to determine the scope of the problem in Australia is the lack of systematic research examining the impact of a young person's substance misuse on family members. Thus, further research is needed both to obtain a better estimate of the number of families affected and to determine which type of service is suited to different families.

Recommendation 8: Methodological issues related to sampling and the lack of control for co-morbid mental health issues should be addressed specifically in the Australian community to provide a more comprehensive picture of the impact on, and support needs of, family members of young substance misusers, including family members other than mothers (i.e. fathers, siblings and extended family members).

Recommendation 9: The impact of alcohol misuse by young people on family members should be systematically investigated given that alcohol is the most widely misused substance within the Australian context. This investigation should address the adequacy of current support services (either informal services such as internet information or formal support services) and consider the specific support needs of family members of young people who are misusing alcohol if current support options are found to be inadequate.

Recommendations regarding government policy and practice guidelines

Recommendation 10: State policy on drug and alcohol treatment service delivery should identify the needs of the family members adversely affected by their young person's substance misuse as a priority area and simultaneously acknowledge that family involvement in the treatment of young people's substance misuse can be critical.

Overview of the report

It is a disturbing feature of today's society that drug and alcohol use by youth has become somewhat normalised and is almost considered a rite of passage to adulthood. Fortunately for many, their foray into substance use will be experimental and time-limited. But for a small minority such use will become problematic and the impact on the family will be immense. The point at which substance use slips from being experimental to problematic is often difficult to determine for both family members and treatment specialists. Practitioners generally refer to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (American Psychiatric Association, 1994) as the gold standard for classifying substance users, yet it has been argued that such criteria, originally developed for adult populations, may have limitations in diagnosing substance use disorders in young people (Deas, Roberts & Grindlinger, 2005).

This report examines the support needs of family members with young people who engage in substance use from early experimental to more regular and, for some, dependent use in young people between the ages of 12 to 25 years. The problems faced by family members differ depending on both the age of the young person and the nature of the substance used. Many young people experiment with substances and this can result in major family disruption. For the majority of families, the young person eventually moves forward from such use without serious incident. For a minority of families, however, the young person's involvement is more prolonged, more intense and evokes very strong reactions from family members. For these families, the young person's substance use becomes a central issue and the struggle is prolonged, lasting for months and sometimes years.

The impact of substance misuse problems on family functioning can thus be far-reaching. Family members are often caught in the difficult dilemma of whether to condone or oppose substance use. This dilemma is made more difficult by the increasing availability of drugs (both illicit and licit) and parental ambivalence about whether the young person's substance use is of sufficient severity to warrant concern. Historically there has been a lack of research into the needs of family members and very little treatment resources have been devoted to this purpose. Unfortunately, not only have their needs been neglected, but also families have often been held to be responsible for the problematic substance use of a young person, with the blame being targeted at parenting practices and a range of parent-related variables within a family deficit perspective.

It is important to acknowledge at the outset that the research outlined within this report is not concerned with the attribution of responsibility. Clearly there is a range of risk and protective factors that are thought to contribute to the onset of problematic substance use in youth (Lloyd, 1998). Within the ecological model (Rutter & Sroufe, 2000), child outcome is considered the consequence of a complex interaction between personal, developmental, familial and environmental factors, over time and across social contexts. Although maladaptive parenting might be seen as a contributing factor to problematic substance use by a young person, it might also be the case that some maladaptive behaviours observed in parents develop directly in response to levels of frustration and stress derived from coping with a young person's behaviour that is out of control.

This report is an investigation into the support needs of families affected by problematic substance use by a young person. Accordingly, we are interested in exploring the impact that problematic substance use has on family functioning, how relatives cope, and consequently what support options best meet families' needs across a range of substance use experiences and different developmental stages.

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1. The scope of the problem

1.1 Introduction

There are so many definitional difficulties posed by the title of this chapter. Who is a young person? What constitutes a family? What is a substance misuse problem when considering young people aged 16 years and under? And after all these far-from-minor definitional issues are addressed, we are left with the task of trying to find datasets that can provide indicative numbers to quantify the extent of the problem. One wonders if the task should even be attempted. The answer for us was: 'Yes, it probably should'. But following this tentative affirmative reply, we begin our chapter by outlining the limitations and definitional problems that surround any attempt to estimate the numbers of families affected by a young person using substances.

1.1.1 Defining a 'young person'

The first issue to consider is the definition of a 'young person'. To the best of our knowledge there is no universally accepted agreement on what age ranges define a 'young person'. One could decide that the legal age (18 years) should be our cut-off point. Alternatively, if we were to use national survey data age bands, we would perhaps consider that a young person is between the ages of 14 and 20 years. Both of these proposals have difficulties, as the research literature on young people and substance use utilises both of these age bands in addition to other cut-off points, e.g. 12–17 years for school-based surveys. In this chapter on prevalence, we will attempt to be clear about the age groups included and, whenever possible, use the same age groups when comparing across different surveys. Whenever possible, we have used a broad age range from 14 years to 25 years, thereby spanning both the adolescent and the young adult periods of development.

1.1.2 What constitutes a family?

The issues of what constitutes a family and how this differs from a young person's community raise significant definitional problems. There are no datasets that attempt to record the family structure or family composition of a young person who is using substances. Further difficulties occur in the definition of 'family', given the diversity of family structures in both Indigenous and non-Indigenous communities. Although most Australian children live in households as members of a family unit, there is considerable variability in family composition. In 2003, 71.8 per cent of children aged 0–17 years were living with either biological or adoptive parents, whilst 8.2 per cent of children lived in step or blended families (Australian Bureau of Statistics, 2004a). A substantial number of young people live in single-parent families: approximately 17 per cent of Australian children live in families with a single mother, while approximately 2.5 per cent live with fathers.

1.1.3 Defining 'problematic substance use'

The third problem rests in the definition of 'problematic substance use'. Once again, definitions vary considerably across studies and surveys. For some, prevalence estimates are based on national definitions of, for example, risky alcohol consumption. For many surveys, no attempt is made to determine whether the use of a substance is problematic, but rather they report on quantity or frequency of use. Again this is often couched in rather simplistic terms, such as recent use (i.e. the last 12 months) and lifetime use.

Key point

Accurately quantifying the number of families affected by the problematic substance use of a young person is a challenging task, particularly in defining a young person, a family and problematic substance use.

In this chapter we draw from the large national household survey, the 2004 National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 2005). It is worth noting that the 2007 National Drug Strategy Household Survey has been conducted by the Australian Institute of Health and Welfare (AIHW). However, data from the 2007 survey were not available at the time of writing this report.

Other national reports of significance include the most recent Australian Secondary Students' Alcohol and Drug (ASSAD) survey (White & Hayman, 2006a; 2006b) and the Victorian Youth Alcohol and Drug Survey (Victoria Department of Human Services, 2004), as well as specialist datasets on patterns of use. These specialist datasets include *Alcohol, Drugs and Crime: a study of juveniles in detention* (Pritchard & Payne, 2005); *Writing Themselves in Again: 6 Years On* (Hillier, Turner & Mitchell, 2005); *Western Australian Aboriginal Child Health Survey: the social and emotional wellbeing of Aboriginal children and young people* (Zubrick et al., 2005).

The national household and school surveys provide population-level information as well as information on trends across time, while the specialist datasets help to quantify substance use in populations that are either under-represented in large surveys or are high-risk groups. The assumption with this approach is that young people will have families – somewhere in their background – and that these families will have needed help and support at some point. Therefore, the number of families affected by a young person's substance misuse may be equated with the number of young people with problematic substance use.

The final section of the chapter provides an international perspective with a focus on those countries that have similar social structures and legislative frameworks to Australia. Information is drawn from work conducted in the United States and the United Kingdom. Comparison is drawn between the major findings from overseas datasets and the current analyses from Australia to ascertain similarities and differences.

1.2 How many young people are using substances?

1.2.1 Findings from the National Drug Strategy Household Survey

The National Drug Strategy Household Survey (NDSHS) (Australian Institute of Health and Welfare, 2005) is Australia's largest population-based survey on drug and alcohol use. This survey is conducted every three years and includes information on perceptions, accessibility and use of all substances. While the national survey included approximately 30 000 Australians, it is important to highlight the problems inherent in any national survey. First, alcohol and other substance use is generally under-reported (Knibbe & Bloomfield, 2001; Stockwell et al., 2004). There are also problems of representativeness. For example, marginalised populations where there are potentially higher numbers of problem substance users are typically under-represented in national surveys, as are Indigenous people. The latter may be due to additional factors such as the exclusion of residents living in non-private dwellings (e.g. hostels, caravan parks, prisons, hotels and hospitals), confidentiality issues and problematic data collection (Chikritzhs & Brady, 2006).

Despite these difficulties, it is significant that the most recent NDSHS was extended to include young people aged 12–13 years. Drug and alcohol use is tabulated across the following age groups: 12–15 years; 16–17 years; 18–19 years; and 20+ years. After tobacco, alcohol use is the most widely reported drug of use across each of the age bands. Rates of illicit drug use are relatively low in comparison with alcohol. Cannabis is the next most frequently used drug, followed by amphetamine-type substances (see Table 1.1).

Table 1.1: Recent substance use (%) (any use in the last year) in young people (NDSHS, 2004)

	Age group			
Substance	**12–15**	**16–17**	**18–19**	**20+**
Alcohol				
Daily	0.1	0.6	1.1	9.8
Weekly	3.3	21.6	45.4	43.1
<Weekly	29.1	55.2	40.6	32.1
Ex-drinker	2.8	3.2	1.3	7.6
Never[1]	64.8	19.4	11.6	7.4
Marijuana/cannabis	5.2	18.0	26.5	10.5
Amphetamine-type substances[2]	1.5	6.6	19.4	8
Any illicit drug	7.6	20.9	30.8	14.6

Notes:

[1] Never a full glass of alcohol

[2] Amphetamine-type stimulants collapsing data on meth/amphetamine, cocaine, ecstasy

1.2.2 Calculating use based on school surveys

The most widely used method of estimating the prevalence of substance use in young people is the large-scale surveys conducted in high schools. The largest and most recent of these is the Australian Secondary Students' Alcohol and Drug (ASSAD) Survey of 21 805 students aged 12–17 years (White & Hayman, 2006a; 2006b). The survey is the eighth in a series monitoring the use of tobacco, alcohol and other substances and was conducted throughout Australia with 376 participating schools. As this survey has used similar data collection methods, it is possible to determine changes across time with the reported use of a range of substances.

1.2.2.1 Australian secondary school students' use of alcohol

The ASSAD adds important information on family-related issues particularly in relation to alcohol, as type of alcohol, context of use (i.e. family-related) and accessibility are recorded. The analysis of the quantity of alcohol consumed was used to calculate risk according to the Australian Alcohol Guidelines (National Health & Medical Research Council, 2001). These guidelines recommend that young people should not drink beyond the levels set for low-risk drinking by adults. For male adults, low-risk drinking is defined as having no more than four standard drinks a day on average and never more than six standard drinks in any one day. For adult women, low-risk drinking involves having no more than two standard drinks a day on average and never more than four standard drinks on any one day. To remain at low risk, total consumption for one week is 28 drinks for males and 14 drinks for females.

Table 1.2: Recent alcohol use (%) in young people (ASSAD, 2005)

	Age					
	12	13	14	15	16	17
Never consumed alcohol	27	20	14	9	6	4
Consumed alcohol in the past year	39	52	68	80	86	89
Consumed alcohol in the past month	17	26	41	54	67	70
Consumed alcohol in the last week (current drinker)	10	16	27	35	46	49
Drank on one occasion in past week Males: 7+ drinks; Females: 5+ drinks	<0.5	2	6	11	19	21
Total amount consumed in one week Males: 29+ drinks; Females: 15+ drinks	<0.5	<0.5	2	2	3	4

As can be seen in Table 1.2, the proportion of young people drinking alcohol rises consistently with age. By middle adolescence the NDSHS suggests that approximately one in five young people drank alcohol in the previous week. The rates are somewhat higher from the ASSAD survey suggesting that approximately one-third of young people reported use of alcohol in the previous week. What is particularly notable from the ASSAD survey are the high rates of binge drinking, with indications that about one-fifth of young people in the 16–17 age range have drunk more than seven standard drinks for males and five standard drinks for females on one occasion.

The ASSAD also allows for direct comparison with previous ASSAD surveys. Table 1.3 highlights some interesting trends in alcohol use amongst young people. First, there appears to be a reduction in lifetime use, use in the previous month and use in the previous week for young people in the 12–15 year age band from 1999 to the most recent 2005 survey. However, no change is found in the 16–17 year age group. Unfortunately, this positive finding is offset by the data on current drinkers aged 12–15 years. In this group the percentage that drank at harmful levels had increased from 16 per cent in 1999 to 21 per cent in 2005.

Table 1.3: Proportion of school students drinking alcohol (in lifetime, previous month, previous week) and proportion of all drinkers drinking at harmful levels (ASSAD, 2005)

	12–15 years			16–17 years			12–17 years		
	1999	2002	2005	1999	2002	2005	1999	2002	2005
Lifetime	87**	86**	82	94	94	95	89**	88**	86
Previous month	43**	43**	34	70	68	68	49**	49**	43
Previous week	28**	29**	22	51	48	47	35**	34**	29
Harmful among all students	5	6	5	22	21	20	9	10	9
Harmful among current drinkers	16**	18	21	42	41	42	26**	27	31

** Significantly different from 2005 at p <0.01.

The final table (see Table 1.4 below) is of particular interest to the current report and integrates information on the relationship between where/how alcohol was obtained, where it was consumed and the average number of drinks consumed. Figures are presented for 12–15 year olds, 16–17 year olds and all current drinkers. It is important to bear in mind that these numbers relate to those young people who are current drinkers. For this subgroup, there is less alcohol consumption in both age groups if the source of the alcohol was parents. It is also important to note that both age groups reported less alcohol use when the setting was their own home compared to a friend's place. Most alcohol was reported to be consumed when the setting was described as a party.

Important additional information can be obtained from the Victorian Youth Alcohol and Drug Survey (Victoria Department of Human Services, 2004). Although both age bands and consumption are reported slightly differently, the high rates of drinking in an 'at-risk' manner are notable. Adding to the picture presented in the ASSAD survey of a pattern of regular heavy drinking amongst young people is information on the effects of alcohol on behaviour. Of those young people who reported alcohol consumption, approximately 13 per cent reported drink-driving in the last 12 months; approximately 25 per cent reported being verbally abusive while under the influence of alcohol; and 16 per cent reported that they had attended work or school while under the influence of alcohol.

Table 1.4: Average number of drinks per week by source of alcohol and where consumed for current drinkers, i.e. drank in the last week (ASSAD, 2005)

	Age		
	12–15	16–17	12–17
Alcohol obtained from:			
Parents	3.6	5.8	4.7
Friends	4.9	6.1	5.5
Someone else bought it for me	9.0	8.8	8.9
Alcohol consumed at:			
Home	3.5	6.0	4.5
Friend's place	5.5	7.8	6.8
Party	7.0	7.9	7.5

1.2.2.2 Australian secondary students' use of illicit drugs

The ASSAD also collected information on the prevalence of the use of over-the-counter and illicit substances amongst secondary students. While it is more difficult to obtain detailed information on frequency and quantity, there was some attempt to gauge the level of use by defining 'regular use' of a substance as 10 or more times in the past year. Data here are reported for cannabis, the most widely used illicit drug, followed by amphetamines.

Cannabis was the most widely reported illicit drug used by secondary students. Nearly 18 per cent of all students reported lifetime use of cannabis and, of these, 14 per cent reported use in the last year. In a closer examination of these recent users, White and Hayman (2006b) highlight the relationship between age and regularity of use, with 2 per cent of those in the younger age group (13 years) reporting regular use, compared to 9 per cent of males 15 years and older and 6 per cent of females aged 16 years. Although this represents a significant number of young people with regular cannabis use, comparison with previous surveys indicates that, on the whole, there has been a significant reduction across all age groups in both lifetime use and recent use of cannabis. For example, lifetime use in 2005 was 13 per cent and 39 per cent for 12–15 year olds and 16–17 year olds respectively, compared to 1996 where data for lifetime use were 28 per cent and 52 per cent respectively for these age groups. Use in the last week has also reduced from 9 per cent and 17 per cent in 1999 for the two age groups (12–15 years; 16–17 years) to 4 per cent and 6 per cent respectively in 2005.

The use of amphetamines, excluding medically supervised use, was relatively low in this survey. The majority of the sample (95%) had never used amphetamines. The proportions of students who had used amphetamines increased with age, with 2 per cent of 12 year olds, 8 per cent of 16 year olds, and 7 per cent of 17 year olds reporting lifetime use of amphetamines. Approximately 4 per cent of students reported recent use of amphetamines. There was some indication of a slight reduction in the use of amphetamines in 2005 relative to other periods. These changes, although significant, were small and spread across different age groups. It was notable that there were almost no changes in the use of amphetamines in the past month across all age groups with a range of 2–4 per cent of students reporting use of amphetamines in the past month.

Key point

In Australia, national household and school surveys highlight that alcohol is the most widely used substance by young people. High rates of binge drinking, 'at-risk' drinking and harmful drinking are reported across all surveys. These rates increase with age, with approximately 11 per cent of 15 year olds reporting recent binge drinking compared to 21 per cent of those aged 17 years. Of particular concern is the finding that approximately 13 per cent of young drinkers report drink-driving and 16 per cent report going to work or school under the influence of alcohol.

Key point

The proportion of young people using substances other than alcohol is considerably lower. The most widely used illicit substance is cannabis, with recent use reported to be approximately 14 per cent for school-age students. Recent use of amphetamines is reported by 4 per cent of students.

1.3 Specialist datasets providing information on prevalence of substance use amongst young people

While large-scale national household surveys and school-based surveys aim to draw a representative sample of respondents, this is not always possible. For instance, household surveys typically under-sample minority and disenfranchised groups and school surveys fail to collect data on those students who are away on the day (missing a proportion of truanting, and therefore high-risk substance use, students) or who have already left the school system. Therefore, drawing from surveys of sub-populations complements the data from the larger surveys.

Key point

Specialist datasets, in addition to national and school surveys, help to inform the prevalence of problematic substance misuse by young people from minority and disenfranchised groups, such as same-sex attracted young people, Indigenous young Australians, and young people involved in the criminal justice system, in state care or in psychiatric care.

One group of young people often overlooked as an at-risk population are those who identify themselves as gay, homosexual or lesbian. While it may not be the case that these young people are absent from school surveys, there is sufficient concern about the difficulties inherent in 'coming out' and the use of substances as a way of coping with this and associated stressors which has led to specialist surveys. *Writing Themselves In Again: 6 Years On* is the second national report on the sexuality, health and wellbeing of same-sex attracted young Australians. The survey conducted in 2004 questioned 1749 young people aged 14–21 years. The survey covered many areas of health and wellbeing including questions on sexual feelings and behaviour, discrimination and abuse, and substance use. In order to enable a comparison to be made with high school surveys, the authors provided data on a subset of respondents aged 15–18 years. The authors report that 86 per cent of their sample reported any alcohol use. In the 14–17 year age range, 32 per cent reported that they drank alcohol on a weekly basis, with a further 37 per cent reporting that they drank monthly. These data are broadly similar to those reported in the ASSAD survey. Cannabis use, however, appeared somewhat higher, with 38 per cent of 14–17 year olds reporting use in the last year. The third class of drugs to be considered was those related to amphetamines, referred to in this report as 'party drugs'. Rates of use appear high, with the authors reporting that 15 per cent of 14–17 year olds had used party drugs (Hillier et al., 2005).

The use of substances in Indigenous communities has received considerable attention in recent years, with high rates of alcohol and other substance use associated with a range of other social, political and cultural issues (see Chapter 4; Dawe et al., 2007). Several surveys have been conducted that provide some indication of levels of use in young Indigenous people. The National Aboriginal and Torres Strait Islander Social Survey (Australian Bureau of Statistics, 2004b) collected information relating to culture, health and education, amongst other things, from 9400 Indigenous Australians aged 15 years and over. Risky and high-risk alcohol consumption, based on a person's reported usual daily consumption and frequency in the previous 12 months, was provided for age bands, the

youngest of which was 15–24 years. In this group, 11 per cent of males and 13 per cent of females were classified as risky or high-risk drinkers. This rate was similar in remote and non-remote geographical areas. The *Western Australian Aboriginal Child Health Survey: the social and emotional wellbeing of Aboriginal children and young people* (Zubrick et al., 2005) is a survey investigating the health of 5289 Western Australian Aboriginal and Torres Strait Islander children aged 0–17 years. Alcohol consumption was measured by asking young people if they drank alcohol. Frequency and quantity were not assessed. However, in order to obtain an indication of excessive alcohol use, young people who reported drinking were asked if they had ever vomited due to drinking too much and, if so, whether it was just once or twice in the last six months, or more than twice. A measure of excessive drinking was based on any occurrence of alcohol-induced vomiting in the previous six months.

Overall, 27.2 per cent of young people reported drinking. The proportion of young people who drank to excess was 12.4 per cent. Drinking increased with age, however, and by 17 years approximately 22 per cent of males who reported drinking also reported drinking to excess, with a corresponding figure of approximately 17 per cent for females. While it is difficult to draw comparisons between surveys due to differences in timeframes and in definitions of excessive drinking, these data follow a similar trend to school surveys, highlighting a worrying pattern of increasingly heavy drinking in the middle to late adolescent period. Rates of illicit drug use were very low in this survey and the analysis was restricted to the self-reported use of marijuana. Approximately 30 per cent reported lifetime use of marijuana. Recent use (in the last week) was reported by 45 per cent of 17-year-old males and 21 per cent of 17-year-old females.

Key point

One of the most comprehensive surveys of young Indigenous Australians found that alcohol use was reported by approximately 27 per cent of young people. As in other school surveys, alcohol use increased with age. By 17 years, 22 per cent of males and 17 per cent of females who reported drinking were doing so to excess.

Other populations that could be considered to be particularly high-risk include those young people in the criminal justice system, young people removed from their families and in alternative care, and young people with mental health problems. Information on the rates of substance use across these populations is patchy.

The Australian Institute of Criminology has looked at the use of substances in a population of 371 young people aged 10–17 years in detention centres in all Australian jurisdictions (Pritchard & Payne, 2005). This was a very high-risk population: the majority were males (93%), just over half (59%) identified as Indigenous; three-quarters (76%) had stopped attending school before entering detention and had left school at an average age of 14 years; and finally, just over half were living at home with their parents prior to detention. These were a very troubled group of young people with multiple problems including histories of child maltreatment. Substance use rates were extremely high with nearly half of the sample reporting regular use of alcohol, cannabis and amphetamines in the six months prior to detention (47%, 67% and 40% respectively). Of the regular users of each of the above, daily use or use several times a day was reported for 37 per cent of regular drinkers, 87 per cent of regular cannabis users, and 58 per cent of regular amphetamine users: this is almost certainly dependent use.

Finally, there are a number of specialist datasets that look at trends in treatment and use of illicit drugs. These are also important sources of information to provide some sense of the extent of problematic drug use in young people. The National Minimum Data Set provides national, State and Territory data on alcohol and other drug treatment services and their clients. This dataset includes information on the class of drug for which treatment is sought and the nature of the treatment received. The sixth report in the series also presents data from other national datasets to allow for comparison. Specifically, information from the 2004 National Drug Strategy Household Survey on patterns of drug use for selected drugs, and treatment data from the 2006 National Opioid Pharmacotherapy Statistics Annual Data Collection and Australian Government-funded Aboriginal and Torres Strait Islander substance use services and primary health care services were referenced. Data on mortality and morbidity attributable to the use of alcohol and other drug use are also reported.

While the age bands reported are rather wide for young people, it is striking that 12.9 per cent of all discrete treatment episodes were provided for young people aged 10–19 years. These treatment episodes were broadly divided into treatment for 'own drug use' and treatment for 'other's drug use'; a total number of 19 508 discrete treatment episodes were recorded. Further information was provided on the principal drug of concern nominated by the client in a discrete treatment episode. For young people aged 10–19 years, 50 per cent of treatment episodes related to cannabis, with the remainder related to alcohol (approximately 23%), heroin (approximately 9%) and amphetamines (approximately 5%).

1.3.1 Summary

In summary, young people surveyed by national and school-based surveys were most likely to misuse alcohol (with a high incidence of binge drinking noted), followed by cannabis and then amphetamine-type substances. Young people attracted to same-sex partners reported high rates of misuse of cannabis and 'party drugs' and a significant proportion of young Indigenous people were identified as high-risk drinkers. Young people involved in the criminal justice system reported extremely high rates of regular alcohol, cannabis and amphetamine use, such that the greater proportion of this population could be considered substance-dependent.

Correspondingly, almost 13 per cent of the total treatment episodes for substance misuse problems were provided for young people aged 10–19 years. Half of these treatment episodes were related to cannabis use with only one-quarter related to alcohol misuse and an even smaller proportion for the treatment of heroin and amphetamine misuse. This pattern of treatment generally corresponds to the patterns of usage identified by the surveys. A notable exception is that there were fewer treatment episodes for alcohol than for cannabis, although alcohol is the most widely reported misused substance. This discrepancy may relate to previously identified factors such as the perception that alcohol misuse is not problematic, or at least largely socially accepted, and therefore does not require treatment. Alternatively, this situation may reflect family members' (particularly parents') confusion about the most appropriate response to this problem.

Key point

It is reasonable to presume that many Australian families are routinely faced with the problem of binge drinking by a young family member. The use of cannabis and amphetamine-type drugs is less common in young people, and it is assumed that fewer families need to manage the consequences of this use.

1.4 International prevalence estimates for drug and alcohol use among young people

1.4.1 United States of America

Monitoring the Future (MTF) is a long-term study of substance use in America (Johnston et al., 2007). The 2006 study targeted 410 secondary schools in North America and surveyed approximately 48 500 students in grades 8, 10 and 12. The most widely used substance is alcohol with nearly three-quarters of American adolescents (73%) having consumed more than a few sips of alcohol by the end of grade 12 and just over two-fifths (41%) having done so by grade 8. In 2006 more than half of 12th graders (56%) and one-fifth (20%) of 8th graders reported being drunk at least once in their lifetime. Binge drinking, defined as drinking more than five drinks in a row in the last two weeks, has continued to decline for 12th graders to 25.4 per cent, has remained stable for 8th graders at 10.9 per cent, and has increased slightly for 10th graders to 21.9 per cent. Binge drinking behaviour continues to increase in the four years immediately following school, with almost half (45%) of all male college students reporting binge drinking (Johnston et al., 2007).

The study also found that more than half of respondents (53%) had tried an illicit drug by the time they had finished high school. When inhalants are included as an illicit drug, almost one-third (29%) reported trying an illicit drug by the 8th grade at an approximate age of 12 or 13. More than one-quarter of students (27%) had used an illicit substance other than marijuana by the end of grade 12 and almost one in five students (19%) from all three grades had used marijuana in the 12 months prior to the survey. Just under one-third (31.5%) of 12th grade students had used marijuana in the last 12 months (Johnston et al., 2007).

Rates of drug use do not appear to be changing across time. For grade 12 students the annual prevalence rates for powder cocaine was 5.2 per cent in 2006 — a small increase from 4.5 per cent in 2005, heroin remained steady at 0.8 per cent in 2006 and in 2005, and narcotics other than heroin remained at 9 per cent in 2005 and 2006. There have been non-significant declines in the use of marijuana in all three grades and a modest decline in the use of hallucinogens other than LSD among grade 12 students from 5.5 per cent in 2005 to 4.9 per cent in 2006, but not among students from grade 8 or 10 whose rates of use stayed fairly steady at around 2.1 and 4.1 per cent respectively.

Overall, use of illicit drugs declined in the United States during the 1980s and 1990s and has remained fairly stable since then. Despite these declines, American students and young adults are amongst the industrial world's highest users of illicit drugs (Johnston et al., 2007).

1.4.2 United Kingdom

A major national survey of smoking, drinking and drug use among secondary school students aged 11–15 years is conducted annually in England. The 2006 survey had a sample of 8200 students from 290 English schools (The Information Centre, 2007). Twenty-one per cent of students reported alcohol use during the previous week, showing a similar pattern to that found in Australia of an increase in recent alcohol use with age. Overall, 20 per cent of students reported that they had 'been drunk' in the last four weeks. This was more prevalent in older students with 37 per cent of 15-year-old boys and 47 per cent of 15-year-old girls reporting that they had 'been drunk'. Drug use among school students had doubled between 1998 and 2002 to around 20 per cent lifetime prevalence (Eaton, Morelo, Lodwick, Bellis & McVeigh, 2005). Over recent

years, this rate has stabilised and the 2006 school survey results showed a slight decline in annual prevalence rates of drug use among 11–15 year olds, down from 19 per cent in 2005 to 17 per cent in 2006. Cannabis was the most widely used drug with 10 per cent of school pupils reporting that they had used cannabis in the previous 12 months (The Information Centre, 2007).

In the United Kingdom the primary sources of information on illicit drug use for young people aged over 15 years are crime and victimisation surveys. The 2005–06 British Crime Survey (BCS) is a national household survey of 29 932 16–59 year olds in private households in England and Wales. The 2005–06 BCS also gathered prevalence information from an additional 2259 16–24 year olds as part of a 'youth boost' (Roe & Man, 2006). The 2005–06 BCS estimates that 45.1 per cent of 16–24 year olds have used one or more illicit drugs in their lifetime, 25.2 per cent have used an illicit drug in the previous year, and 15.1 per cent in the past month. The survey also estimates that 16.9 per cent have used a Class A drug in their lifetime, 8.4 per cent have used at least one Class A drug in the previous year, and 4.0 per cent in the past month. Class A drugs include cocaine (powder and crack), ecstasy, hallucinogens and opiates (Roe & Man, 2006).

As in North America, cannabis is the illicit drug most likely to be used, with 21.4 per cent of English 16–24 year olds using cannabis in the previous year. Cocaine is the next most commonly used drug, with an annual prevalence of 5.9 per cent. Ecstasy followed at 4.3 per cent, then amyl nitrate at 3.9 per cent, hallucinogens at 3.4 per cent, and amphetamines at 3.3 per cent. The 2005–06 figures show a decrease in the use of cannabis and an increase in the use of LSD among 16–24 year olds compared to the previous year (Roe & Man, 2006).

Younger people reported higher levels of illicit drug use than those aged 25–59 years. The 16–19 year and 20–24 year age groups reported the highest levels for illicit drug use in the previous year and in the past month. Young people aged 20–24 years recorded higher rates of Class A drug use in the previous year and the past month. Rates of illicit drug use have declined for the 16–24 year age group over recent years. Between 1998 and 2005–06 the reported use of any drug decreased among 16–19 year olds (from 32.9 per cent in 1998 to 24.8 per cent in 2005–06) and the 20–24 age group (from 30.9 per cent in 1998 to 25.6 per cent in 2005–06). The overall decrease in illicit drug is mostly due to a decline in cannabis use over the same period from 28.2 per cent to 21.4 per cent (Roe & Man, 2006).

The highest levels of drug use were reported by those who had ever truanted or been excluded from attending school. Young people who had never truanted nor been excluded from school reported the lowest levels of drug use (Roe & Man, 2006). Prevalence is also considered to be higher amongst certain groups of young people including young offenders, homeless young people, care leavers, and children of drug-using parents. These young people are more likely to use a wider range of drugs and to use with greater frequency (Eaton et al., 2005).

Key point

International household surveys and other population estimates show a similar pattern of alcohol use and binge drinking in young people. Cannabis is the illicit drug most likely to be used, with 21.4 per cent of English 16–24 year olds reporting use of cannabis in the last year and 19 per cent of American high school students reporting recent use of cannabis.

1.5 Summary and conclusions

A significant number of families encounter problematic substance misuse by a young person in their family. In Australia, the most commonly reported misused substance is alcohol, followed by cannabis and then amphetamine-type substances. Higher rates of misuse of these substances are reported for minority groups such as same-sex attracted youth and young people involved in the criminal justice system. While rates of alcohol use amongst young Indigenous people appear to be lower, there are a significant number of drinkers who drink to excess.

As in Australia, alcohol is the most commonly misused substance in the United States and the United Kingdom. Patterns of use are also similar with a steady increase in binge drinking across the adolescent period. Data on college students indicate very high rates of alcohol consumption. Cannabis use is the next most commonly used substance, although it is difficult to distinguish problematic use from recent use (i.e. in the last 12 months).

Given the prominence of alcohol misuse by young people in Australia, it appears that the family members of these young people will most frequently be exposed to the consequences of alcohol misuse. There appears to be a disproportionately low percentage of treatment episodes delivered to manage alcohol misuse. This may be because either alcohol misuse does not have a significant impact on family members to the same degree as illicit drug misuse, or the impact of this abuse is not known. Regardless, further research is required to understand the needs of these family members so that appropriate education and support interventions can be developed and implemented.

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2. Impacts of drug use on family and household functioning

2.1 Introduction

This chapter provides an outline of current research into the ways in which substance use by a young person impacts on family functioning and on relationships between family members and the young person. The chapter begins with a review of current knowledge about the way problematic substance use by a young person impacts on family functioning with a view to establishing the identified needs of the different family members. The needs of parents and carers are considered across a spectrum of substance use levels from those that may be described as experimental through to regular use and to daily or almost-daily use. Clearly the last category causes the greatest problems and is associated with a range of other family and personal problems that often predate the current substance use itself. But the impact of less frequent substance use, such as binge drinking, by young people can equally cause significant problems for family members and their needs should not be neglected.

The response of the family unit is explored initially with specific focus on the way it affects the physical and psychological health of family members, their finances, employment and engagement in support networks, as well as the impact it has on family relationships. Finally, the different experiences of mothers, fathers, siblings and extended family members are considered, with particular attention focused on the long-term impact that problematic substance use has on these family relationships. However, after reviewing this literature it is prudent to acknowledge that research in this area is very much in its infancy. This chapter concludes with a brief overview of these research limitations, which relate to sampling issues, inadequate study design and measurement difficulties.

This chapter draws on a number of key qualitative studies which document the experiences of family members coping with the problematic substance use of a young family member (Barnard, 2005; Davies, Hopkins & Clark, 2005; Dorn, Ribbens & South, 1994; Salter & Clark, 2004; Sayer-Jones, 2006). Each provides insight into the experience of one or both parents, as well as younger and older siblings, with the majority of substance users exhibiting longstanding problems which are best characterised as poly drug use.

2.2 Impact on family members

It is well established that alcohol use, in particular heavy or binge use, is widespread amongst young people in Australia today. There is, however, a remarkable lack of systematic research investigating the impact of this use on family members and, further, the needs of parents and other family members in managing this use. The paucity of research of this kind may potentially be attributed to several factors. Some evidence indicates that parents generally are more concerned about illicit drug use than they are about alcohol use (Taylor & Carroll, 2001, cited in Hayes et al., 2004). While there is a tendency for parents to underestimate their adolescents' use of alcohol (Guilamo-Ramos et al., 2006), parents are in broad agreement that those who are under the legal age should not be provided with alcohol (Kypri et al., 2007). Further, information and advice for parents on managing alcohol use in young people are not difficult to find on the internet. However, whether this information is adequately meeting the support needs of parents and other family members is uncertain.

Research has focused primarily on the impact of illicit drug use within the family. It seems clear that the initial discovery that one's son or daughter is using illicit drugs is often surrounded by a haze of confusion exacerbated by a lack of knowledge about drugs. Parents report being unsure of what substances are being misused and the extent and seriousness of their child's use (Salter & Clark, 2004). For some parents, there is a gradual awareness of their child's use coupled with some hope that, despite evidence to the contrary, the young person is not using (Dorn et al., 1994). Such uncertainty is also fuelled by a generalised confusion about when a young person's substance use moves from being experimental to problematic.

As one mother explains drawing on her own experience as a drug user:

> When you first begin to use, you can go for a long time believing it won't take over your life. You think you won't end up like that. For a long time, you think you have control and then slowly but surely, you lose it. (Sayer-Jones, 2006, p.48)

Initially, many parents do not realise the full implications of daily or dependent substance use. It is often only through witnessing the extremes to which the young person will go in order to obtain drugs that they start to appreciate the powerful hold that drugs have over their child's life (Barnard, 2005). In the face of such behaviour, parents feel helpless in protecting their child and also the broader family from the general havoc that drugs inflict on their lives.

Key point

The way in which families respond to the information that a young person has a substance misuse problem depends on a range of social and contextual factors. However, an important starting point to help manage the effects of such knowledge is to have access to accurate information about different substances, the consequences of substance use and its associated lifestyle, as well as information on issues of overdose, withdrawal, treatment and relapse.

The initial discovery of the illicit drug use of a young person is typically met by a range of strong emotions by family members, including shock, anger, dismay and guilt (Velleman et al., 1993). Many studies report that the most common initial impulse is to attempt to contain the problem and keep the problem within the family without recourse to outside agencies or support (Barnard, 2005). Often families attempt to physically restrain the young person from further access to drugs in the belief that this will solve the problem. Such attempts to contain the young person are described by Barnard (2005) as 'never successful' (p.8). As the young person's substance use becomes more problematic, the impact on day-to-day functioning intensifies. As a consequence, family members experience uneasy dilemmas and conflict about how best to respond.

Most parents whose experiences are documented in the literature report a time when their lives were totally dominated by pervasive worries about the problematic substance use of their son or daughter. They describe worrying about what the young person is doing, whom they are with, whether they are getting into trouble, whether they themselves are to blame for their child's problems, whether they could have done anything differently and what they can do in the present to create change for the future. Underlying all of these surface worries is the deeper fear that something very bad might happen to their child. Unfortunately fatal overdose is not uncommon among problem drug users, nor is injury or even death through drug-related violence. As Sally, mother of Jack (15 years), explains:

> You become absolutely obsessed by it because, even if it's a quiet moment, you are waiting for the next disaster to happen. You think you can make it work by persistence and you constantly strategise and go 'If I do this, this and this... he'll understand, he'll realise, it'll make a difference', you know? ... and so you constantly have these different scripts running through your head about how to make a difference or make it work in a different way and so it is really crazy making. The most bizarre thing is that you actually become just as demented yourself. (Sayer-Jones, 2006, p.88)

The self-image and self-confidence of family members are often badly affected by their experiences. At some level all parents report feelings of self-blame and guilt for what has happened to their child.

> You feel terribly responsible for bringing them into the world; you think what have I done? ... You see them making mistakes and think what can I do about it? You feel you must have made awful mistakes not getting through to them about the dangers. (Orford et al., 2005, p.113)

> Everyone starts by blaming themselves. 'It's because I was too strict,' 'It's because I wasn't strict enough.' The thing is that nobody really knows why. What you've got to do is deal with the problems you have now. (Dorn et al., 1994)

Key point

When family members discover that a young person has problematic substance use, they experience a range of intense and overwhelming emotions that impact on all areas of family life. They need to receive ongoing support to help them better manage the impact of these emotions on their day-to-day functioning.

2.2.1 Impact on families according to substance type

Different types of substances create different stresses and demands on family members. Partners of illicit drug users report being exposed to significantly more stressful life events than partners of those who misuse prescribed tranquillisers. For instance, they experience more violence, more stealing and greater pressure for money (Velleman et al., 1993). Problematic use of illicit drugs can also result in engagement in illegal activity and thus increase the potential for family involvement within the legal and criminal system (Hogan, 1998). Some illicit drugs also present more serious health hazards for the young person, thus creating additional family anxiety with regard to the risk of infectious disease transmission or the potential overdose of the young person. Finally, the direct effects of the substance type will have an impact on levels of family functioning. For example, both cannabis and amphetamine use have been linked to increased prevalence of psychosis and early onset of mental health issues and this in turn presents the family with an overwhelming range of secondary issues to manage.

> Not long after that she started doing ice and the effect of the psychotic drugs over the past three years has been devastating. Paranoia, delusions, madness... I'd be walking in the street and there would be my daughter in this crazy out-of-her-head state digging in a park – with a shovel digging for buried treasure. (Sayer-Jones, 2006, p.48)

Unfortunately, much of the research that has examined the impact of substance use by young people on family functioning has paid limited attention to the variable of substance type, with some studies generally drawing on samples of problem drug users (not defined by substance type) and others studying use of both alcohol and drugs (Krishnan et al., 2001). A relatively small number of investigations have directly examined the impact of specific substances; for example, use of opioids (Andrade et al., 1989; Luthar, Anton, Merikangas & Rounsaville, 1992) and cocaine (Luthar & Rounsaville, 1993) on family members. Our literature search did not locate any studies that have focused on the impact of problematic amphetamine or cannabis use by a young person on family functioning. There has also been minimal attention to the impact of poly drug use by a young person on family functioning. It could be speculated that the nature and extent of distress are likely to increase as a family perceives escalating drug use which, in turn, is often associated with the use of multiple substances.

The nature of concerns that parents have regarding cigarette smoking has received relatively little attention. This is despite the well-established link between parental smoking, attitudes and knowledge about the dangers of tobacco use, and young people's use of tobacco (e.g., Kalesan, Stine & Alberg, 2006; Komro et al., 2003).

Key point

Families need to be provided with clear information about the impact of different types of substances on behaviour. Support should be provided to help them better cope with the behavioural disturbances associated with specific substance types.

2.2.2 Impact on physical and psychological health of family members

Living with a problematic substance user has been found to negatively impact on the physical and psychological health of family members. It has been conservatively estimated that 'every substance misuser will negatively affect at least two close family members to a sufficient extent that they will require primary health care services' (Velleman, 2002, as quoted in Macdonald et al., 2002). Parents struggling on a day-to-day basis with a young person's problematic substance use report elevated levels of stress, anxiety, depression, domestic violence and other behavioural disorders (Bancroft et al., 2002; Barnard, 2005; Davies et al., 2005).

Similar submissions were made to the recent inquiry by the House of Representatives Standing Committee on Family and Human Services, *The Winnable War on Drugs: the impact of illicit drug use on families*, from Australian families with particular reference to the high levels of stress and anxiety that occurred when a young person was using drugs (Parliament of Australia, 2007, p.231).

For example, the report states (on page 224) that 'Families of illicit drug users feel isolated and ashamed because of the stigma attached to drug use and other reactions follow according to the severity of the situation ... in many cases family members have been living with the negative impacts of the user for extended periods of time and they present with issues such as anxiety, depression, marital stress and breakdown, affected job performance and reliance on alcohol and drugs for their own self-care.'

In the long term, health problems reported by family members include physical symptoms such as shingles, ulcers, raised blood pressure and angina; and psychological symptoms such as anorexia, depression, panic attacks and 'nervous breakdown' (Barnard, 2005; Effective Interventions Unit, 2002; Velleman et al., 1993). Family members also describe increased consumption of food, tobacco, alcohol and drug use, with some family members admitting that one or both parents had started to drink heavily to cope with the additional levels of stress (Bancroft et al., 2002). Elevated levels of health disorders have been found in both qualitative studies which document the perceptions of family members and also in empirically based studies which compare the health status of family members and those in general population samples. For example, there is evidence of significantly greater use of health care services within families containing a dependent substance user.

Svenson, Forster, Woodhead and Platt (1995) reported that family members living with a drug-dependent person had twice the rate of specialist doctor visits, twice the number of laboratory services and four times the number of non-referred visits to medical practitioners than population matched controls. The authors suggest that the pattern of 'multiple doctoring' coupled with the greater use of laboratory services among family members reflect difficulties experienced by physicians in isolating the underlying cause of morbidity in this group. There is also evidence that the completion of a treatment program by a family member with alcohol dependence can positively impact on the health status of other family members, resulting in a significant decrease in health insurance claims (Spear & Mason, 1991).

Key point

Family members need support in managing the psychological and health implications of living with a young person with problematic substance use. Treatment services need to recognise the need for family members to receive support and counselling in their own right, regardless of the treatment status of the young person.

2.2.3 Impact on family relationships

Family members report that one of the foremost reasons why life becomes so stressful centres on the deterioration in family relationships. They describe an overwhelming sense of loss – what had previously been perceived as an affectionate and loving relationship is now transformed into a relationship characterised by suspicion and mistrust. In most families, coping with the young person's substance use becomes the focus of all the family attention, leaving little time or energy to address the needs of other relatives including siblings (Barnard, 2005). The young person's behaviour is seen as unpredictable, and the onset of sudden mood changes creates uncertainty about how the young person will react at any point in time.

As one mother describes:

> Within weeks we went from things being a little bit topsy-turvy to having somebody who was not coming home, somebody who was disappearing, somebody who you could clearly see was using many drugs... It was suddenly like living with a Dr Jekyll and Mr Hyde. (Sayer-Jones, 2006, p.87)

The stress of living with a young person with problematic substance use places great strain on all relationships within the family. Aggressive outbursts become more common and range in severity from those characterised by irritability, anger, rudeness or verbal abuse to more physically threatening behaviours such as punching, hitting, breaking things, threatening with weapons or making death threats.

> Sometimes I was so physically frightened, I'd call the police... I was scared that he was going to hurt himself; I was scared he could hurt us. I knew he was out of control and so I was just terrified. (Sayer-Jones, 2006, p.87)

As the young person's substance use becomes more problematic, the constant pressure for drugs is reported to take precedence over the fulfilment of family obligations. The contribution of the young person to daily family life becomes limited or, at best, unreliable. Parents report concerns about young people being missing from home for hours or up to days without planning or forewarning. They may be unreliable when keeping appointments and either absent or disruptive at important family rituals such as Christmas or birthdays.

Parents, typically mothers, are placed in the difficult position of having to balance the competing demands of protecting the substance-using child from problems associated with drug use as well as trying to protect the rest of the family from the harms resulting from the young person's problematic substance use. This in itself creates severe strain for the parent involved but also illustrates the way the substance use of a young person can permeate and transform many aspects of family life.

It is not unusual for divisions to occur between parents regarding the best way to manage the young person's problematic substance use. For example, one parent might try to suppress or minimise knowledge of the young person's use from the other parent as a way of protecting the young person from their anticipated response.

> When I found out Mick, my son, was using drugs regularly, I didn't tell my husband. I just knew that he wouldn't have been able to deal with it and would have made things worse. He always over-reacts and shouts if there is any sort of crisis — and with something as serious as drugs I was scared it would drive Mick away. (Dorn et al., 1994)

The different responses of mothers and fathers to a young person's substance use can be a source of major conflict and, in turn, lead to the degradation of the marital relationship.

2.2.4 Impact on siblings

The impact of substance misuse on siblings has received scant attention, with most studies in this area focusing on the likelihood of transmission of problematic substance use between siblings. One notable exception is a study by Barnard (2005) who completed semi-structured interviews with a range of problem drug users (ranging in age from 16 to 26 years) and other family members including 20 siblings, all younger than the problem drug user. Many siblings described experiencing a pervading sense of loss that was associated with older sibling drug use. They spoke of the striking discordance between their expectations of a normal supportive sibling relationship and the current reality of a 'selfish' drug-using brother or sister who prioritised drug use over obligations to the family. Siblings characterised drug users as self-absorbed, preoccupied with drugs, uninterested, and extremely quarrelsome.

> I think when people, anybody, that starts takin' drugs, they totally lose all reality ... they do definitely change. Definitely, they become totally different people ... when they speak tae ye, you dae feel as if they, they are the same person but a lot of things change ... wi' people that take drugs, it's as if they don't care for life at all, and they don't care about anybody else apart fae themselves basically. (Barnard, 2005, p.19)

Barnard's (2005) interviews with siblings confirmed the imbalance of attention that occurs within the family with the drug user occupying centre stage and the needs of the non-drug-using sibling being sidelined. Siblings were expected to display an understanding and tolerance with regard to the changing family environment and often a level of maturity that was beyond their years. Siblings differed in how they responded to this. Some siblings endorsed this focus and saw it as a legitimate strategy to try to solve the young person's drug problem. Others felt resentful, particularly with respect to the cost it had on their own wellbeing. For some siblings the altered focus was not a bad thing, as it enabled greater personal freedom; yet for others it was a source of sadness and anger. This experience of neglect within the family was also echoed in many of the submissions made to the inquiry by the House of Representatives Standing Committee on Family and Human Services (Parliament of Australia, 2007). Relationships Australia commented on the way in which siblings can become the forgotten victims due to their emotional needs being sacrificed in order to meet the more urgent needs of their substance-using brother or sister (Parliament of Australia, 2007, p.237).

As was the case with their parents, siblings of drug users experienced anxiety and concern about the wellbeing of brothers and sisters which, in turn, impacted on their daily lives.

> Last year I found it really hard to focus on my study because I was so worried about Danny all the time and I'd tell Mum and get really emotional and one of my best friends at school who knows about Dan, she was always saying, 'It's okay, you can't worry about this. It's not your problem.' But it was still hard. Letting it go is easier said than done. (Sayer-Jones, 2006, pp.12–13)

Barnard reported that the most common worry for siblings was fear of overdose.

> Like it, it just eh like ... ran through your head all the time [worry about overdose] and you used to like try and block it but ... it'd just always be there. (Barnard, 2005, p.22)

Siblings almost universally report a significant reluctance to share publicly what is happening with their brother or sister. Given the stigma associated with problematic drug use, such behaviour appears self-protective. However, often it is impossible to avoid public humiliation. Barnard (2005) describes the shame and embarrassment experienced by siblings when they see their brother or sister under the influence in public places or they come face to face with those to whom their brother or sister has behaved inappropriately. Siblings also have to cope with seeing their parents as they struggle to manage the ongoing distress of having a drug user in the family.

> My mum's not going to like that I say this, but its aging her 'cause it's just making her so stressed out and physically and emotionally drained. It's making her less able to do things because she's emotionally just a wreck... (Sayer-Jones, 2006, p.13)

The most prolific body of research in the area of siblings of drug users has focused on the possible transmission of problematic substance use between siblings. Younger siblings of drug users have been identified as being at increased risk of exposure to drug use and drug initiation (Luthar, Merikangas & Rounsaville, 1993). Brook and colleagues (1988), in a study of 278 white middle-class college students and their older brothers, found a strong effect of older brother drug use on younger brother drug use. This relationship remained even after controlling for peer and parental influences. There are many potential ways in which drug use by a sibling may, in principle, increase the risk of a young person's initiation into illicit drug use. For example, the use of drugs in the household or within close proximity of the sibling increases the likelihood of experimentation. It is also possible that drug use by an older sibling will increase the probability that the young person will develop a positive attitude towards drug use. Research by McKeganey, McIntosh and McDonald (2003) found that 10–12 year olds who reported having someone in their family using illicit drugs were five times more likely than their peers to have initiated some form of illicit drug use.

At present our knowledge about the process through which substance misuse by an older sibling increases the risk of drug initiation by a younger sibling is unclear. Longitudinal research conducted by Duncan, Duncan and Hops (1996) suggests that a young person's drug use can be a significant and continuing source of influence on the target sibling's

drug use, resulting in increased use over time. Although the level of later use by the target was best predicted by their own past behaviour, drug use by siblings served to maintain or exacerbate the target's ongoing substance use, thus contributing to the target's future use in an indirect way.

Key point

The needs of siblings of drug users are significant, yet they have been much overlooked by research and treatment providers. There is evidence that sibling drug use may increase the likelihood of initial use by another child, with factors such as availability and a family's positive attitudes to drug use playing a key role.

2.2.5 Impact on family finances

Perhaps one of the most difficult events endured by families of young people with problematic substance use is the unrelenting pressure for money. Parents report experiencing ongoing financial stress in response to various issues such as providing money to support the young person's substance use, providing money for the young person's drug treatment, and paying off the young person's debts.

As one father puts it:

> for an addict, everything is about how to get money to buy more drugs ... it doesn't matter what comes out of their mouth, what they are really saying is, 'Give me more money to buy heroin'... So, for example, ... 'I love you, Dad...' (Please give me money for heroin), 'The cat's eaten the dog' (Please give me money for heroin), 'My girlfriend's about to commit suicide' (Please give me money for heroin). (Sayer-Jones, 2006, p.16)

Requests for money create uneasy dilemmas for family members. The young person's desperate need for money leads to a heightened state of vigilance which greatly impacts on the stress levels of family members. For some families, refusal to concede to financial requests can result in angry and distressing interactions which have the potential to escalate into violence.

There is a strong fear that if parents do not concede, they, or others, might become the victim of theft. The persistent theft of goods and money from the family home was a major cause of problems for all families in Barnard's study. It meant that 'nothing was safe, whether the most mundane items such as toiletries and food in the freezer or more valuable items like jewellery' (Barnard, 2005, p.13). Family members also have to live with the worry that the young person may engage in additional criminal activities to obtain money for drugs. Such ongoing financial pressure may have long-term implications for family members that often extend beyond the immediate confines of the young person's problematic substance use.

As one parent describes:

> If we want to spend money on anything, we've got to think about it because ... we've got so many bills to pay off because of problems caused directly or indirectly through my son's habit. (Salter & Clark, 2004, p.17)

Key point

Problematic substance abuse by a young person creates enormous financial pressures within the family, leading to ambivalence and confusion about appropriate ways to respond. Parents need support to find ways of best meeting these demands.

2.2.6 Impact on families' social relationships

When family members find out about the problematic substance use of a young family member, they are often unsure about whether they want to disclose this to their network of friends and relatives.

> We started to withdraw even from friends because we felt that they didn't understand. We didn't talk about it a lot to anyone but we did talk to close personal friends and even some of those we have taken out of our lives. I don't tolerate their judgements very well. (Sayer-Jones, 2006, p.6)

Often the stigma associated with substance misuse problems results in family members concealing the problem from friends and some parents report that it inhibits the establishment of new relationships.

> I'm probably a bit more guarded in striking new friendships ... you don't want them to find out that your son is a drug addict. So I think it does close down quite a bit if you allow it to. (Salter & Clark, 2004, p.21)

For most parents, activities such as going out socially or on holiday are disrupted as a result of the young person's substance misuse. This might be due to a range of factors including fears relating to the young person's wellbeing in their absence, general worries regarding the state of the house on their return, and other issues such as not feeling well enough to socialise or feeling the limits of financial restriction (Salter & Clark, 2004, p.21).

A detailed study of social support by Orford et al. (1998) found there was wide variation in the perceived adequacy of support experienced by family members living with a serious drinking or drug problem. For many families the availability of social support does not automatically translate into levels of actual support received. In many cases those who might be perceived as being able to provide support do not do so for a number of reasons, including geographical distance or lack of awareness about the problem or relationship issues with the relative. In other cases a potentially supportive relative does not provide support due to interpersonal differences including a lack of understanding of the relative's problem. Orford concluded that much of the responsibility for failure in support provision lies with the 'other' who often withdraws, takes sides and makes assumptions with regard to the relative's responsibility. In simple terms it appears that family members want support people to just listen in a non-judgmental way to their accounts of living with a young person with problematic substance use. Yet they also seek a listener who remains optimistic and supportive of the plight of the young person.

Key point

The families of young people with substance misuse problems often make limited use of social support due to difficulties accessing and receiving support and the stigma attached to drug use.

2.2.7 Differential impact on mothers, fathers and extended family members

There is a general consensus that mothers tend to be most affected by the substance use of a young family member and that they tend to get more involved. It has been suggested that women are more likely than men to take responsibility for family health problems (Klassen et al., 1991 as quoted

in Howells & Orford, 2006). A British survey found that 33 per cent of callers to the ADFAM helpline were mothers compared with calls from fathers at 6 per cent (Bancroft et al. 2002, p.12). Mothers are perceived as more open to contacting treatment agencies, and service providers are generally geared towards meeting the needs of mothers.

Although limited data exist on the impact on fathers, there has been some suggestion that they tend to be more detached from the problems of dealing with a young person's substance misuse than mothers. Dorn et al. (1994) found that fathers are often seen to become emotionally withdrawn and rejecting of the young person's behaviour and suggest it may be due to an apparent lack of control over the young person's drug use. The gendered nature of support services means that little support is directly targeted at fathers. Although this is partly due to practical reasons, it does place greater responsibility on one family member (the mother) and overlooks the potential benefits of engaging male family members.

We know very little about the impact that problematic substance use by a young person has on the extended family system, and professionals working in the field do not typically seek the views of extended family. Clearly, the extent to which the young person's use impacts on broader family ties such as cousins, nephews, nieces, uncles, aunts and grandparents will be mitigated by the quality of the relationship and the degree of contact and extent of information shared by family members about the young person's substance use.

A study examining the extent of pre-teenage children's knowledge of illicit drug use within the extended family found a wide variation of experience and, in only a small number of cases, had the children been provided with a detailed understanding of their relative's substance use (McKeganey, McIntosh & McDonald, 2003). Most children reported having worked it out in response to their relative's behaviour or the presence of drugs or drug-related paraphernalia in the home. The authors noted that many of the children expressed concerns about their relative's use that appeared out of proportion to the pattern of use that was described. Most commonly, the children coped with these anxieties by themselves, with only limited knowledge and considerable mistrust of the reactions of others.

Findings from this study raise the issue of whether it is better to provide extended family, particularly children, with a detailed account of a family member's substance use, or alternatively to keep such information hidden. As this study indicates, many children have greater knowledge of their relative's illicit drug use than the significant adults in their life might assume. In situations where children have started to become aware of their relative's substance use, it might be helpful to provide them with a detailed explanation rather than leaving them in isolation to cope with their own fears and anxieties.

Key point

The impact of a young person's problematic substance use varies across family members in response to the intensity of their involvement. Children appear to be more aware of the young person's illicit drug use than adults generally assume. The issue of whether it is better to provide children with information about the young person's drug use is not clear.

2.3 Research limitations

2.3.1 Limitations due to sampling issues

Although the impact of problematic substance misuse within the family has received research attention, the vast majority of studies in this area have focused on the experiences of marital partners; most commonly, partners of men with alcohol use problems. The current review was unable to locate any research that had specifically examined the impact of alcohol use by a young person on family members. There are a small number of studies that draw on heterogeneous samples of close relatives including partners, parents, siblings and children of drug users (Orford et al., 2002; Orford et al., 1992). However, there is little systematic analysis undertaken of differences within the sample. For example, a study by Velleman and colleagues (1993) collected information on the coping strategies of 50 close relatives of people with substance misuse problems, including 19 parents and four siblings. The study outlines the experiences of family members in a range of areas including the impact of substance use on family life, coping strategies employed, and levels of social support attained by family members. Although the authors report marked, but non-significant, differences in the types of problematic behaviours experienced by spouses and parents of substance users, with partners reporting more physical violence and unpredictable mood changes and parents reporting more lying, manipulation and self-neglect in response to the behaviour of their substance-using child, the omission of further analyses of sample difference creates an impression of uniformity of response across *all* relatives. It is uncertain whether the lack of difference is a consequence of small sample size or a valid reflection of congruence in experience. Indeed, the assumption of uniformity of experience appears to be taken for granted within much of the literature. It is somewhat concerning that many of the findings included within this report are drawn from studies where the responses of close family members have been thus merged, with the focus on similarity of experience rather than difference. Clearly the findings of this report must be regarded as tentative and subject to further investigation.

Key point

The impact of problematic substance use has mainly been examined in the context of marital relationships. Research that has specifically investigated the impact on the broader family typically draws on heterogeneous samples of parents, siblings and children of substance misusers and makes assumptions of uniformity of experience rather than differences.

A second concern relates to the gender bias that exists within relatives selected for study inclusion. The vast majority of studies feature the experiences of mothers. There appears to be a widely accepted view that 'family' means 'parent' and 'parent' means 'mother' (Bancroft et al., 2002). In part, this reflects a general belief that mothers tend to be most affected by the substance misuse of a young family member and that they tend to get more involved. It has been suggested that women are more likely than men to take responsibility for family health problems (Klassen et al., 1991, as quoted in Howells & Orford, 2006) and mothers are more likely to seek support services for help in dealing with their child's substance misuse than fathers (Bancroft et al., 2002). This assumption, however, renders the needs of fathers as invisible and stereotypes all fathers as disengaged. Clearly this is not the case. There is a need for future studies to

pay more attention to the issue of gender in sample selection in order to further clarify the different responses of mothers and fathers to their child's problematic substance use.

Thirdly, it is concerning that the majority of studies in this area draw on family members of young people who are engaged in treatment, thus largely ignoring the experience of families where young people are not accessing treatment. This gap in research is regrettable as there is evidence that a greater number of young people remain untreated in contrast to a smaller number who are engaged in treatment. For example, a recent estimate by the United States Department of Health and Human Services (2002, cited in Waldron et al., 2007) indicated that 93.6 per cent of 2.6 million young people exhibiting severe substance abuse problems receive no treatment. It is unclear to what extent the population of young people engaged in treatment adequately represents the overall population of young people who have problematic substance use. It is possible that families of treatment seekers have more problems than families with a young person who does not access treatment. Alternatively, engagement in treatment might indicate these family members are actually less chaotic and possess more resources than those who do not access treatment services.

Key point

Many studies examining the impact of problematic substance use on *family members* focus on the experience of *mothers* and the experience of family members of young people who are currently engaged in treatment. Consequently, the range of events and impacts likely to be experienced by all family members of young problematic substance users has not been conclusively established.

2.3.2 Limitations due to lack of control for co-existing mental health issues in the young person and in family members

The relative contribution of co-existing mental health issues in the young person and the main effect of substance misuse per se on family functioning are difficult to disentangle and have not been systematically examined. Studies of psychological factors and co-morbid disorders have suggested that the mental health problems most frequently associated with substance abuse are conduct disorder and attention deficit hyperactivity disorder (ADHD) (Nation & Heflinger, 2006). These disorders alone have the potential to place significant strain on family functioning. The impact of these disorders may be compounded by a young person's substance misuse and, similarly, the substance misuse is impacted by these psychiatric diagnoses.

Key point

Young substance misusers often present with co-morbid mental health issues; the impact of these separate, yet overlapping, issues on family functioning has not been systematically examined.

2.3.3 Limitations due to study design

Most of the studies into this area have been cross-sectional and uni-dimensional in design, measuring family functioning at one point in time, through the responses of one family member with no analysis of broader variables such as the socioeconomic status of the family, mental health status of relatives, or duration of the young person's substance misuse. Instead, it is assumed that all families coping with substance use by a young person share a relatively homogenous social environment and that their experience is unchanging over time. Evidence, however, indicates that families of substance users are in a constant state of flux and they oscillate through a range of strategies in their attempt to best cope with the impact of the substance misuse (Orford et al., 2005). Substance use, likewise, changes over time and cycles through the various stages of active use, abstinence and relapse (Glantz & Leshner, 2000). It seems highly likely that the impact on family members will vary over the course of a young person's addiction and fluctuate also in response to broader stressors that impinge on family life. Longitudinal studies have the potential to provide much valuable information on the impact of substance use over time and the differing developmental trajectories of family members in response to coping strategies employed.

Key point

Cross-sectional designs that measure family functioning momentarily, at one point in time, are commonly employed in research examining the impact of problematic substance use by a young person so that the dynamic nature of substance misuse and a family's response to it cannot be adequately identified.

2.3.4 Limitations due to difficulties generalising findings across international contexts

The majority of research that has investigated the impact of problematic substance use by a young person on family members has been conducted within the United States and Canada, with a smaller number of studies completed within the United Kingdom. This research has primarily focused on the experiences of one socio-cultural group – usually white family members, living in a western country. A notable exception is a cross-cultural project completed by Orford and colleagues (2005) which compared the experiences of family members across three contrasting cultural locations – Mexico City, south-west England and the experience of Indigenous Australians living in the Northern Territory. Findings suggest that, despite the obvious presence of socio-cultural difference, all family members shared a set of universal experiences as they managed to

cope with the problematic substance use of a close relative. Yet there was also evidence of diversity which arose in response to the social context of each community. For example, a key theme that emerged in interviews with Indigenous Australians was the very public, community nature of a family member's experience of substance misuse, whereas in Mexico and England substance misuse was considered as an individual drug or alcohol problem.

Key point

Much of the research relevant to this report has investigated the impact of substance misuse on family members in the United States, Canada and the United Kingdom, with a limited amount of information derived from Australian family members.

Despite the above limitations, there is overwhelming evidence that substance use by a young person can have a profound impact on family members (Andrade et al., 1989; Barnard, 2005; Orford et al., 1998; Velleman et al., 1993). Dependent substance use is usually accompanied by a range of problematic behaviours such as violence, stealing, aggression, volatility, lethargy and unpredictability, which heighten levels of stress experienced by family members (Velleman et al., 1993). Families also report experiencing ongoing frustration and despair in their attempts to negotiate treatment services due both to inadequacies in current levels of service provision and treatment access protocols. Four areas have been identified as points of particular impact for families. These include: (a) the physical and psychological health of family members; (b) relationships within the family; (c) family finances; and (d) levels of social support accessed by family members (Effective Interventions Unit, 2002). Clearly, these are not discrete areas of family experience and there is much overlap in the way each area affects general levels of family functioning. However, for the purposes of trying to disentangle the impact of substance use of a young person within the family, each of these areas will receive attention separately within the following section.

2.4 Summary and conclusions

This chapter has reviewed the research literature (limited by methodological issues and a paucity of empirical evidence) examining the impact of a young person's substance misuse on family and household functioning. First, the most widespread problematic substance used by young people is alcohol. However, there is little contemporary information on the needs of parents and carers in relation to this issue. Despite a plethora of available information, at least via the internet, it is not clear whether this information is sufficient to help families deal with the introduction of young people to alcohol and to monitor alcohol use, at least in those young people in the early to mid-teenage years.

Second, and in contrast, the research we reviewed highlighted that problematic substance use by a young person frequently impacts negatively on the physical and psychological health of family members; relationships within the family; family finances and employment patterns; and levels of social support. These effects are wide-ranging and generally escalate or intensify when the substance misuse occurs frequently, across developmental milestones, and illicit substances are used (compared with alcohol). Family members, including parents or carers, siblings or other family members, require support to manage the range of issues that accompany their young person's substance misuse.

In summary, it is recommended that family members of a young person with a substance misuse problem have access to:

- accurate information about different substances, the consequences of substance misuse (and the associated lifestyle), and issues of overdose, withdrawal, treatment and relapse
- accurate information about the impact of different types of substances on behaviour as well as support to cope with the behavioural disturbances associated with specific substance types
- appropriate support to manage the range of intense and overwhelming emotions and physical health issues that impact on all areas of day-to-day family functioning, and
- strategies to help facilitate a young person's engagement in treatment.

Additionally, critical areas that require further investigation by researchers and treatment providers alike are:

- the needs and appropriate support options for family members of young people engaged in problematic alcohol misuse, and
- the needs of siblings of substance misusers, specifically focusing on the increased likelihood that these siblings may initiate substance use, which has implications for support and treatment interventions.

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3. How families respond to drug use by a young person

3.1 Introduction

There are a range of factors that play a role in determining a family's response to the discovery of a young person's substance misuse. First, the age of the young person and the quality or strength of their relationship with family members are important. Secondly, the extent of substance use disclosed and whether the young person might be regarded as being in the initiation, experimental or problematic range of use may influence a family's response. Thirdly, a family's response may be determined by their current levels of functioning as well as pre-existing stressors and prior strategies for dealing with conflict within the family. Finally, the type of substance used and the family's familiarity with that substance will also be influential.

The family's response at any one point in time will be influenced by a complex interplay between these factors as family members search for a way to understand and manage the problem. For example, the response by family members to the discovery that their 21-year-old son has a daily heroin habit will be significantly different from a family's response to news that their 14-year-old daughter has been binge drinking on the weekend with some friends from school. In each case, however, the discovery will have a significant impact on many aspects of family life.

Key point

A family's response to substance misuse by a young person is determined by a complex interplay of factors. Indeed, the response of each family member may be different for a particular situation and this response may change across time.

The majority of research attention in this area has focused on *problematic* substance misuse and the strategies employed by family members in their management of this predicament. This chapter explores the range of strategies typically engaged by family members in the management of a young person's substance misuse from the experimental phase to use at more problematic levels. We also draw on research evidence to develop a list of critical issues that parents need to resolve in their efforts to support the young person through this difficult phase.

3.2 Substance initiation and experimental use: the response of family members

For most Australian families, alcohol consumption is an acceptable part of life and use by young people is seen as 'normal' and inevitable. For these reasons, parents are generally uncertain of how best to approach the issue of alcohol use by their young son or daughter. Some parents report being pressured by adolescents to allow them to use alcohol in the home. Others report being asked by their children to buy alcohol for their use when they attend parties or other social outings. Parents might acquiesce to these requests with the goal of encouraging more responsible alcohol use in their adolescent. They might also regard alcohol use as preferable to illicit drug use and, in response, 'turn a blind eye' to early alcohol consumption. There is evidence that parents are often unsure of the level of alcohol consumed by their adolescents and tend to underestimate intake (Guilamo-Ramos et al., 2000).

The way in which parents can guide their adolescents through this phase of initiation to the use of alcohol has been the subject of an extensive review by Hayes, Smart, Toumbourou and Sanson (2004). The authors propose a set of guidelines based on the evidence reviewed in their report, *Parenting Influences on Adolescent Alcohol Use* (see box below). This phase is an important component of 'problematic substance use', as young people have high rates of binge drinking that, in turn, may lead to both short-term problems (i.e. engagement in a range of risky behaviours) and long-term harm (i.e. increased risk of alcohol and other substance use problems in adulthood).

Guiding adolescents towards responsible alcohol use

(based on Hayes et al., 2004)

1. Adolescents are less likely to drink and less likely to engage in binge drinking if parents actively disapprove of this behaviour. Conversely, adolescents whose parents display a permissive attitude towards alcohol consumption tend to drink more.
2. Parents should delay the onset of alcohol use in young people as long as possible in order to avert adverse impact of alcohol on adolescent body and brain development as well as reducing the likelihood of high-risk alcohol abuse and use in adulthood.
3. Once adolescents have started experimenting with alcohol, enhanced parental monitoring is regarded as the most effective strategy in minimising the progression to harmful or risky levels of alcohol consumption.
4. Good parental monitoring is contingent on the establishment of a strong parent–child relationship and is responsive to the level of rule observance shown by the young person.

Although every parent hopes that their child will abstain from illicit drug experimentation, the reality is that illicit drugs are easily accessible and many young people do experiment with their use. Parents are often unaware of the young person's level of contact with illicit drugs. They might also be unsure whether such experimentation is just normal adolescent behaviour or rather an indicator of other problems in the young person's life. Parents who suspect the young person is experimenting with illicit drugs might choose to search the young person's room or belongings looking for evidence of use. If evidence is found, parents might confront the young person and invoke stringent consequences for such behaviour. In the long term such parental strategies may harm the parent's relationship with the child and encourage the young person to become more secretive about their illicit drug use.

The Australian Government's National Drugs Campaign seeks to raise awareness within families about the potential harms associated with illicit drug use. Parents and carers are encouraged to talk openly about illicit drugs with their children, to be alert for opportunities to raise drug use in an impersonal manner, and to engage young people in conversations about drug use. It is also important to recognise that experimentation does not inevitably mean that the young person is going to develop a significant substance problem or become dependent on drugs.

3.3 Problematic substance use: the response of family members

A helpful synthesis of the ways in which families respond to and cope with problematic substance use by a young person has been proposed by Orford and colleagues (2005). Based on interviews with 297 family members of relatives who were using alcohol or drugs in a problematic way, Orford et al. proposed a typology of coping styles displayed by family members. These are broadly categorised as: (i) putting up with it; (ii) trying to regain control; and (iii) withdrawing and gaining independence from the young person. Some of these coping styles may be easier to adopt than others depending on the quality of the connection between the family member and the young person and the history of the young person's substance use. It is hypothesised that there may be a natural sequence in coping styles for parents which starts with 'putting up with it', moves to 'trying to regain control', then possibly changes to 'withdrawing and gaining independence' or moves back to 'putting up with it'. Orford also refers to a fourth strategy – seeking help and support – which is often regarded as ubiquitous in all the coping styles of family members yet is surprisingly very difficult to achieve satisfactorily. Each of these strategies is described below.

Key point

Typical coping styles employed by family members of a young person engaged in problematic substance use are: putting up with it; trying to regain control; withdrawing and gaining independence; and seeking help and support. Families often use a combination of these approaches as they search to find an optimal strategy to respond to the young person's substance misuse.

3.3.1 Putting up with it

This way of coping is described by Orford et al. as 'giving in to' the relative's substance misuse, 'becoming resigned to it', or 'doing nothing' to confront the problem. Family members might choose to ignore or overlook the behaviour, thus taking a seemingly inactive stance with regard to the problem. For some family members, 'putting up with it' can result in considerable levels of self-sacrifice as the parent's needs become secondary to those of the user. Family members might also experience significant levels of cost with regard to levels of peace and quiet, personal safety and financial security.

Family members who 'put up with' the problematic substance use are often criticised by family or friends and labelled by professional people as 'co-dependent' or passive. Family members taking this stance put forward reasons such as 'not wanting to know the worst, not wanting to provoke further drinking or drug use, or feelings of fear, hopelessness or sympathy for the relative' (Orford et al., 2005, p.125).

3.3.2 Trying to regain control

This way of coping describes attempts made to regain some control in the family and requires a significant investment in time and effort on the part of the family member. This way of coping includes a broad range of strategies including confronting and talking to the young person, trying to control their behaviour, refusing to be deceived or 'humbugged', and protecting family interests and resources. Some family members try to regain control by keeping the young person in as close contact as possible through a warm and supportive relationship.

> I got a lot closer to him by being like that... At the beginning I threatened to throw him out. It's no good at all. They'll just go anyway, they don't care... as long as they get their stuff... You've got to try and go along with them and get close to them... (Dorn et al., 1994, p.61)

3.3.3 Withdrawing and gaining independence from the young person

The effort of coping with the problematic substance use of a young person can totally take over the family or, at least, the lives of key family members. The question of putting distance between oneself and the young person's problematic substance use is widely recognised to be a central dilemma for family members. At some stage each family member has to make the decision that 'enough is enough' and start to reassert their own and other family members' rights and needs. To do so, the family member must turn their attention away from the problematic substance user and onto their own best interests. Family members have to accept that they might not have control over the

young person's substance use but they do have control over themselves. There is no monetary amount that must be outlaid or a point on the addiction process that must be spanned – each parent has to come to that decision in their own time but, in the process of coming to that decision, parents need an enormous amount of support.

> In the end it became more: What is the best relationship I can have with him while setting some reasonable boundaries for myself? What's the best way for us both to survive? It was about doing my best for him and trying to feel okay about what he chose to do and what he didn't choose to do... I'd let go of any wishes, dreams I had for him and I'd just think, 'Well, he's alive today.' (Sayer-Jones, 2006, p.92)

Most family members cycle through a range of these strategies without clear advice from elsewhere on a trial-and-error basis. Some of these strategies are quickly abandoned, whilst others are carefully adapted in response to changing family circumstance over time. Strategies might include: helpful ways to talk to the young person; setting limits or deciding on strategies for responding to financial requests; setting limits with regard to substance use in the home; finding ways to balance firmness and consistency with kindness and care for the young person; and adopting strategies for protecting the broader family unit, in the home as well as self.

3.3.4 Seeking help and support

In light of the stressful circumstance of coping with a young person with problematic substance use, it is not surprising that family members place significant importance on levels of support they receive from family and friends. Simply having someone to share the burden and to talk to about what is happening is the most common form of support sought by family members (Orford et al., 2005). Support might also take the form of the provision of accurate information or practical support such as financial assistance or the offer of respite when things become overwhelming. In light of the perceived advantages of family members accessing support, a striking finding in the Orford study was the frequency with which the networks of people surrounding family members failed to provide the level of social support that was needed. Often, although surrounded by friends and relatives, family members struggled as the potential support was not forthcoming or found to be wanting in some important respect. 'In the end the problematic nature of support for family members of relatives who drink or take drugs excessively was so evident to us that we started to be surprised, not at the failure of support, but rather at the fact that support was ever satisfactorily received' (Orford et al., 2005, p.155).

The barriers to family members receiving adequate support are many and include their own reluctance to discuss openly with others what is happening with their son or daughter, which might be based on a belief about the importance of keeping family problems within the family due to a sense of shame or failure. Often when family members have

previously reached out for support, they found the reactions of others had not been helpful and this inhibited further support-seeking behaviours.

> You just haven't got anyone to talk to. You can't tell your friends, your family. I mean, even now there are none of our personal friends who know about Ann. You find they're just not sympathetic. (Dorn et al., 1994, p.42)

Key point

Family members place significant emphasis on the importance of support from family and friends. Unfortunately, the support they receive is often perceived as inadequate or inappropriate for various reasons which, in turn, may inhibit seeking further support and lead to an increased sense of isolation.

3.3.5 The stress–strain–coping–support model

The stress–strain–coping–support model (Orford et al., 1998; 2005) has been proposed as a useful way of conceptualising the family's response to substance misuse problems by a young person. As an alternative to models that view families as key contributors to the problem, the stress–strain–coping–support model sees family members as having to make key decisions regarding how best to cope with the substance misuse problem.

Central to the model are a number of assumptions:

- Ongoing substance misuse problems by a young person within the family is highly stressful both for the young person and also for family members. As a consequence, family members are at risk of experiencing strain in the form of both physical and mental ill-health due to levels of chronic stress associated with living with a young person who has a substance misuse problem.
- All family members of a young person with a substance misuse problem face the central dilemma of how to respond to their relative's problematic use. Each family member will develop their own way of coping, including ways of responding to and understanding the problem behaviour.
- Coping strategies elicited by relatives vary in their effectiveness both in terms of the way they buffer and/or reduce the strains they experience and in terms of the impact they have on the young person's substance misuse.
- Family members can have an impact on the levels of substance use by a young person in both a desired and an undesirable direction.
- Social support is potentially a powerful factor in mitigating the effects of stress and strain caused by the substance misuse of a young person. However, if such input is perceived as being unsupportive, it can further intensify levels of stress and strain within the family.

3.4 Summary and conclusions

The multi-faceted pressure that substance misuse imposes on the family's emotional, behavioural, social and financial capacities makes it one of the most threatening and difficult-to-manage stressors that a family will encounter. There are no definitive rules about how best to manage this problem. The diversity of family structures and family environments that are at play means there can be no one solution or set of procedures recommended – families need to find their own unique solution, often through a process of trial and error.

Families respond in a variety of ways to the presence of problematic substance use by a young person. They do not simply choose an optimal way of coping and then just stick with it. On the contrary, research suggests that most families move from one way of managing to another in a frantic effort to find the ideal way of coping with their situation. In doing so, each family experiences significant dilemmas and uncertainties about how best to respond as they are confronted by a range of critical issues in both the initiation and problematic stages of a young person's use (see box below). Even those family members who attempt to achieve greater consistency in their approach have the problem of being unsure concerning what to be consistent about – whether it is best to engage the problem user or to leave them to their own devices; whether it is best to be 'tough' or soft and supportive. Unfortunately the current state of research provides no clear guidance on the most effective strategy for family members to adopt when confronted by a young person's problematic substance use. Every family has to develop their own solution to help steer the young person through this difficult stage. What is clear is that parents need to be provided with ongoing support through this process.

Critical issues for families to resolve

1. **Issues to resolve at the initiation and experimental stage of substance use**
   - Attitude of parents towards substance use – are they permissive or condoning?
   - At what age should young people begin to drink alcohol or use illicit drugs?
   - Is it better for parents to supervise early substance use within the home?
   - What stand should parents take with regard to tolerated levels of substance use?
   - How does the parent create opportunities for honest and open family discussions on substance use?
   - If a parent suspects illicit drug use, what is the best approach to take?
2. **Issues to resolve when the young person's substance use is problematic**
   - Should the parent give the young person money to support their illicit drug habit?
   - Should the young person be allowed to use illicit drugs within the home environment?
   - Is it best to take a 'soft', 'strong' or 'supportive' position with regard to the young person's illicit drug use?
   - How long should the family tolerate inappropriate behaviour by the young person before asking them to leave?
   - Should illegal behaviours be reported to the police?

3.5 References

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4. Support and treatment options for family members

4.1 Introduction

The previous chapters describe the impact that problematic substance use can have on the parent/s, carer/s and other family members of a young person and the various coping strategies frequently adopted by families in response to this issue. In general, awareness of the young person's substance use may be associated with significant personal distress for many family members. This distress may be related to anxiety or stress concerning the dangers and risks the young person may be exposed to as a consequence of substance abuse; guilt and shame about the origins of the young person's substance abuse (characterised by statements such as 'Where did we go wrong?' and 'If I'd done things differently, it would not have happened'); and sadness or grief for the unrealised potential of their child. This chapter reviews the research literature surveying support and treatment options for family members of young people experiencing substance misuse problems.

There are three key support and intervention options for family members of young substance abusers:

a. *support interventions for family members* of a young person with a substance misuse problem irregardless of the young person's treatment status;

b. *family-based interventions* which utilise family members in the engagement and retention of young people in substance abuse treatment programs, thereby improving treatment outcomes (substance use and other psychosocial variables) and indirectly supporting and assisting family members; and

c. *intensive multi-systemic interventions* that broaden the family therapy framework to include other factors in a young person's social ecology, thereby improving treatment outcomes and indirectly supporting family members.

The following section reviews each of these three target areas and the effectiveness of the relevant approaches.

4.2 Support interventions for family members of young people with problematic substance use

The primary objective of support interventions for family members of young substance abusers is to enhance the psychological functioning and wellbeing of the family members independent of the young person's substance abuse treatment involvement. Two interventions with this precise mandate were located in a review of the published literature (McGillicuddy et al., 2001; Toumbourou, Blyth, Bamberg & Forer, 2001). Whilst specifically focusing on the needs of family members affected by youth substance abuse, both of these programs acknowledge that improvements in family members' psychological functioning and wellbeing may assist the process of the identified young person engaging successfully in substance abuse treatment programs. A third intervention by Copello and colleagues (2000) will also be reviewed. This intervention was not specifically designed for intervention with young people but it includes an approach that is transferable to support the families of young alcohol-misusing people.

4.2.1 Behavioural exchange systems training (BEST)

Toumbourou and colleagues (Bamberg, Toumbourou, Blyth & Forer, 2001; Toumbourou et al., 1997; 2001) reported the findings of their ongoing investigation into a parent-training program as a method of supporting parents to cope with youth substance abuse. This program was designed for parents concerned by substance abuse in a child aged between 12 and 24 years.

4.2.1.1 Theoretical framework of the program

The BEST program integrates a wide range of theoretical frameworks including family therapy (Stanton, Todd & Associates, 1992), behavioural therapy (Azrin et al., 1994), attachment theory (Catalano & Hawkins, 1996) and analytic developmental concepts. This integration has resulted in the formation of a transactional, reciprocal and mutual influence model of the parent–adolescent relationship (Toumbourou et al., 1997) which underpins this program. According to this perspective, parental interactions with the adolescent are the product of both the adolescent's behaviour and the parent's perceptions. Therefore, this approach values the role of reframing negative family perceptions of adolescent problem behaviour advocated by family systems theory. This is achieved by (a) supporting and assisting parents in their own right to manage the distressing emotions that frequently accompany the young person's substance abuse; and (b) improving parents' mental health and parenting competence so as to enhance their ability to assist the young person in changing their substance use.

The aspect of the program targeting the improvement of parents' emotional wellbeing focuses specifically on addressing the reciprocal issues of responsibility and shame. Based on their previous work with parents of young substance abusers (Toumbourou et al., 1997), the researchers identified firstly that many parents blame themselves for the young person's substance misuse; and secondly that the parents' emotional state or wellbeing is determined by their perception of the young person's behaviour. The authors suggest that the core parenting challenge for all parents during this period of development is to gradually withdraw the support

that previously characterised the parent–child relationship so as to increase the adult responsibilities of the young person. This process will then give rise to a graded increase in the opportunity and challenge faced by the adolescent, thereby facilitating an increasing adult–adult relationship. In the experience of the researchers, parents of adolescent substance misusers can have difficulty with this transition, which may partly give rise to the young person's substance abuse.

Toumbourou and colleagues (1997) further argue that the parental changes such as increasing adult responsibilities for the young person advocated in their model should increase the consequential learning experiences available to the adolescent. However, evaluations to date have focused on parents, and aspects of their model addressing impacts on adolescents have not yet been tested.

Key point

The BEST program focuses on understanding and changing parental interactions with the young person, which are determined by the young person's behaviour and the parents' perception of the young person's behaviour.

4.2.1.2 Program content

The BEST intervention is a nine-week group training program, comprising eight concurrent weekly sessions (two hours per session) with an additional follow-up session at approximately the sixteenth week. A summary of the content of each session is presented below. In addition, parents had access to clinical counsellors to assist with the identification of personal and family issues and with information about adolescent health and development.

The first four weeks of the program focused on challenging parents to adopt a different perspective on their relationship with the young person. The adolescent developmental task of separation was highlighted, thereby encouraging parents to reduce their sense of responsibility for addressing the young person's behaviour problems. It was hypothesised that, in turn, parental distress may be reduced. The remaining four weeks of the program were based on behavioural theory principles and aimed to increase assertive parenting responses likely to elicit responsible adolescent behaviours, thereby reducing substance misuse. This component of the treatment was based on the finding by Azrin and colleagues (1994) that parents' use of contingent behavioural management strategies can reduce youth substance abuse.

In summary, during the course of the program, parents are challenged to consider alternative views of the young person's substance misuse, particularly that it is not helpful for parents to accept responsibility and consequences for their adolescent's choices. Additionally, parents are encouraged to initiate small changes in the way they interact with their family and their difficulties. This interactional change process is enabled by a reduction in parental depression and an increase in the range of strategies available to deal with family issues.

Outline of BEST intervention sessions	
Session	**Content/objectives**
1	Introductions Discussion of expectations Review of the effects of drug problems on the family
2	Exploration of drug types and their effects
3	Family development through the life cycle Parents' needs post-children The young person's task of identity development and healthy separation
4	Identification of parental needs and the young person's responsibilities
5–8	Identification of strategies for altering parental practices in the family
8	Parent articulation of strategies to implement in order to alter their situation Establishment of a support group to assist with the ongoing implementation of changes
9	Follow-up meeting to describe successes and amend approaches where necessary

Key point

The BEST program is an eight-week group training program (with one further follow-up booster/review session) which focuses on changing parental perceptions of their relationship with the young person and instructing in assertive parenting responses.

4.2.1.3 Program evaluation

The BEST intervention was trialled with families in metropolitan Melbourne. Families accessed the intervention via advertising materials in drug treatment centres, welfare agencies and public media releases. Criteria for substance abuse by a young person were injection of illicit drugs, drug use disrupting school or other significant role development, and drug use with antisocial behaviour, including harm to others. The intervention was examined using a wait-list control design in which 32 families were offered immediate entry to the program and 16 families were entered onto the waiting list (n = 48 families; 85% of the primary parent and participant in the intervention was the mother). The adolescents of the participating parents were primarily male (71%); aged 18 years and older (71%), ranging from 14 to 22 years old; at least half were injecting drug users (mainly heroin); and their drug use had persisted for at least three years in over one-third of cases.

Dimensions measured pre- and post-intervention (at the eighth and sixteenth weeks of the program) included: parental mental health (28-item version of the General Health Questionnaire (Goldberg &

Williams, 1998)), parenting satisfaction (the Kansas Parenting and Family Life Satisfaction Scales (James et al., 1985)) and perceived adolescent behaviours (parents indicated their perceptions of the adolescent's substance use and efforts to reduce substance use over the past month). Additionally, two scales were developed specifically for application to the study, targeting those factors hypothesised as affecting parental mental health. The first scale comprised two subscales distinguishing emotional dependence on adolescent behaviour and attributions blaming parents for adolescent behaviour. Secondly, a measure of parental behaviour was devised to assess change in parenting behaviours hypothesised as targeted by the intervention.

Rates of mental health symptoms at intake were high amongst both the wait-list and the immediate intervention parents, with 87 per cent of parents scoring above the cut-off for recognisable depressive mental health problems on the General Health Questionnaire.

Participation in the BEST intervention was associated with significant reductions in mental health problems and improvements in parental satisfaction and adoption of assertive parenting behaviours. Significantly, these changes were maintained until the second follow-up assessment at the sixteenth week of the program. The authors conclude that participation in the program was associated with large and stable reductions in mental health problems, suggesting that the parental problems observed may have been reactive responses to stressful conditions, rather than due to endogenous causes. This assertion was further supported by analysis indicating that parents' emotional dependence on adolescent behaviour may have been particularly related to depressive symptoms. Contrary to prediction, there was no evidence to link adoption of assertive parenting with improvements in mental health, and participation in the program did not have a significant impact on reported adolescent behaviour. Nonetheless, parents did perceive that the adolescents were making efforts to reduce their drug use.

Key point

Parents of young illicit substance misusers who participated in the BEST intervention demonstrated significant improvement in their mental health and wellbeing.

4.2.2 Parent coping skills training

McGillicuddy and colleagues (2001) reported the preliminary findings of their investigation into a coping skills training program for parents of substance-abusing young people. This program was designed for parents concerned by substance abuse in a child aged between 12 and 21 years.

4.2.2.1 Theoretical framework of the program

McGillicuddy and colleagues (2001) offered an alternative perspective to the hypothesis that maladaptive parenting is often a key contributing factor to adolescent substance abuse. They suggest that some maladaptive behaviour observed in the parents of adolescent substance users develops in response to stress brought on by frustrated efforts to cope with adolescent behaviour that is seemingly uncontrollable and demanding, suggesting that the parent behaviour–adolescent substance abuse relationship is not clear and may be bidirectional and reciprocal. This stress and coping perspective hypothesises that more effective parental coping in response to adolescent substance

use and associated problems will improve the parent's own psychological functioning which may then help reduce the adolescent's substance use. Conversely, unconstructive and dysfunctional parental coping is speculated to lead to maintained or increased adolescent substance use and poorer parental functioning (e.g. Gelfand & Teti, 1990; Orford et al., 1992). Based on this conceptualisation of the parent–young person substance abuse relationship, McGillicuddy and colleagues (2001) developed a coping skills training program for parents of substance-abusing young people.

Key point

The Parent Coping Skills Training program is underpinned by a stress and coping perspective in which more effective parental coping in response to a young person's substance misuse may improve parents' own psychological functioning and concurrently reduce the young person's substance misuse.

4.2.2.2 Program development

A significant strength of this program was its attempt to translate theoretical and clinical knowledge of problematic behaviours, which parents of young substance abusers frequently encounter, into systematic ways of assessing and training coping skills. McGillicuddy and colleagues (2001) used the behavioural–analytic model for construction of skill training programs by Goldfried and D'Zurilla (1969) to facilitate this process. In order to develop a meaningful and targeted skills training program for parents, McGillicuddy and colleagues (2001) sought firstly to measure parents' current coping to problematic situations associated with youth substance abuse. In response, they developed the Parent Situation Inventory (PSI), an inventory of representative problem situations encountered by parents of substance-abusing young people. These situations were derived from a review of parent self-help literature; consultation with parents of substance-abusing adolescents; substance-abusing adolescents; and substance abuse counsellors. The typical situation vignettes were then role-played by experienced substance abuse counsellors, parents who had received treatment regarding their adolescent's substance abuse, and parents who had not received treatment regarding their adolescent's substance abuse. The role-playing required the counsellor or parent to respond to an administrator reading the vignette as if that person was an adolescent. An analysis of the psychometric properties of this instrument is published by McGillicuddy, Rychtarik and Morsheimer (2000; cited in McGillicuddy et al., 2001).

Key point

The Parent Coping Skills Training program includes a quantitative evaluation of parents' responses to typical problem behaviours associated with substance misuse by young people, using the Parent Situation Inventory.

4.2.2.3 Program content

The overarching goal of the Parent Coping Skills Training program was to teach parents more effective skills in coping with problems resulting from the young person's substance abuse. The PSI problem situations, scoring criteria and written counsellor responses obtained in the development of the PSI were used in the content development of the program, an outline of which is presented below.

Parent Coping Skills Training program	
Session 1	Introduction to: • general parenting principles (including 'dos' and 'don'ts') • Stress and Coping Model related to parenting behaviour • ABC model of thoughts, feelings and behaviour • general problem-solving model
Sessions 2–8	Review of the previous week Individualised problem solving Individualised modelling and rehearsal Skill training in a specific PSI topic area Homework Program completion (Session 8)

The content of sessions 2–8 consists of a discussion of PSI situations under the framework of a specific topic/s fundamental to general problem solving, general parenting, or parenting a substance-abusing young person. The topics discussed from sessions 2–8 respectively were: replacement of negative thoughts with positive thoughts; factual information about drugs and alcohol; communication essentials; use of positive and negative consequences; establishment of house rules; issues related to adolescent treatment; and issues related to post-treatment help for parents. Additionally, the PSI situations were discussed amongst the parent group using a standard problem-solving model (D'Zurilla & Goldfried, 1977) in which the problem was identified and alternative solutions suggested and evaluated. The group facilitator would role-play possible responses with a parent volunteer and parents were also encouraged to role-play situational responses.

Key point

The Parent Coping Skills Training program is an eight-week group training program that teaches parents alternative skills to manage common problem situations arising from a young person's substance misuse.

4.2.2.4 Preliminary program evaluation

Results of a pilot study evaluation of the program were reported for parents of 22 participating families. Parents were recruited from mail, newspaper, radio and television advertisements and randomly assigned to receive the skills training immediately (skill training condition) or following an eight-week delay (wait-list condition). Parents completed an assessment pre-treatment and another at the conclusion of the eight-week training program. Characteristic features of the sample were: 93 per cent female, 86 per cent white ethnicity, 93 per cent employed; parent to a young person aged 12–21 years who was actively engaged in substance use

(at least monthly use of alcohol or illicit drugs over the previous six months) but not receiving any substance abuse treatment. Parents were excluded from participation if they met criteria for a severe psychiatric disorder and/or an alcohol or drug use problem; and/or if they had used illicit substances more frequently than once per month.

Data were collected for parents' coping skills (PSI), psychological functioning (Beck Depression Inventory (Beck & Steer, 1993)); Brief Symptom Inventory (Derogatis & Spencer, 1982); State-Trait Anger Expression Inventory (Spielberger, 1996), family functioning (Parent–Adolescent Communication Scale (Barnes & Olson, 1982)) and adolescent alcohol and other drug use (parent report of substance use using the Timeline Follow-back technique (Sobell & Sobell, 1978)) for the 50 days preceding assessment and the 50 days that composed the treatment. Compared to the wait-list control parents, parents who received the skills training immediately showed significantly improved coping skills as measured by the PSI. Non-significant trends favouring the skills training for parents was evidenced for scores on the depression scale of the Beck Depression Inventory; the communication problems scale of the Parent–Adolescent Communication Scale; and marijuana usage of the adolescent (reduction in the number of days used) but for no other substance. Interestingly, parents in both conditions reported nearly 50 per cent fewer days of adolescent alcohol consumption post-treatment.

Key point

A pilot study of parents of a young person engaged in problematic use of alcohol or illicit substances demonstrated that participation in the program was associated with improved psychological functioning and wellbeing, together with improved coping skills.

4.2.3 Support for families based on the stress–coping–health model

Building on the model proposed by Orford and colleagues (2005) (see Chapter 3), Copello and colleagues (2000) developed a step-wise approach to counselling relatives of problem drinkers and drug users in a primary care setting. While the focus of the program was not exclusively on young people, this model has been adopted elsewhere (e.g. Odyssey House, described later) and used with a range of family members.

4.2.3.1 Theoretical framework of the program

This brief psychosocial intervention was based on the work of Orford and colleagues (2005) who proposed the stress–strain–coping–support model in which families are viewed as having to make decisions regarding how best to cope with the young person's substance misuse problem. Refer to Chapter 3 for further explanation.

4.2.3.2 Program content

The program comprises a brief psychosocial intervention delivered by general practitioners, practice nurses and health visitors in a primary care health setting. Primary care professionals were targeted to deliver the program because of their access to, and their perceived trustworthiness and credibility by, the population. The program is manualised and consists of a maximum of five sessions, with the amount of input by the professional determined by the particular circumstances of each family member. Completion of the program within one session is emphasised (although five sessions are permitted) with the practitioner stepping through a series of response options. The program includes: Step 1 — listen, reassure, explore concerns; Step 2 — provide relevant information; Step 3 — counsel about coping; Step 4 — counsel about social support; and Step 5 — discuss need for other sources of professional help.

4.2.3.3 Program evaluation

There has been some evidence supporting the effectiveness of this program in reducing family stress. Copello et al. (2000) reported on a study in which the impact of the intervention on 38 relatives' stress was determined. Further, they also assessed the feasibility of training 36 primary care professionals to use the package. Both relatives' coping and symptoms and the primary care professionals' attitudes and confidence were measured before and after the intervention. Results found that once the intervention was completed, relatives showed a significant decrease in physical and psychological symptoms and a reduction in engaged and tolerant forms of coping. In addition, a significant improvement was found in the confidence and attitudes of the group of professionals who tested the intervention when compared to those who did not. The authors concluded that the program resulted in positive outcomes for both relatives and professionals.

Key point

A brief psychosocial treatment package with a step-wise approach to intervention was successful in improving the physical and psychological functioning of relatives of adults with alcohol misuse problems in a primary health care setting. This approach may be appropriate for supporting family members of young people who misuse alcohol and/or other drugs.

4.2.4 Summary and conclusions

In summary, the BEST program (Toumbourou et al., 2001) and the Parent Coping Skills Training reported by McGillicuddy and colleagues (2001) acknowledge the reciprocal relationship of family member wellbeing and coping and the use of substances by the young person. Both programs offer time-limited treatment options presented in a group format, identifying them as potentially cost-effective and practical intervention options for the support of family members of young substance abusers. Similarly, both programs include psychoeducational and problem-solving components which may enhance the generalisation and maintenance of the predicted changes in family member functioning over time. It appears that the BEST program evidence was primarily derived from family members of young substance abusers with chronic illicit substance abuse and parents were not excluded on the basis of their mental health issues. This is in contrast to the program of McGillicuddy and colleagues (2001) which held seemingly narrower inclusion criteria.

However, both programs are similar in that they target the family members of young people misusing illicit substances. Whilst the needs of this population of family members are extremely important, Chapter 2 identified that the majority of families are affected by the misuse of alcohol by a young person. Therefore, the brief treatment package offered by Copello and colleagues (2000) may fill a critical gap in the support and treatment options available to family members whose young person is engaged in problematic alcohol use. Although the intervention was not specifically designed to

target young substance misusers, it appears that the program principles could be successfully transferred to support the family members of young alcohol misusers. This program is again time-limited and delivered in a primary health care context, thereby making it ideally placed to access a significant proportion of family members of the young alcohol-misusing population.

Thus far, this chapter has considered specific support options for family members of young substance abusers who may or may not be motivated to join, or currently engaged in, a substance abuse treatment program. The alternative perspective on the support of family members of young substance abusers is that this support is provided by focusing more directly on changing the young person's substance use. This can occur by modifying the family system (family-based interventions) or the wider social environment in which the young person and family functions (multi-systemic/multi-dimensional family interventions). This chapter will now examine a review of family-based interventions and multi-systemic/dimensional interventions for the treatment of youth substance abuse. The final section presents information on the efficacy of these approaches in modifying youth substance abuse treatment, engagement, retention and outcomes combined.

4.3 Description of family-based interventions for treatment of youth substance abuse

The phrase 'family-based intervention for youth substance abuse' is used to encapsulate a relatively diverse range of treatment approaches. Largely, this phrase is a collective term for treatment models that regard the family as a primary intervention unit in the treatment of youth substance abuse (Liddle & Dakof, 1995; Mitchell et al., 2001; Ozechowski & Liddle, 2000). Substantial variability exists in how these interventions conceptualise the involvement of family members in the treatment of youth substance misuse. However, historically, family involvement in a young person's treatment for a substance abuse problem has been to assist change in the young person's substance use, via strategies to facilitate engagement and retention in treatment. In some instances, the intervention may occur indirectly through a family member, without the young person present (i.e. a unilateral intervention approach).

Family-based interventions are founded in family systems theory and, more recently, have expanded to include cognitive behavioural principles. A brief overview of these theories follows, with a specific focus on the conceptualisation of youth substance abuse problems. This review provides an introduction to the main family-based interventions for the treatment of adolescent substance abuse.

4.3.1 Family systems theory

Family systems theory is the 'conceptual cornerstone' (Ozechowski & Liddle, 2000) of most family-based interventions for youth substance abuse. This theory considers individual functioning to be reciprocally connected to a person's primary relational context, which is typically the family. Functional difficulties are conceptualised with reference to the recurring patterns and interactional sequences between family members (Ozechowski & Liddle, 2000). Specifically, youth substance abuse is considered to be related to parental, sibling and extended family member functioning and particularly the patterns of communication and interaction with and between various family subsystems (e.g. parent–adolescent, parent–parent, parent–sibling) (Szapocznik, Kurtines et al., 1983; 1986).

In this form of intervention, the family is conceptualised as a natural social system that establishes routine patterns of transacting among its members and with its environment. These repetitive patterns of interactions define a family's structural organisation. Dysfunction may result from a particular family's way of organising itself in an attempt to cope with internal or external changes or stresses. Families in which the symptomatic behaviour is expressed in the young person tend to label the adolescent as the family's problem (the young person is then considered the identified patient). The focus of therapy is then on changing the interaction patterns that permit, maintain or encourage the problematic behaviour. Therefore, the behaviour of the adolescent is perceived in the context of the concurrent interactions of the entire family. This framework has been particularly influential in engaging young people in substance abuse treatment.

Key point

Interventions based on family systems theory focus on changing the interaction patterns between family members that may permit, maintain or encourage problematic behaviour; in this case, problematic substance use.

4.3.2 Strategic structural-systems engagement therapy

Szapocznik and colleagues (1988) developed the strategic structural-systems engagement intervention to increase young people's attendance at the initial treatment session for substance abuse treatment. This program comprised the provision of therapist support to concerned family members to encourage the young person to attend treatment. This support was provided on a continuum from low-level support with minimal family interaction (for example, Level 2 intervention comprised joining, inquiring about family interactions, inquiring about the problems, values and interests of family members, supporting and establishing an alliance with the caller) through to Level 5 intervention (higher level ecological interventions, home visits to family members or significant others, and using significant others to help in undertaking restructuring of family dynamics).

Szapocznik and colleagues (1988) examined the effects of a strategic structural-systems engagement (SSSE) intervention on adolescents' attendance at the initial treatment using a controlled trial methodology. Seventy-four families, of primarily Hispanic ethnicity, with adolescents suspected of, or who had been observed, using drugs (marijuana 82.5%; cocaine 80%; frequency of primary drug use several times per week, but 41 per cent restricted their primary drug use to once per week or less) participated in the trial. Families

were randomly assigned to an experimental group: strategic structural-systems engagement intervention; or 'engagement as usual' (i.e. no attempt to restructure the family's resistance). Participants in the SSSE intervention were engaged at a rate of 93 per cent compared with participants in the control condition (engagement rate of 42%). Furthermore, 77 per cent of adolescents in the experimental condition completed treatment compared with 25 per cent of those in the engagement-as-usual condition.

Santisteban and colleagues (1996) replicated this study with a larger sample of families (193 Hispanic families) who were randomly assigned to one of three conditions (SSSE intervention; family therapy only; group therapy only). The results of this study confirmed the initial findings, with 81 per cent of SSSE families compared to 60 per cent of control families successfully engaged in treatment.

4.3.3 Cognitive behaviour theory family-based interventions

Cognitive behaviour theory (CBT) has been incorporated with traditional family systems theory to form behavioural family-based interventions for youth substance abuse problems. From this perspective, youth substance abuse is seen as a conditioned behaviour that is reinforced by cues and contingencies within the family. Examples highlighted by Ozechowski and Liddle (2000) are that substance misuse may be directly modelled and reinforced by other family members or parental permissiveness toward the young person's initial experimentation with drugs and/or alcohol. The treatment of youth substance abuse from this perspective again occurs within the context of the family and particularly in skills training to alternatively manage the behavioural cues within the family, so that the conditions and behaviours compatible with substance use are diminished simultaneously with the reinforcement of conditions that are incompatible with substance abuse.

The intervention techniques implied by this theoretical perspective are varied and include family communication skills training, problem solving and conflict resolution, parent skills training; and implementing positive rewards for the young person's non-drug use behaviour. An example of interventions that utilise this integrative theoretical approach is community reinforcement and family training (CRAFT) (Meyers et al., 1999).

Key point

Interventions based on cognitive behaviour theory (incorporating family systems theory) focus on contingency management training to reinforce reduced substance abuse, together with a range of other skills training (e.g. problem solving, communication and conflict resolution).

4.3.4 Community reinforcement and family training (CRAFT)

CRAFT is provided as a unilateral family treatment approach initially designed to assist family members or concerned significant others in modifying the behaviour of unmotivated substance abusers and engaging them in treatment (Kirby et al., 1999). Waldron and colleagues (2007) report the findings of a study targeting families with a treatment-resistant, drug-abusing young person. The main target of this intervention was the engagement of young people in substance abuse treatment. However, a significant, and the first, aspect of the program aimed to enhance the psychosocial functioning of parents. For this reason, CRAFT is discussed here in some detail.

4.3.4.1 Program content

The objectives of the CRAFT intervention are to enhance the psychosocial functioning of the parents, assist parents in building skills necessary to help engage the resistant young person in treatment, and to improve family relationships by teaching the parents adaptive social skills. Specific components of CRAFT include:

- raising awareness of the negative consequences of substance use and potential benefits of treatment
- contingency management training to reinforce abstinence or reduced substance use and avoid interfering with natural consequences
- communication training
- planning and practising activities that interfere and compete with drug use
- increasing the parents' own reinforcing activities
- preventing dangerous situations, and
- preparing to initiate treatment when the parents are successful in engaging the young person.

CRAFT consists of 12 sessions to develop skills needed to assist parents to engage the resistant young person in treatment, with additional crisis sessions available. Parents continue to receive CRAFT intervention even after the young person has engaged in treatment to continue their own skill building. A six-month window of opportunity after parents have initiated CRAFT is permitted for the young person to engage in treatment.

4.3.4.2 Program evaluation

This research examined the efficacy of CRAFT for parents of treatment-resistant young people and the potential of the intervention to engage young people in treatment. The second phase of this study then examined the efficacy of a CBT intervention for the young people engaged in treatment using the CRAFT approach. Forty-two parents were offered 12 sessions of CRAFT. Parents or parent surrogates (35 mothers, 7 fathers and 2 other family members) were recruited primarily through newspaper advertising. Thirty adolescents who were successfully engaged in treatment following their parents' participation in Phase I participated (23 male and 7 female; 14–20 years old) in the CBT program. The CRAFT intervention was successful in engaging 71 per cent of adolescents in treatment and these young people attended an average of two-thirds of the treatment sessions offered.

Critically, this study examined changes in parent functioning on participation in the intervention. Parental functioning dimensions that were assessed were: depression symptoms – Beck Depression Inventory (BDI) (Beck, Steer & Garbin, 1988); state anger – the State–Anger sub-scale of the State–Trait Anger Expression Inventory (STAXI) (Spielberger, 1988); and anxiety – the State-Trait Anxiety Inventory (STAI) (Spielberger, 1983). Parents experienced improved emotional functioning on each of these dimensions (with the exception of state–trait anger) across assessment points, and these improvements did not depend upon the young person's engagement in treatment.

Key point

The CRAFT program is designed to assist family members to engage the young person in substance misuse treatment, whilst enhancing the psychosocial functioning of the family members themselves.

4.4 Description of multi-systemic/multi-dimensional family treatment interventions for youth substance abuse

Multi-systemic and multi-dimensional family therapy approaches evolved from traditional family-based interventions and are commonly referred to as the 'new generation' of family-based interventions (Ozechowski & Liddle, 2000). These interventions extend the focus of intervention beyond the family and incorporate knowledge derived from both family systems theory and social ecology theory (Bronfenbrenner, 1979).

Individual behaviour is considered within the wider social environment or multiple ecological systems (e.g. family, school, peer, neighbourhood, community and cultural systems). Furthermore, the importance of risk and protective factors for negative developmental outcomes is highlighted. In particular, multiple risk factors are conceptualised as acting independently and in combination to influence normal adolescent development (Cichetti & Toth, 1997). This approach recognises that many factors influence the development and maintenance of youth substance abuse and other associated functional impairments, and therefore individualised, comprehensive intervention strategies are necessary which acknowledge the unique profile of developmental risk and protection. Critically, these approaches identify other factors, other than the family unit, that have an impact on youth substance abuse.

Key point

Multi-systemic and multi-dimensional family therapy interventions broaden the focus of intervention beyond the family to consider the influence of the wider social environment on a young person's problematic substance use. Individualised comprehensive intervention strategies are implied.

4.4.1 Multi-dimensional family therapy

Multi-dimensional family therapy (MDFT) was designed to target risk behaviours and promote competence, and to buffer risk across multiple realms of adolescent and family functioning (Liddle, 2004) in a similar manner to multi-systemic therapy (MST). MDFT is a comprehensive, developmental/ecological, family-based, multi-component, stage-orientated intervention (Liddle, 2002). It targets intrapersonal aspects including those of the adolescent (e.g. drug use as a means of coping with distress), the parent/s (e.g. parenting practices) and other family members (e.g. substance-abusing adults in the home), as well as those interactional patterns (e.g. parent–young person conflict and relationship problems) that contribute to the development and continuation of substance abuse and related problems. The treatment also addresses the young person's and family's functioning indirectly via the social systems influencing the young person's life, such as school, work, antisocial or substance-abusing peer networks, and the juvenile justice system.

MDFT is provided in phases, with the initial emphasis on engagement and establishing a foundation for treatment. This involves the cooperation of family members and others in a highly focused and sustained effort to reorganise the young person's daily life,

thereby facilitating developmentally appropriate competence across areas of the young person's life. In the second phase of treatment, parenting practices are targeted by examining the current parent–young person relationship and educating parents in strategies to influence the young person. In the third and final treatment phase, the emphasis is on generalisability and facilitating the durability of the gains evidenced during treatment. Individual sessions with the young person, parents and family are held in the home and treatment clinic, or at community locations such as school or court throughout the process.

Different versions of MDFT, including both prevention and treatment approaches, have been developed, tested and proven efficacious with diverse clinical populations, including different ages, males and females, co-morbid youth, multi-ethnic backgrounds and in different treatment delivery settings (Dennis et al., 2004; Hogue et al., 2002; Liddle, 2002 cited in Liddle et al., 2004; Liddle et al., 2002; 2001). MDFT has been evaluated in randomised studies, including a multi-site study and prevention trial, in comparison to other state-of-the-art treatments (individual cognitive–behavioural treatment, peer group treatment, and family education models). In comparison to these treatments, MDFT was significant in reducing substance use up to one year following treatment completion.

Consequently, MDFT has been recognised as a 'best practice' in substance abuse prevention and intervention (for example, National Institute on Drug Abuse, 1999). This recognition was facilitated in part by the fact that the approach is manualised, training materials are available, and the treatment can be taught to non-research, clinical therapists. Furthermore, the originators of the program are working specifically to transport the research-developed therapy approach into an intensive day treatment program (Liddle et al., 2002).

Key point

Multi-dimensional family therapy is a comprehensive treatment program designed to target risk behaviours and promote competence across multiple realms of functioning of a young person and their family. It has been trialled in diverse settings and with diverse populations and has proved efficacious.

4.4.2 Summary

Family-based and multi-systemic or multi-dimensional family therapy interventions are united in their focus on changing a young person's problematic substance misuse. This can occur by facilitating the engagement of a young person in treatment (strategic structural-systems engagement therapy; CRAFT) and/or their successful completion of treatment (CRAFT; MST; MDFT). One possible distinction between family-based and multi-systemic or multi-dimensional family therapy interventions is the intensity of the intervention, especially family member involvement. Therefore, the capacity of these interventions to support family members of young substance abusers is dependent on the initial risk and resilience profile of the family, both the young person and their family members.

Key point

The suitability of these interventions for families depends on the specific needs of the young person and their family — specifically the profile of risk and resilience factors present.

4.5 Efficacy of family-based interventions for treatment of youth substance misuse

It is critical to highlight that the research literature does not delineate family-based and multi-systemic/multi-dimensional family therapy treatment approaches when reviewing the efficacy of treatments of youth substance abuse. Rather, multi-systemic and multi-dimensional family therapy interventions are classified as 'family-based' interventions. The authors of this chapter believe that the distinction between family-based and multi-systemic/multi-dimensional family therapy interventions is important in the context of this report because this distinction can inform recommendations for support options for family members of young substance abusers. However, in summarising the research reviews of the efficacy of treatment options for young substance abusers, the authors use the widely accepted description of 'family-based' interventions. Several research reviews have examined the efficacy of family-based interventions for treating adolescent substance abuse (e.g. Catalano et al., 1990; Deas & Thomas, 2001; Liddle & Dakof, 1995; Ozechowski & Liddle, 2000; Spooner, Mattick & Howard, 1996; Williams & Chang, 2000). A brief summary of the key findings of these reviews follows.

Catalano and colleagues' (1990) review of the literature on adolescent drug abuse treatment concluded that: (a) some treatment is better than no treatment; and (b) post-treatment relapse rates were high in adolescents. These authors found no evidence of the primacy of one treatment modality but stated that this assertion was not conclusive because of the small number of controlled studies available at the time.

Liddle and Dakof (1995) further examined the treatment outcome literature on the efficacy of family-based treatment for both adult and adolescent substance misuse problems. Based on controlled clinical trials, family therapy was found to be more effective than other treatments in engaging and retaining adolescents in treatment and reducing their drug use.

In contrast to these two reviews, Spooner, Mattick and Howard (1996) concluded that the effectiveness of treatments for adolescent substance abuse problems could not be conclusively determined, mainly because of the reliance on single-group treatment studies and the small number of unreplicated controlled trials in this research field. However, they did conclude that 'family therapy may be an effective intervention with selected clients in substance-dependence treatment programs when delivered by adequately trained therapists' (Spooner, Mattick & Howard, 1996, p.ix).

Ozechowski and Liddle (2000) identified 16 controlled trials and four therapy process studies which examined the efficacy of family-based therapy in treating adolescent substance use problems. They concluded that there is a solid empirical base for the efficacy of these interventions in ameliorating drug abuse, externalising and internalising behavioural problems, and symptoms of psychiatric co-morbidity among drug-abusing adolescents. Furthermore, empirical support was identified for hypothesised mechanisms of change within these therapies, including improved family functioning, involvement in school, and reductions in peer-associated delinquent behaviour.

Williams and Chang (2000) conducted a comprehensive review of adolescent substance abuse treatment outcome in order to update the review completed by Catalano and colleagues in 1990. They located 53 studies (compared to 13 studies in the review by Catalano et al.), eight multi-program, multi-site studies and 45 single-program studies. Of the outpatient treatment studies located, family therapy was deemed superior to other outpatient treatments. This form of treatment was more effective than other forms of non-family outpatient treatment such as individual counselling, adolescent group therapy, family drug education and meetings with probation officers. They acknowledged the superiority of family therapy in adolescent substance abuse treatment and recommended that family therapy should be a component of treatment for this population.

Deas and Thomas (2001) limited the family-based intervention component of their review of the adolescent substance abuse treatment literature to controlled trials which compared a family therapy intervention to another modality of treatment. The authors located four such studies (Friedman et al., 1989; Henggeler et al., 1991; Joanning et al., 1992; Lewis et al., 1990) and concluded that family-based therapies were, for the most part, effective for the treatment of adolescent substance abuse disorders. However, many of the reviewed studies failed to utilise validated measures of substance abuse outcome, frequently relying on adolescent self-reports of substance use.

Liddle (2004) conducted the most recent review of this literature, with a specific focus on the developmental status of the family-based adolescent substance abuse treatment area by identifying and discussing research and clinical advances. Liddle (2004) concluded that a significant strength of family-based treatment approaches is the development of detailed therapy, training/supervision, and adherence manuals. Furthermore, this review supported others of this kind in identifying that engagement and retention rates for family-based treatments are superior to standard treatment engagement/retention methods. Also, in clinical trials in which they are compared with alternative interventions, in the majority of studies, family-based treatments produce superior and stable outcomes with significant decreases in target symptoms of alcohol and drug use, and related problems such as delinquency, school and family problems, and affiliation with substance-abusing peers. In addition, mechanisms of change studies support the theory basis of family-based treatments such that improvements in family interaction patterns coincide with decreases in core target substance misuse symptoms.

4.5.1 Summary

The empirical investigation of interventions to treat adolescent substance use is an emerging field which substantially lags behind the investigation of adult treatment options (e.g. Catalano et al., 1990; Deas & Thomas, 2001; Liddle, 2004; Liddle & Dakof, 1995; Williams & Chang, 2000), although the research base has advanced significantly in recent years. However, methodological limitations are frequent (e.g. small sample sizes, lack of post-treatment follow-up, poor follow-up rates, failure to include treatment drop-outs in the results, and lack of control groups) (Willams & Chang, 2001). Despite these issues, there is substantial empirical support for the efficacy of family-based interventions in the treatment of youth substance abuse. Moreover, family-based interventions have received the most attention in the empirical research of all the treatment modalities for youth substance abuse (Deas & Thomas, 2001; Weinberg et al., 1998; Williams & Chang, 2000). Several commentators have recognised family-based interventions as a core intervention modality (Crits-Christoph & Sequeland, 1996; Weinberg et al., 1998; Williams & Chang, 2000).

Key point

There is good evidence that a family-based approach to the treatment of a young person with substance misuse can be effective. This approach is an intensive intervention and requires considerable resources and time. Nonetheless, such approaches are well validated and have been associated with significant cost savings in families with complex and multiple problems.

4.6 Conclusions and recommendations

The review of the literature investigating support and treatment options for family members of young people with substance abuse problems has identified a number of issues.

First, empirical support for specific intervention options for family members of a young person with problematic substance use is limited.

Secondly, the substance abuse treatment literature distinguishes *adult* and *adolescent* substance abusers, but there appears to be limited targeted consideration for *young adults* (those aged 18–25 years). In terms of recommending support options for family members, this distinction is important because there is potentially a difference between the needs of a parent of a 14-year-old adolescent and a 25-year-old young adult.

Thirdly, there are three levels of support options available to family members. First, family members can be supported directly to improve their psychological functioning and wellbeing. Alternatively, support for family members can be provided indirectly via change in a young person's substance use, facilitated by engagement and retention in treatment. This change can be facilitated by modifying the family system, using family systems theory and cognitive behavioural treatment principles. In an extension of this approach, change in a young person's substance use behaviours can also be effected by modifying the broader social context in which the young person functions. Consequently, the appropriateness of a particular support or intervention option is best evaluated by considering the specific needs of the family members concerned and the young person.

Factors requiring consideration are:

- the age of the young person
- the chronicity of the young person's substance misuse
- the nature of the family member's distress and psychological functioning
- the current level of engagement or contact between family members and the young person, and
- the profile of risk and resilience factors within the family's ecological context.

The needs of the family member and young person should then be analysed in comparison to the intensity of the support interventions available. Figure 4.1 displays the notion that support and intervention options for family members concerned about their young person's substance misuse problem exist on a continuum defined by the intensity of the support.

Some general guidelines about the appropriateness of these options to address the needs of family members follow.

4.6.1 Self-help publications

Whilst this form of support was not formally reviewed, self-help books and resources may be helpful to those family members *concerned* about a young person's substance use (i.e. for family members of young people initiating or experimenting with substances). This information may educate concerned family members on issues such as the effects of substance misuse and may offer some suggestions to minimise the likelihood of problematic substance abuse emerging and/or strategies to intervene.

4.6.2 Support groups

The applicability of participation in a support group to buffer the effects of a young person's substance abuse provides another opportunity to enhance family members' coping with a young person's problematic substance misuse. A search of the literature on this option failed to locate empirical evaluations of the effectiveness of this approach. However, Chapters 5 and 6 include the use of support groups in the provision of Australian alcohol and drug treatment services.

Support group participation may be particularly useful for those family members who are disengaged from the young person (either by location or family disengagement) in that the active ingredient of most other interventions with greater intensity is the family system.

Figure 4.1: Continuum of support options in response to intensity of needs displayed by the family

Minimal support	Moderate	High
Self-help publications	Targeted support interventions	Family-based/multi-systemic interventions

4.6.3 Individual mental health intervention

Family members of a young person with problematic substance misuse may experience significant mental health-related issues, such as a psychiatric disorder or a substance abuse problem. For some family members, the aetiology of these symptoms may relate to the young person's substance misuse problem and, for others, it may indicate functional difficulties distinct from this distress. Specific mental treatment may be implied for the latter group of family members. This form of support could be provided by independent consultation with a counsellor, social worker, psychologist, general practitioner or other appropriate health practitioner. Alternatively, the BEST program includes this intervention as an option in its program structure.

4.6.4 Targeted support interventions for family members

This level of support refers to the two specific programs identified in the literature directly supporting the needs of family members with a young person with problematic substance abuse (BEST; and parent coping skills training). These programs share more similarities than they do differences in that both include components directly addressing the wellbeing of family members themselves, followed by strategies to modify the family member's relationship with the young person, which may potentially modify the young person's substance abuse or engagement with treatment services. The Parent Coping Skills Training program of McGillicuddy and colleagues (2001) was evaluated on *parents* with no mental health issues or recent substance abuse. Therefore, it seems most applicable to relatively high-functioning parents who are actively involved in the parenting of a young person. Consequently, this may imply that it is most suited to parents of young people from early to late adolescence.

Alternatively, the BEST program seems appropriate for family members who may present with functional difficulties in addition to those presented by the young person, as it includes the previously identified option of personal issues counselling and support. Furthermore, the BEST program advocates for small changes in the interaction between family members and the identified young person and, as such, the skills utilised to facilitate these interactional changes may be implemented without regular or immediate contact with the young person. However, presumably such contact would have a significant impact on positive treatment outcome.

The CRAFT intervention can be identified under the heading of skills training programs because of its initial treatment components which aim to enhance the coping and wellbeing of family members. Although the primary objective of the program is to engage the young person in treatment, the preliminary finding of the impact of this program on parental mental health is important independent of the young person's engagement.

The brief treatment package offered by Copello and colleagues (2000) is considered a critical program for the support available to family members whose young person is engaged in problematic alcohol use. Although the intervention was not specifically designed to target young substance misusers, it appears that the program principles could be successfully transferred to support the family members of young alcohol misusers.

4.6.5 Family-based and multi-systemic or multi-dimensional family therapy interventions

These programs are the most intensive of the support interventions available to family members of a young person with problematic substance misuse and potentially the most distal in effecting change in family members' coping and wellbeing. This is because the focus of intervention is considerably more wide-ranging than the previous options in that both approaches facilitate change across ecological levels. Selection of these forms of intervention is most likely for family members of young people in early adolescence or for those young people whose family members hold the capacity to effect or facilitate change across ecological domains (e.g. family, neighbourhood, school, community). Conversely, they may not be suitable for family members of young adults.

Best practice principles for the support of family members of a young person with problematic substance misuse, as derived from the available literature, are summarised as follows:

- An analysis of the needs of family members based on risk and resilience factors should be completed to inform the selection of or referral to an appropriate support service.
- On the basis of the three levels of support services identified from this review (direct skills training or indirect support via family-based or multi-systemic approaches), programs should be theoretically framed to acknowledge the reciprocal relationship between family members' coping and wellbeing, the young person's substance misuse problem, and the wider ecological context.
- Programs should directly address the functioning of family members themselves (through reframing of the young person's substance misuse, education and coping skills training) and attempt to modify interactions between family members.

In conclusion, it is critical to highlight that the field of literature examining support options for family members of a young person with problematic substance abuse is emerging. The recommendations made in this publication are based on the evidence reported thus far and may be further informed by the literature specific to supporting family members of adult substance misusers. Secondly, another important consideration is the point of intervention. There is a distinct literature reporting the efficacy and effectiveness of prevention and early intervention programs for children at risk of later substance misuse. These options would provide the most efficient form of support to family members in their attempt to reduce the likelihood of substance misuse problems occurring. A review of this literature is, however, beyond the scope of this report.

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5. Current support services for families: an Australian snapshot

5.1 Introduction

Historically, services offered by Australian alcohol and drug treatment providers have focused primarily on the needs of the substance user, with little attention directed to the broader needs of family members in their own right. This situation parallels the limited research identified in Chapter 4. More recently, however, a number of self-help organisations, non-government agencies and government agencies have stepped in to fill the gap and services in this area have expanded. In addition, there are a number of telephone helplines and internet information sites for parents.

We begin this chapter with a brief overview of key telephone helplines and internet sites. We then report on the results of a telephone survey conducted with agencies across three States — New South Wales, Queensland and Western Australia — to gauge the nature and extent of service provision to family members. Secondly, we provide a description of a number of programs operating across treatment agencies that we have been alerted to through our survey and through other literature searches.

5.2 An overview of key helplines and associated internet sites

5.2.1 Alcohol and Drug Information Service

Information and support are offered through the Alcohol and Drug Information Service (ADIS). This is a 24-hour, 7-day-a-week telephone helpline that offers information, support, counselling and referral options to anyone affected by drug and alcohol issues, including parents and family members of problematic drug users. This service may be a first port of call for families seeking appropriate support options available in their particular State. ADIS also offers written resources to families, providing drug information and outlining strategies to use with a person who is taking a specific drug.

Alcohol and Drug Information Service

Australian Capital Territory:
(Alcohol and Drug Service Helpline)
02 6205 4545

New South Wales:
02 9361 8000
1800 422 599 (regional)

Northern Territory:
1800 131 350

Queensland:
07 3837 5989
1800 177 833 (regional)

South Australia:
08 8363 8618
1300 131 340 (regional)

Victoria:
1800 888 236

Western Australia:
08 9442 5000
1800 198 024 (regional)

Tasmania:
1800 811 994

5.2.2 Family Drug Support

A non-government agency, Family Drug Support (FDS), has been supporting families experiencing problematic drug use since 1997. In addition to self-help and support groups (see Stepping Stones to Success program at 5.4.4), the agency has a telephone helpline and a website with current information on illicit drugs and alcohol. The telephone helpline is available nationwide 24 hours a day, seven days a week, for families who may be experiencing a crisis situation and/or who are seeking coping strategies and information.

Their website offers a range of information about support groups, specific programs, links and a downloadable brochure with contact information for services in each State related to drug and alcohol use. FDS has also produced an information kit for parents titled *A Guide to Coping*, which can be purchased for $15 from the website. Contact details are listed below:

Family Drug Support

Website:
http://www.fds.org.au

Helpline:
1300 368 186

New South Wales:
1300 368 186

Queensland:
07 3252 1735

South Australia:
08 8384 4314
0401 732 129

5.2.3 State-based helplines and websites

In addition to the services above, a number of state-based helplines and internet sites provide information and support for young people with problematic substance use and their families.

5.2.3.1 Family Drug Help (Victoria)

In Victoria, Family Drug Helpline provides a 24-hour telephone helpline, in addition to support groups (25 groups state-wide), education programs (see Action for Recovery program in Table 5.4), a quarterly family newsletter, a website and a renegotiating family relationships resource kit for those families where problematic drug use has led to imprisonment of a family member.

Callers have the choice of speaking to a peer support volunteer from 9 am to 5 pm, Monday to Friday, or after hours to professional staff from Turning Point Directline, who work in partnership with Family Drug Help to provide a 24-hour service. Helplines are available for Spanish speakers on Tuesdays and Thursdays from 9 am to 9 pm and for Italian speakers on Mondays from 9 am to 5 pm.

The website provides information on services available to family members seeking support, including printable (pdf) versions of the Family Drug Help Coping Skills booklets, *Is someone you care about using drugs?* and *Why can't they just stop?* In addition to information about programs and support groups, the website offers sections on family stories, publications, events and links to family support sites as well as drug and alcohol information.

Family Drug Help

Website:
http://www.familydrughelp.sharc.org.au

Helplines:

Regional/after hours
1300 660 068

Italian-speaking helpline
1300 660 068

Spanish-speaking helpline
03 9573 1704

Melbourne callers only
03 9573 1780

SHARC Family Drug Help
(Program helpline)
03 9573 1770

SHARC Drug and Alcohol Family Support Service
03 9573 1754

5.2.3.2 Turning Point Alcohol and Drug Centre (Victoria)

Turning Point Alcohol and Drug Centre offers drug and alcohol online counselling for individuals with problematic drug use and for their family and friends. Information, support and referral are provided 24 hours a day, 7 days a week, by professionally qualified counsellors. Counselling is provided via text communication. The website also advertises the Directline telephone helpline (ADIS) for individuals and families seeking information, support or referral regarding drug and alcohol issues.

Turning Point Alcohol and Drug Centre

Website:
http://www.turningpoint.org.au/

Directline helpline:
1800 888 236 (ADIS)

Counselling online:
http://www.counsellingonline.org.au/en/

Other Victorian helplines

DrugInfo:
1300 858 584

Youth Substance Abuse Service:
03 9418 1920
1800 014 446 (regional)

5.2.3.3 Parent Drug Information Service (Western Australia)

In Western Australia, the Parent Drug Information Service (PDIS) provides a 24-hour confidential telephone support service for families by both professionally trained staff and trained parent volunteers who give support, information and referrals. PDIS is part of the Alcohol and Drug Information Service (ADIS). Information offered includes education about drugs and their effects, treatment options, strategies and family support options. Counselling focuses on the strengths of families and ongoing telephone support. Referrals may be made for treatment options as well as support for the drug court or Perth Children's Court, in addition to counselling.

Parent Drug Information Service

Telephone helpline:
08 9442 5050
1800 653 203 (Toll-free)

The PDIS *Information and Support Pack for Parents and Families* was specifically developed for parents and families of a person with problematic drug use. This resource can be downloaded from the PDIS webpage on the Drug and Alcohol Office (DAO) website: http://www.dao.health.wa.gov.au/AboutDAO/ClientServicesDevelopment/ParentDrugInformationServicePDIS/tabid/70/Default.aspx

5.2.3.4 Parentlink

Parentlink, based in the Australian Capital Territory, maintains a website offering information on teenagers and drug use, and links to relevant websites on raising teenagers as well as other resources for parents.

Website: http://www.parentlink.act.gov.au/parenting_guides/teens/teenagers_and_drugs

5.3 A snapshot of existing services: results of a telephone survey

In order to gauge the extent of support services for family members, a random sample of drug and alcohol treatment providers in three States (New South Wales, Queensland and Western Australia) were contacted in April 2007. Information was obtained from them about the nature of the services available for family members of young people with problematic substance use. Treatment providers included within this survey were selected from a national register of government and non-government services (Siggins Miller Consultants, 2005) with every third entry being contacted within each State. This procedure resulted in coverage of 168 treatment providers across the three States (see Table 5.1).

5.3.1 Method

The telephone survey asked treatment providers about the availability of support within their service for family members who have a young person with problematic substance use – *Does your agency have any services or programs that are available for families who have a young person who is misusing substances?* Responses were recorded and coded in a YES/NO format. Of those who answered YES, a series of questions were asked in order to determine the nature of the service provided.

5.3.2 Results

Of the total number of treatment providers surveyed across Australia (168), the vast majority (107, 64%) did not provide any direct service for family members. Respondents indicated that typically, when contacted by family members, they would listen to the family member's concerns and refer them on to parent support groups or other services and/or send out information on drug education and treatment options. When the data are analysed on a State-by-State basis, there appear to be proportionally fewer services offered in New South Wales compared to Queensland and Western Australia (see Table 5.2). The lowest levels of service provision were reported by treatment providers surveyed in New South Wales, with just over 1 in 4 treatment providers (27%) reporting the availability of programs or services for family members. This contrasted with the reported levels of direct service provision in Western Australia, where just over half of all treatment providers surveyed (59%) indicated availability of support for family members. Although this difference might be a confound arising from specific services contacted within the survey, it is also possible that these results reflect different models of practice and service delivery across the three States.

Table 5.1: Number and type of treatment providers surveyed in three States (NSW, Qld and WA)

	Government	NGO[1]	Total services contacted
New South Wales	56	25	81
Queensland	23	35	58
Western Australia	4	25	29
Total	**83**	**69**	**168**

Note: [1] Non-government organisation

Table 5.2: Provision of support services by treatment providers surveyed in three States (NSW, Qld and WA)

	No. of treatment providers contacted	Support provided	NO support
New South Wales	81	22 (27%)	59 (73%)
Queensland	58	22 (38%)	36 (62%)
Western Australia	29	17 (59%)	12 (41%)
Total	**168**	**61 (36%)**	**107 (64%)**

Treatment providers who reported service provision to family members were asked to provide more information on the type of support options provided within the service. Respondents reported three different, though not mutually exclusive modes of support. First, family members might be provided with a brief counselling intervention, usually one to two sessions which typically addressed the family member's need for information on substance use and treatment options. In Queensland and New South Wales this type of intervention was provided by just over one-quarter of all treatment providers who indicated the availability of support provisions for family members (27% and 27% respectively). In Western Australia this type of intervention was less common (12%).

Second, family members could access ongoing counselling which was not time-limited and was responsive to the individualised needs of the family. Here the focus was to assist the family cope with the young person's substance misuse. This type of support provision was more common in Western Australia and delivered by over half (10 out of 17; 59%) of treatment providers surveyed. In Queensland and New South Wales this type of support was provided less frequently by treatment providers with the corresponding figures being 14 per cent (3 out of 22) and 18 per cent (4 out of 22) respectively.

The third way in which treatment providers responded to the needs of family members was through the provision of group programs to address specific educative and coping needs of family members. In Queensland, 13 of the 22 treatment providers who indicated support services for family members provided group programs. The corresponding figure reported in New South Wales was 12 out of 22. In Western Australia, family members appeared to have only limited access to group programs with only 5 out of the 17 agencies surveyed indicating availability of this support option. Table 5.3 provides a summary of the types of support provisions for family members reported by treatment providers across the three states surveyed.

Key point

A telephone survey of providers across New South Wales, Queensland and Western Australia found that the vast majority (64%) did not provide any direct service for family members affected by the problematic substance use of a young person. Of those who did provide a family-focused service, three levels of support were identified across agencies: brief counselling; ongoing counselling; and access to specific programs or groups.

Table 5.3: Types of support services provided by surveyed treatment providers in three States (NSW, Qld and WA)

	No. providing support	Limited counselling	Ongoing counselling and support	Access to group programs
New South Wales	22	6 (27%)	4 (18%)	12 (55%)
Queensland	22	6 (27%)	3 (14%)	13 (59%)
Western Australia	17	2 (12%)	10 (59%)	5 (29%)
Total	**61**	**14 (23%)**	**17 (28%)**	**27 (44%)**

5.4 Group-based programs available within Australia

A number of programs operating across Australia are designed specifically to address the needs of family members with young people whose substance use is at problematic levels. These programs come from diverse sources and are underpinned by quite differing philosophies. Almost all subscribe to a harm minimisation philosophy in which the harms associated with substance use are acknowledged and parents are supported by helping them to understand that the struggle with substance abuse involves repeated attempts at treatment and relapse to use. While none of the programs supports the misuse of substances as a reasonable lifestyle choice for their young people, all endorse the importance of harm minimisation strategies that ensure that their young people are least affected by the consequences of substance use during active phases of use.

In the following section we provide a brief overview of a selection of these programs and some indication of both the extent to which the program is used, where it is used and, if possible, some indication of program effectiveness. The programs were located during the telephone survey and by a request sent out on the list server of the Alcohol and other Drugs Council of Australia (15 March 2007).

5.4.1 Behavioural exchange systems training (BEST) program

The BEST program is an eight-week structured parenting program designed to help parents to cope with youth substance abuse. The premise of the BEST program rests on two assumptions: that parents have their own needs that warrant support; and that improved emotional wellbeing and parenting capacities of parents may heighten the chances of helping the youth with their substance misuse problem (see Chapter 4).

Following the initial evaluation (see Toumbourou et al. (2001) and review in Chapter 4), the BEST program was disseminated widely in Victoria, funded by the Victorian Department of Human Services in 2000. Agencies received funding to deliver the service for specific regions, and Odyssey House Victoria delivered training over the first two years. Odyssey is currently successfully delivering this service in partnership with TaskForce, a not-for-profit community agency. Anecdotal evidence indicates that parents continue to benefit from participation in the BEST

program. The following parental endorsements documented by Odyssey House outline some significant outcomes that parents have linked to the BEST program.[1]

> Since involvement with this program I can talk with my child, and can cope better.
>
> I feel as if I have my life back, I feel more in control.
>
> The support from the group is a lifesaver, I don't feel so alone.
>
> My husband and I were attacking each other, constantly at each other's throats. Now we can talk and come to agreement about what to do.

However, concerns have been expressed with regard to levels of resources allocated through the dissemination, specifically to address the broader needs of families serviced by the BEST program.[2] For example, although there is adequate funding to deliver the BEST program itself, limited funding exists to employ additional staff to respond to the needs of the families independent of their engagement participation in the BEST program. Some families have been identified as benefiting from support from a pre-group intervention to facilitate their entry into the program. Other family members might benefit from the provision of additional support at the completion of the BEST program. The recruitment of families is acknowledged as being an extensive process and additional funding is required to initiate program engagement, particularly with those family members who may be disconnected from mainstream treatment providers.

5.4.2 Behaviour exchange systems training (BEST) Plus

The BEST Plus program adds to the BEST program by extending the parent education approach toward individualised family strategies that involve a greater range of family members, including siblings and the targeted substance user. The format involves approximately 12 sessions of individualised, structured work.

The program assists families to redevelop positive family environments that encourage responsible behaviour and recovery from drug and alcohol abuse. The BEST Plus program was recently modified to help families cope with other high-risk and disruptive behaviours in addition to drug and alcohol abuse. BEST Plus can now offer the benefits of its interventions to families who are struggling to manage a wider range of adolescent behavioural problems.

BEST Plus is currently being evaluated by the Centre for Adolescent Health at the Royal Children's Hospital in Melbourne to assess its effectiveness as a multi-family model for use within community settings. As part of this trial, the intervention is being piloted across various services in Victoria and in other Australian states.

BEST Plus is currently implemented by a number of treatment providers, including the REACH Foundation in Victoria and a consortium of three Melbourne schools which collaboratively run the program a few times each year. Queensland Health has recently bought a licence for BEST Plus and intends to deliver the program in Longreach and Roma in the near future.

1 Personal communication, Miranda Manning, Odyssey House Victoria, April 2007.

2 Personal communication, Miranda Manning, Odyssey House Victoria, September 2007.

5.4.3 Holyoake programs

The Holyoake model is based on a systemic approach that acknowledges the impact that substance use has, not only on the person with a drug problem, but also on the immediate and extended family. In keeping with this philosophy, Holyoake in Perth, Western Australia, has developed two treatment programs:

- Parent Services program, specifically designed to meet the needs of parents/carers of a young person with problematic substance use, and
- Relationships in Focus program, which addresses the needs of a broader range of family members including partners and siblings of the substance user.

Holyoake affiliates and sites across Australia have adapted the Holyoake model to various degrees to meet the particular needs of families in their communities. The Parent Services program (PSP) and the Relationships in Focus program are discussed in more detail below as well as adapted programs that use the PSP framework, such as the PAUSE and Parent Empowerment Group outlined below.

5.4.3.1 Parent Services program

The Parent Services program aims to provide support, education and coping skills to parents, grandparents or carers coping with the problematic substance use of a young person (youth or adult). The 12-session intervention provides education about drugs and their effects and the impact of substance use on families. Each session follows a prescribed format which includes: relaxation exercise; presentation of information; teaching practical skills and strategies; and the provision of group support from other parents.

A qualitative study by Brown (2003)[3] explored the impact of the Parent Services program on parental experience of carer burden, perceived coping and relationship satisfaction as it related to the problematic substance abuse of a young family member. Twenty parents who had voluntarily presented at Holyoake, seeking help for their son's/daughter's substance abuse behaviours, participated in this study. The mean age of the identified problematic substance user was 19 years (son) and 29 years (daughter). Data were collected from each parent at the completion of the program via a one-hour, semi-structured interview. Results of a thematic analysis indicated that, since the commencement of the program, parents had experienced significant and positive changes in their relationship with their son/daughter and reported positive changes in the way they coped with their child's substance use. All parents interviewed attributed the Holyoake intervention as the reason for the positive changes to their levels of carer burden, coping style and relationship dissatisfaction. In addition, parents reported reduction or cessation of their child's substance misuse concomitant with positive changes experienced by the parents.

Brown (2003) includes a number of quotes from participating parents who attest to benefits of the Parent Services program:

> I'm back to my old self, its fantastic!
>
> Oh, it's a 100% gorgeous, my son is back.
>
> We discuss, talk more.
>
> He's got a job, pays board...
>
> The anger and frustration seem to have gone.
>
> His brother says he is the best he has seen him.
>
> I'm much more honest, I let him know that I love him and that I am there for him but I am not responsible for him. (Brown, 2003, p.48)

3 For further information about this study, contact Dianne Brown: Di@holyoake.org.au

Unfortunately, the small sample size, lack of a control group and the use of retrospective data in this study do not allow these outcomes to be generalised outside the experimental study. Certainly results from this preliminary study indicate further research into the effectiveness of the Parent Services program is warranted. See box below for an outline of the Parent Services program.

The delivery of the Parent Services program across Holyoake services is contingent with the provision of appropriate levels of funding and some services. For example, Holyoake Tasmania has recently discontinued the delivery of the Parent Services program due to the cessation of funding. As a consequence, the needs of parents in Tasmania are currently being addressed by the Relationships in Focus program (see below), which is receiving ongoing funding. More parents than partners are reported to be currently attending the program and a high demand for the program means that it is run 16 times per year.

Parent Services program

The Parent Services program utilises a family systems model that offers families support, information and practical skills using the following content:

- information on the effects of alcohol/drugs and their impact on the family
- acquisition of practical skills and strategies to create positive change regarding problems experienced
- facilitating positive changes in the relationship between parents and their son/daughter and other family members.

Specific topics addressing these themes include:

- alcohol and drug information
- process of dependency
- process of change
- family dynamics
- communication boundaries
- self-responsibility
- focus
- grief
- letting go
- stress, coping and self-esteem.

5.4.3.2 Relationships in Focus program

The Relationships in Focus program is a 12-week program designed for spouses, partners, family members and friends of any person who is misusing alcohol and/or other drugs. The program provides information and strategies whilst aiming to strengthen awareness of the broader impact that substance misuse has on family members. The program is open-ended and flexible, which means family members can join in at any stage and attend as many or as few sessions as they wish. The structure of the sessions begins with a DVD addressing the session topic, followed by a coffee break and then a group discussion where people are given the opportunity to discuss their response to the video and their own situation.

Research conducted by Montgomery and colleagues (unpublished report, 2003) assessed the impact of the program on a sample of 62 family members who completed the Relationships in Focus program. Pre- and post-data were obtained to determine whether significant positive changes had occurred over time. Results showed program completion was associated with significant reductions in levels of participant stress as well as a large reduction in the number of problems experienced by the participant as a consequence of the family member's substance misuse. Participants also reported significant positive change in their level of physical health as well as improvements in the quality of their relationship with the relative identified with the substance abuse problem. Some of the participants also received additional one-to-one counselling over the duration of the intervention.

The Relationships in Focus program is delivered on a regular basis through Holyoake and Holyoake affiliates in Tasmania, Western Australia, New South Wales and Queensland (see box below for program content).

Relationships in Focus program

The Relationships in Focus program is based on family systems and cognitive-behavioural approaches and covers a range of topics including:

- the process of dependence
- stresses and strain
- family dynamics
- different coping styles and strategies
- creating change
- effective communication
- self-responsibility
- grief
- power of thoughts
- being in relationships, and
- managing an alcohol and/or drug crisis.

5.4.4 Stepping Stones to Success

Family Drug Support delivers the Stepping Stones to Success program for families who are supporting drug-dependent family members. It is a structured and experiential course that aims to provide a process for families to deal with substance misuse issues to facilitate strengthening relationships and enhancing the wellbeing of the whole family. Additional goals of the manualised program are:

- to provide a safe and trusting place for family members to share their story
- to improve confidence and competence in managing substance use issues
- to strengthen communication and problem management skills
- to provide drug education
- to develop self-awareness of areas that need improving.

The program has been in operation since 2000 and participants are required to commit 27 hours of their time by attending either nine weekly three-hour sessions or longer sessions over two weekends (see box below for the range of topics covered by the Stepping Stones to Success program).

According to the *Stepping Stones to Success Annual Report* issued by Family Drug Support (2007), in 2006–07 the program was delivered approximately 13 times each year across different locations – Sydney (4), Port Macquarie (1), Canberra (3), Adelaide (1), Geelong (2), Byron Bay (1) and Brisbane (1), with a total number of 139 participants. In the 2004 and 2005 financial years the respective total participant attendance numbers across all sites were 175 and 153.

Although no formal evaluation has yet been completed with regard to participant outcomes from the Stepping Stones program, a questionnaire (measuring eight domains including anger, boundaries, control, denial, family, self-esteem, trust) is administered both pre- and post-treatment to assess change over time. Data collected are used to provide feedback to participants and funding bodies, as well as for program improvement. A consumer satisfaction survey is also conducted. Plans are in place to conduct an independent formal evaluation at the end of 2007. This program is supported by the Australian Government's Strengthening Families Initiative through the Department of Family and Community Services and the Ian Potter Foundation.

Stepping Stones to Success

In keeping with the goals of the Stepping Stones program, topics covered by the program include:

- setting workable boundaries
- self-care with a focus on acknowledging and dealing with emotions such as denial, fear, guilt, shame, anger and grief
- coping strategies and skills such as relaxation techniques, seeking help and support, effective communication, and modifying thoughts
- education about drug issues such as harm minimisation, types of drugs, reasons why young people take drugs, dependence, adolescent use of drugs
- stages of change that also help to facilitate realistic expectations of treatment, i.e. that lapses can be a normal stage of recovery for the substance user.

5.4.5 Toughlove

Toughlove is a self-help program to assist parents to regain control when coping with problematic substance misuse by a young person (York, York & Wachtel, 1982). It was developed by Phyllis and David York in response to their daughter's own struggle with substance misuse. As implied in the name, the Toughlove program is based on the premise that strict discipline and clear limit-setting are required in order for children to regain control over their lives. According to the Toughlove program, parents must confront their child about the suspected drug and alcohol abuse and stipulate the behaviour they expect.

Toughlove recommends that parents require the child to stop using substances and seek treatment if needed. If a child refuses to comply, he or she is to be ejected from the home and sent to reside with other Toughlove families until they meet their own parents' stipulations. Children who refuse to live with another Toughlove family are considered out on their own until they agree to their parents' rules. Parents are supported in maintaining these strict behavioural limits through weekly attendance at a Toughlove support group.

An initial examination of Toughlove in the United States (Wayne, 1990) found that assertiveness training and community support were important factors in the Toughlove process and the program is promoted as providing parents with the opportunity to learn assertiveness within a supportive community. Further support was added to this notion in a later study (Klug, 2000), which used both quantitative and qualitative data to show that non-assertive mothers attending a Toughlove program for six months showed significant, albeit modest, gains in assertiveness and self-esteem but not in internality of locus of control. These gains were also significantly associated with improvements in adolescents' behaviour, although the data showed two periods of deterioration followed by improvements (Klug, 2000, p.9).

Toughlove support groups are run in most Australian States. Three States (Queensland, Victoria and South Australia) monitor the number of calls received and numbers who attend groups. In 2007 there were nearly 1000 enquiries and, of these, approximately 250 parents attended a support group (data provided by Toughlove, Queensland, August 2007). The Toughlove program has not been evaluated within an Australian context. See box below for an outline of the topics covered in the Toughlove program.

Toughlove program

The Toughlove program views parents modifying their own behaviour as the main impetus for creating positive change in their adolescents and, to facilitate this, the program provides 52 different topics of information for every week of the year, some of which include:

- education about drugs, e.g. types of drugs, how to recognise abuse, etc
- changing behaviours that support substance misuse
- setting limits and expectations
- navigating educational, legal and health systems
- how parents' behaviour affects kids and kids' behaviour affects parents
- the importance of the adolescent having a second family
- relaxation techniques
- how to communicate with teenagers
- how to enhance parenting skills.

5.4.6 Parents, Kids and Drugs (Qld)

The Parents, Kids and Drugs program was developed by Vanessa Winchester and colleagues in order to help parents become aware of options and strategies that may be useful in coping with a young person's substance use. A significant theme running through the program addressed the importance of parents caring for themselves and their families in addition to the young person using substances. Parents, Kids and Drugs offers five modules that run on a weekly basis for approximately two hours in the evenings. The program is available to parents or those in a parenting role who are concerned about substance use by their son or daughter.

Parents, Kids and Drugs (PKD) builds on the tenets of adolescent and substance abuse knowledge, introduces positive parenting responses/practices and teaches problem solving and skills development. The program slowly shifts parents from focusing on adolescent change to developing parenting change using motivational enhancement strategies. The program uses a process-based learning style to ensure all parents have the opportunity to identify and associate with the information, in order to empower participants and assist with increased applicability and acceptability. Behaviour change is achieved through education and skills enhancement, and aims to empower and skill parents in making change. This is achieved through providing accurate, relevant, evidence-based information, opportunities for parents to problem-solve, as well as an opportunity to practise some of the skills discussed. The goal is to improve parental self-efficacy and parenting confidence.

The program is currently being evaluated using standardised psychometrics to assess the impact of PKD on parents' alcohol and other drug knowledge, psychological well-being (depression, anxiety and stress), caregiver strain, parenting practices, self-efficacy and satisfaction, together with the impact of parental change on adolescent behaviour. Parents are followed-up 12 months after completion of the program to evaluate the longer-term impact of their participation in the program. See box opposite for an outline of the Parents, Kids and Drugs program.

A four-year implementation project was recently completed in Queensland. During the implementation period, 52 service providers engaged staff in training and delivery of PKD throughout Queensland, with approximately 600 families completing PKD. Data collection and collation are currently continuing; however, preliminary data are very encouraging. Preliminary analyses suggest that parenting practices have changed, and parental mental health has improved. Qualitative comments are encouraging and indicate that parents are finding that the chance to meet other parents in similar circumstances is both a validating and empowering experience. In the words of the parents:

> The best thing I got from this group – being with other parents in the same situation and being able to talk about what is really going on at home.
>
> Everyone tells you that you have to wait until they hit rock-bottom, but what do you do in the meantime? Thank God for these courses [PKD] that have taught me that there is something I can do, even if he [son] won't.

To be told I need to look after myself was something I hadn't really thought about. You never stop to look at how you are going; you just keep going because you have to. I think I might go on a holiday.

After every door is closed in your face, you start to believe that you are the cause for all their [child's] problems. But then in a group like this, you see all these normal parents and you think, maybe I didn't do this to them.

The facilitators really seemed to understand our situation and they didn't judge me or my daughter, they really helped me to look at me and what I was doing.

Parents, Kids and Drugs

The Parents, Kids and Drugs program incorporates cognitive–behavioural and solution-focused theories within a harm minimisation framework. Topic areas covered in the program include:

- accurate and realistic information about the different types of drugs, their associated effects, and the ways in which they are used by young people
- adolescent development and the impact of drug use/misuse on the psychosocial development of a young person
- process of change model and the process associated with changing habitual behaviours, and effective parenting practices at different stages
- an awareness of the changes in parenting roles as a young person approaches adulthood, and issues associated with managing this transition
- the importance of parents meeting their own needs — socially, emotionally and physically, and the needs of other family members.

Skills and strategies for addressing drug use in the family include:

- building relationships
- effective communication
- conflict resolution
- strategies for difficult situations
- overcoming personal blocks.

5.5 Programs for Indigenous families

5.5.1 Family Coping: Indigenous family treatment program

Centacare NT provides support for Indigenous families using the Family Coping model. This model is Indigenous-specific and recognises that families are a complex system of inter-dependent parts, each of which affects the other. Centacare NT's Family Coping program aims, through working in a holistic way, to reduce the harm on families experiencing substance-related harm. The program has three primary goals: (1) to support families affected by alcohol and other drug (AOD) issues to develop strategies to reduce the stress in their lives by exploring their strengths; (2) to equip family members in communities with strategies to keep safe and well in an environment that is often surrounded by AOD misuse; and (3) to assist people who work in AOD or similar fields to reduce their stress to be better able to respond to the needs of families using their services (recognising that in Aboriginal communities many of the front-line staff are dealing with substance misuse in their own families).

Initially family members may seek help on behalf of the person with a substance misuse problem. However, once they have an increased understanding of their own needs through focusing on themselves, they gain confidence and strength to cope differently. Centacare NT has worked to support and strengthen families in Indigenous communities at Nguiu, Katherine, Wadeye, Daly River, Tennant Creek and Pirlangimpi. For further information, see Centacare's website: http://www.centacare-nt.org.au/welcome.htm. See the box below for a description of processes and topics covered in the program.

Family Coping model run by Centacare NT

The Family Coping model aims to reduce harm by:

- using research and practitioners' own experiences to identify the needs of a family in the treatment of AOD stress-related issues
- educating families on the nature of alcohol and other drug dependency
- recognising that although both substance user and family members suffer from similar health, emotional and spiritual issues, the greater capacity for change is found with the family member
- identifying the level of stress caused as a result of the behaviour associated with AOD use
- identifying strategies to lower the family's stress to enable the adult member to be in a better position to make decisions for the family's safety
- recognising the difference between being responsible to family and community and not being responsible for feelings of others when setting boundaries within cultural frameworks
- identifying people who will support the person, and
- assisting families to problem-solve and develop action plans.

5.5.2 Yeaca Dhargo Family Project

The Yeaca Dhargo Family Project (YDFP) offers a range of programs aimed at enhancing the capacity of Aboriginal and Torres Strait Islander families in the outer northern suburbs of Brisbane to address drug and alcohol issues. Programs offered by YDFP are part of a holistic approach that is reflected in the aims of the project, which include a focus on culturally appropriate knowledge and referral to agencies to assist families, individuals and young people with substance use problems. The YDFP is part of the Kurbingui Youth Development Association Inc. which has been in operation in Zillmere, Brisbane, since 2001 and has implemented various programs aimed at training, employment and families. The YDFP receives referrals from both government and non-government agencies in addition to community and self-referrals.

One of the family programs facilitated by Yeaca Dhargo is the Indigenous Families, Young People, Drugs Education and Support program called 'Supporting Our Mob'. It has been adapted from the Parents, Kids and Drugs program to work with Aboriginal and Torres Strait Islander families. It specifically provides training and support to families with a young person or loved one who is experimenting with alcohol or other drugs. This five-week program is delivered once per week for approximately two hours in a group setting. Two Indigenous workers facilitate the program, and community elders as well as guest speakers are invited to attend.

The YDFP has been implemented since 2006 and is run to meet demand at an approximate rate of once per quarter. The program has not been formally evaluated. However, ongoing evaluation is conducted using an action research model where feedback from the clients and facilitators is used to constantly inform the program's development.

In keeping with the holistic concept of Indigenous health as well as the wider impact of problematic drug use on the family and community, YDFP also has the capacity to address issues related to drug misuse such as family violence, relationships, cultural identity, social skills and school non-attendance. Further community needs identified as a priority for the service to provide in the future include mental health, and in particular dual diagnosis. See the box below for a description of topics covered in the program.

Yeaca Dhargo Family Project

The content of the Supporting Our Mob program includes:

- drug education about types of drugs, signs of drug use and the effects of drugs
- young people and drugs, the spectrum of drug use and the cycle of change
- young people growing up with drugs, the changing role of parents, and the consequent effects.

5.6 Summary and conclusions

This section has examined a small number of programs that are delivered by Australian service providers to meet the needs of family members who have a young person with problematic substance misuse. A number of the programs outlined have experienced operational difficulties arising through funding problems which have affected their ability to adequately meet the needs of all family members requesting or needing service. Few of the programs outlined have been subjected to systematic evaluation to ascertain the effectiveness of these interventions for Australian families.

Further examples of programs operating across Australia to address the support needs of family members affected by the problematic substance use of a young person are outlined in Table 5.4. This list is not considered to be exhaustive but rather intended to provide an overview of the types of group programs offered to family members by Australian treatment providers. The majority of these programs have been developed to support family members and have not been formally evaluated and the operation of a number of them is hampered by access to sufficient funding and resources.

Based on the evidence presented in this chapter, several conclusions about current Australian service provisions for families affected by the problematic substance use of a young person can be made:

a. Results of a telephone survey suggest that the majority of family members who contact drug and alcohol treatment providers have difficulty accessing specific services or support to address the broader needs of the family members living with the problematic drug use of a young person. Of those providers who do provide a family-focused service, support provisions generally lie in three non-exclusive categories – brief counselling, ongoing counselling, and access to specific programs or group. There appears to be marked variation in the level and type of support provisions across the States surveyed.

b. Family members typically approach Australian treatment providers to seek assistance for a young problematic substance user, but do not seek help to address the impact of problematic substance use on the broader family system.

c. The type of advice or level of support accessed by family members is often dependent on the philosophy of the service provider. Although most of the Australian programs reviewed in this chapter are relatively consistent in their approach, some services provide an alternative way of managing youth substance misuse which might potentially create confusion as to what is best practice for parents.

d. Family-based services are seldom regarded as an integrated component of the treatment provider's response to a young person's substance misuse problems.

e. Not all Australian alcohol and drug treatment providers are adequately resourced to deliver interventions to family members when they request treatment.

f. Treatment providers overall report a limited capacity to evaluate the effectiveness of services and programs delivered to family members. Although the majority express a general belief that their programs are of value and are well received, there has been little systematic study of outcomes.

g. There appears to be little uptake by service providers of those programs that have received systematic evaluation within the research literature.

h. A number of gaps detected in the provision of services to family members include the delivery of services to siblings of substance users and the delivery of family-based services for those young people who are experiencing difficulties with dual diagnosis.

Table 5.4: Support programs in Australia for families of problematic substance users

Program	Format	Cost	Duration/frequency
Action for Recovery Course (ARC)	Closed group	$40	6 weekly sessions (2.5 hour) 8 programs per year
BEST	Closed group	Free	8 weekly sessions (2 hour)
BEST Plus	Closed group	Free	8 weekly sessions (2 hour)
Family and Friends Day	Open group	$50 per session	6 sessions (first Saturday of every month) 3 hour per session

Program content	Evaluation	Contact
Steps to change Boundaries and personal responsibility Positive communication strategies Drug education Creative arts therapy	Evaluation underway	Family Drug Help ph: 1300 660 068 email: arc@sharc.org.au
Drug education Family development through life cycle Adolescent tasks & healthy separation Parental needs & adolescent responsibilities Strategies for modifying parental practices in the family	Participation in the BEST intervention was associated with significant reductions in mental health problems and improvements in parental satisfaction and adoption of assertive parenting behaviours. (Toumbourou et al., 1997; 2001)	Odyssey @ Southern Youth Services ph: 03 9521 4366 Contact John Bamberg ph: 03 9345 6614
Based on BEST program and modified to help families cope with other high-risk and disruptive behaviours in addition to drug and alcohol abuse	Evaluations support the BEST Plus program as an effective forum for parents and siblings of youth drug users Future plans to conduct a randomised controlled trial	The Reach Foundation email: reception@reach.org.au http://www.reach.org.au Contact John Bamberg ph: 03 9345 6614
Understanding addictive behaviour Stages of change, and relapse prevention Exploring trust issues Dual diagnosis Focusing on the positives Self-care	No formal evaluation	Belmont Private Hospital, Brisbane, Queensland ph: 07 3398 0111

Program	Format	Cost	Duration/frequency
Family Assistance Drug Support program (FADS)	Individual families	Free	12 sessions
Family Matters SA	Support network for families of substance misusers	Free	n/a
Family Support Group	Open group	Free	10 weekly sessions (1.5 hour) Run 4 times per year
Frameworks for Change	Open group	$550	8 weekly sessions (2.5 hour) Run 4 times per year
Holyoake Programs			
Family Support Worker Project	Individual families	Free	Ongoing support to families in their homes once every 3 weeks
Parents Empowerment Group	Open group	Free	10-week program After-care support group available

Program content	Evaluation	Contact
Initial assessment conducted and then program individualised to meet each family's specific needs	No formal evaluation completed	Drug Arm Toowoomba, Warwick, Stanthorpe, Queensland ph: 07 4639 1313
24-hour support, counselling, drug and alcohol information, education and peer support groups	No formal evaluation	Adelaide, South Australia email: familymatters@steadfasthouse.com.au ph: 1800 607 947
Establish boundaries Development of skills to reduce burn-out and interpersonal conflict Create trusting relationships	No formal evaluation	Gold Coast Drug Council, Mirakai, Queensland ph: 07 5535 4302
Education, support and skills training, drug education, setting personal boundaries, partner/family stress and coping styles, effective communication, process of change, crisis management	No formal evaluation	South Pacific Private Hospital Curl Curl, New South Wales ph: 02 9905 3667
Drug education Setting boundaries	No formal evaluation	Wheatbelt Community Drug Service Team Northam, Western Australia ph: 08 9621 1055
Drug information, communication skills, self-esteem, impact of setting boundaries on family. Parents are encouraged to provide ongoing support to each other outside group	No formal evaluation	Northeast Metro Community Drug Service Team Midland, Western Australia ph: 08 9274 7055

Program	Format	Cost	Duration/frequency
Parents Services program *Also known as* Parents of Adolescent with Drug Use (PAUSE)	Open group Closed group	$480 (sliding scale applies)	12 weekly sessions (2.5 hour) 12 weekly sessions (2.5 hour)
Relationships in Focus	Open group		12 weekly sessions (2.5 hour)
Narcotics Anon	Open group	Free	Ongoing weekly meetings (1.5 hour)

Program content	Evaluation	Contact
Drug education Practical parenting strategies	Qualitative study (Brown, 2003) found program participation associated with changes in parent's wellbeing with regard to levels of carer burden, coping style and relationship satisfaction with their son/daughter	Holyoake Perth, Western Australia ph: 08 9416 4444
Utilises same framework as PSP with some adaptation Information and skills based		Holyoake Sydney, New South Wales ph: 02 9904 2700 Holyoake Hunter, New South Wales ph: 02 4934 8537
Psycho education on addiction Coping strategies Creating change and self-responsibility Crisis management	Formal evaluation (Montgomery et al., 2003) found an overall improvement in levels of client emotional and physical wellbeing associated with program participation	Holyoake Inc. Tasmania, Hobart ph: 03 6224 1777 Holyoake, Spring Hill, Queensland ph: 07 3831 4094 Holyoake New South Wales Holyoake Western Australia
Uses the 12-step program Provides collective support and practical guidance in coping strategies for the family	No formal evaluation	Lane Cove, New South Wales ph: 02 9418 8728 Meetings are held in all States across Australia. Further details can be accessed on website: www.naranon.com.au

Program	Format	Cost	Duration/frequency
Parent Group	Open group	Free	Fortnightly meetings (2.5 hour)
Parent Support group	Closed group	Free	3 weekly sessions Option to continue into Parent Program (see below)
Parent Program	Closed group	Free	8 weekly sessions (includes 3 sessions of Parent Support group)
Grandparent program	Closed group	Free	8 weekly sessions
Parents and Friends group	Closed group	Free	8–10 sessions Run 3 times per year
Parents, Kids & Drugs	Closed group	Free	5 weekly sessions (2.5 hour) Run to demand approx 3-4 times per year

	Program content	Evaluation	Contact
	Peer support model wherein parents with more experience may offer help to those less experienced 1:1 counselling also available	No formal evaluation	Great Southern Community Drug Service Albany, Western Australia ph: 08 9842 8008 Palmerston Association Albany, Western Australia
	Drug information Parenting strategies Adolescent behaviour	No formal evaluation	North Metro Community Drug Service Team St John of God Hospital Subiaco, Western Australia ph: 08 9382 6724
	As above plus setting boundaries, examining belief systems, guilt, letting go and stress management	No formal evaluation	As above
	Similar to Parent Program plus inclusion of drug information, parenting strategies, support options	No formal evaluation	As above
	Drug education, setting boundaries and reinforcing parenting roles, effective communication, self-care, crisis management	No formal evaluation	Addiction Help Agency Cairns, Queensland ph: 07 4051 6262
	Drug information Parenting strategies Crisis management Self-care for parents Skills	Evaluation underway	Hot House, Indooroopilly Alcohol, Tobacco & Other Drug Service (ATODS) Brisbane, Queensland ph: 07 3878 3911 Bayside Health ATODS, Queensland

Program	Format	Cost	Duration/frequency
Parents Using Motivational Practices (PUMP)	Individual treatment for families	Free	1 day session Run to demand
Paving Ways Family Program	Closed group	Free	6 weekly sessions (2 hour) Run 4 times per year
Stepping Stones to Success	Closed group	Free	9 weekly sessions (3 hour) or 2 blocks over 2 weekends An average of 20 groups per year across Australia
Support & Education group for parents and family members	Closed group	Free	10 weeks Run 2/3 times per year
Toughlove	Open group	Fee for materials & small weekly fee	Weekly sessions Ongoing

Program content	Evaluation	Contact
Drug education and support, stages of change, motivational interviewing, referral to support groups	No formal evaluation	Adolescent Drug & Alcohol Withdrawal Service, Mater, Child & Youth Mental Health Service Brisbane, Queensland ph: 07 3840 8400
Understanding stages of change, fears, coping strategies, relaxation, preparing for crisis, responsibility, trust, letting go and self-esteem	No formal evaluation	Manly Drug Education and Counselling Manly, New South Wales ph: 02 9977 0711
Structured and experiential to provide an opportunity for parents to manage drug issues in young people	No formal evaluation	Family Drug Support Leura, New South Wales Tony Trimingham (founder) ph: 1300 368 186 www.fds.org.au
Drug education, coping skills, crisis management, setting boundaries, referrals to other agencies	No formal evaluation	ATODS Toowoomba, Queensland ph: 07 4616 6100
Parent support group, self-help information, focus on managing behaviour rather than dealing with emotions	Not evaluated within the Australian context	New South Wales ph: 1300 856 830 Queensland ph: 07 3354 2533 South Australia ph: 08 8449 2702 Victoria ph: 03 9513 7222 www.toughlove.org.au

Program	Format	Cost	Duration/frequency
Yeaca Dhargo Family Project 'Supporting Our Mob'	Open group	Free	5 weekly sessions (2 hour) Run 4 times per year

5.7 References

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Program content	Evaluation	Contact
Drug education, kids and drugs, kids growing up with drugs, communicating with young people experimenting with drugs, improving family relationships Input from elders	Research ongoing	Kurbingui Youth Development Association Inc. Yeaca Dhargo Family Programs Zillmere, Brisbane, Queensland ph: 07 3265 3260 email: ydfp@kurbingui.org.au www.kurbingui.org.au/YDFP.htm

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6. Intergenerational effects: the problems faced by kinship carers

6.1 Introduction

There is a growing awareness that family members – in particular, grandparents – play an important role in caring for children whose parents are affected by substance misuse. Young parents with problematic substance use sometimes find themselves unable to provide safe, nurturing and stable care as a consequence of their substance misuse or incarceration resulting from substance misuse.

It is important to keep an open mind on the appropriateness of grandparents raising the children of parents who are affected by substance misuse. While there are a number of reasons identified in this chapter to suggest that the outcomes of grandchildren will be positive when raised by their grandparents, an argument has been proposed that intergenerational problems may adversely affect outcomes for grandchildren. Grandparents who take on a primary caring role due to their own children's substance misuse may have their own set of problems, including substance misuse. We explore this issue in this chapter and make recommendations regarding future research and policy.

6.2 Estimating the number of children in the care of their grandparents

It is difficult to gain a precise estimation of the number of children living in the primary care of grandparents. The Family Characteristics Survey conducted by the Australian Bureau of Statistics in 2003 found there were approximately 22 500 grandparents caring full-time for their grandchildren in Australia, involving 31 100 children aged 0–17 years (Australian Bureau of Statistics, 2004). According to the Australian Institute of Health and Welfare (2005) the total number of children officially recognised by child protection agencies to be in kinship care was 8618. However, this figure does not recognise the large number of children who are informally placed with their grandparents.

6.3 The route into care

For a minority of grandparents, taking on the full-time care of their grandchildren as a consequence of parental substance misuse is a sudden and unexpected event. Pitcher (2002), for example, reported that nearly one-quarter of grandparents who became carers were shocked to discover that their children were having problems with substance misuse. However, for the majority of grandparents, knowledge of their own child's substance use was a key reason for an extended involvement in the caring role.

Kroll (2007) describes how escalating parental substance misuse places increasing responsibility on grandparents who step in to provide care. Initially this care may include providing food, buying the children essential items such as school uniforms and books, and taking the children home for periods of time. The care can often be a response to an emergency situation such as the parent's failure to pick up the child from school. In response to escalating parental drug use, grandparents begin to provide care for increasing periods of time. This can include providing full-time care on a short-term basis while the parent is in prison or homeless. Grandparents and other relatives may begin to take on a monitoring role when they suspect increasing substance misuse. Examples include the visit of a grandparent in the morning to ensure that the children have been sent to school or in the evening to ensure the grandchildren are fed. While some substance-misusing parents may find this supportive, it is frequently a source of tension and arguments in the extended family (Kroll, 2007).

A large proportion of grandparents raising grandchildren who take on full-time care on an ongoing basis do so informally without involvement of family courts or child protection agencies. Grandparents are often reluctant to involve legal services or child protection authorities believing that the consequence of such involvement might be detrimental to the children. Approaching a child protection agency creates the anxiety that they will be perceived to be in need of support because they are not coping and that this could lead to statutory involvement and removal of the child into foster care. It does not appear that such concerns are warranted, as current policies of welfare agencies in Australia generally aim to place children in need of out-of-home care with kinship carers, including grandparents. For example, kinship care placements are the first preference under Victoria's *Children Youth and Families Act 2005* (section 10(h)), and now comprise one-third of all placements in Victoria (http://www.office-for-children.vic.gov.au/placement-support/library/publications/placement/kinship_policy_review).

It has been argued that the placement of children with grandparents may not necessarily be in the best interest of the child when parental substance misuse is involved. Parental substance misuse can be seen as a long-term consequence of living in a dysfunctional family environment. It is possible, therefore, that intergenerational problems associated with the parent's own development of substance abuse may still be present when grandchildren are placed with grandparents (e.g., Bailey, Hill, Oesterle & Hawkins, 2006). This led Barnard (2003) to write: 'If some grandparents have shaped the parent's drug problem, is there a degree to which placing children in their care can compound the problem?'

In Barnard's study, a high proportion (58%) of parents who were misusing substances reported parental alcohol abuse in their family history. However, most of the informants also reported that their parents no longer engaged in the same level of drinking and that the home environment was more settled than when they were growing up. Increased maturity, wisdom and experience in raising children may have led to the grandparents being better equipped to provide the care to their grandchildren they were unable to provide to their own children. While it is possible to speculate on these issues, there is an urgent need to conduct research to clarify those factors distinguishing grandparent carers capable of providing safe, stable, nurturing care leading to positive developmental outcomes from those who cannot.

6.4 Issues faced by grandparents and other family members who become carers

Grandparents raising grandchildren face a variety of stressors that others at the same stage of life are not required to deal with. The presence of grandchildren often results in decreased contact with friends who have provided company and support. Many grandparents report that the increase in stress and decrease in social support are overwhelming. A number of the main issues confronting grandparents are discussed below. While the focus is on problems faced, it is important to emphasise that for many grandparents the new role may lead to a sense of satisfaction in being able to provide a stable, safe and loving environment for their grandchild(ren). Most grandparents would not relinquish the care of their grandchildren and find the grandchildren's presence in their life an immense source of satisfaction.

> As a grandparent of two children, a boy and a girl, and the mother of a drug user, my life is hard. Starting over, as it were, with another family at an age when most people are thinking of retirement to some people may seem crazy... but I would do it all again rather than see my grandchildren lost to us in an often uncaring organisation. The financial hardship, the doing without, all that takes second place when it comes to the love I feel, a love that is reciprocated... I am as proud as any parent whenever the children are recognised at school for some achievement... I may not see them grow into adulthood. But I know the seeds I have planted will help them become kind human beings and because of their mum's past will help them learn tolerance for those who are weaker and more vulnerable than they. (ADFAM, 2006, p.2)

Key point

Grandparents raising grandchildren experience multiple challenges as they attempt to provide stability of care for their grandchildren, often at the expense of their own quality of life. Yet, despite this, many also experience a sense of satisfaction and purpose associated with their ability to provide stable care and protection. Seeing grandchildren develop into healthy adolescents and young adults is an immense source of satisfaction.

6.4.1 Child emotional and behavioural problems

The primary caring role assumed by grandparents is often complicated by child behaviour that is difficult to manage. Emotional and behavioural problems are common in children who have experienced inconsistent care and a chaotic lifestyle that characterise the life of many substance-abusing and dependent young people. These emotional and behavioural problems are likely to manifest as internalising symptoms (e.g. depression, anxiety, difficulty sleeping and eating) and/or externalising symptoms, including emotion regulation and conduct problems (e.g. aggressive, non-compliant behaviour, delinquency), poor performance at school and difficulties initiating and maintaining friendships (Kaufman & Cicchetti, 1989; Luntz & Widom, 1994).

Key point

Children who have been exposed to parental substance misuse have frequently experienced a range of life events that make them vulnerable to developing emotional and behavioural difficulties, which can make the parenting role assumed by grandparents even more complicated and challenging.

The onset and development of emotional and behavioural problems in children imply a complex process as described by the developmental psychopathology model (Cicchetti & Toth, 1997). This model contends that child development outcomes are determined by the complex interaction between ontogenic (or personal) developmental, familial and environment factors, over time, and across social contexts. Implicit to this model are the concepts of equifinality, which refers to varied pathways resulting in similar outcomes, and multifinality, contending that a single factor may act differently within different systems of behaviour, to explain the diversity of outcomes experienced by children, regardless of the similarity of risks to which they were exposed (Cicchetti & Toth, 1997).

Children of substance-abusing parents may be exposed to a range of risk factors that increase the likelihood of negative developmental outcomes. Exposure to a specific risk factor does not lead inevitably to a specific outcome. However, studies have shown that the number of contextual risk factors to which a child is exposed is a significant predictor of negative developmental outcome than the particular type of risk factors (Mohr & Tulman; 2000; Pellegrini, 1990).

In the following section we present a brief review of the most widely cited risk factors associated with outcomes for children who have been exposed to parental substance misuse. This summary provides an insight into the types of parenting demands encountered by grandparents who assume parental responsibilities of their grandchildren.

6.4.2 Child maltreatment

The term 'child maltreatment' describes the use of physical, sexual or emotional forms of abuse, together with the neglect of basic life essentials. The association between substance abuse and child maltreatment is well documented. Co-occurring substance abuse and child maltreatment in parents are evidenced in both substance abuse treatment and child protective service settings (e.g. Dawe et al., 2007). Child maltreatment has been linked with clinical levels of internalising and externalising symptomatology in children, such as higher rates of depression and anxiety disorders, conduct disorder and delinquency, and post-traumatic stress disorders (Kaufman & Cicchetti, 1989; Luntz & Widom, 1994). Furthermore, abused and neglected children have been shown to be at increased risk of academic failure (Eckenrode, Laird & Doris, 1993; Shonk & Cicchetti, 2001).

6.4.3 Inconsistent parenting practices

The lifestyle of substance-abusing parents exposes children to several additional risk factors which, in turn, increases the likelihood of negative developmental outcomes. Many children grow up in single-parent households where the mother is often the primary care giver and households tend to be unstable, with multiple male father figures and other significant persons who transiently reside with the mother (Chance & Scannapieco, 2002). Children in these families may be exposed to inconsistent, negative and potentially punitive parenting practices which in themselves are a risk factor for child emotional and behavioural problems (Barlow, Parsons & Stewart-Brown, 2004). In addition, the chaotic lifestyle can result in frequent changes in homes, day care centres or schools, and carers.

6.4.4 Trauma exposure

Many adult substance abusers meet diagnostic criteria for post-traumatic stress disorder. The trauma may have predated the substance use problem and indeed played a major aetiological role in the development of the substance use problem, e.g. childhood sexual and/or physical abuse. However, the life experiences of substance abusers can involve higher rates of exposure to sexual and physical violence which, in turn, can result in post-traumatic stress in adults (Gutierres & Van Puymbroeck, 2006; Ouimette, Moos & Brown, 2003). Children raised in a family environment associated with violence and crime are often exposed to traumatic events of this nature. In particular, witnessing domestic violence, particularly violence that occurs over long periods of time at intense levels, can have a severe emotional impact on children. This appears to be even more profound if the children's mother is the victim of domestic violence.

6.4.5 Grief and loss

Children of substance-abusing parents may share with their grandparents the common experience of sadness and grief that is precipitated by the loss of the parent/s. This loss may be brought on by the equally traumatic experiences of the death of a parent due to substance abuse and/or the associated lifestyle risks, or the absence of a parent due to imprisonment.

6.4.6 In-utero exposure to drugs and alcohol

To this point, discussion of the origins of the emotional and behavioural problems that grandparents caring for the children of their substance-abusing children may display has focused on the factors that can arise during a child's development from birth. However, child development outcomes are influenced by in-utero exposure to drugs and/or alcohol consumed by a mother during pregnancy. The effects can range from severe (neurological damage and growth retardation) to minor (resulting in normal developmental outcomes). Infant and child long-term development depends not only on the prenatal exposure (type of drug, amount, length of time of use), but on factors related to the child's own biological vulnerability and environmental conditions (Manning & Hoyme, 2007). The effects of various illicit and prescription drugs on the unborn child have been examined in the research literature. However, the effects of excessive exposure to alcohol in utero on later child development have dominated the literature because of the relatively high incidence of this exposure (at least 1 per cent of live births) and the significant consequences for this exposure.

Prenatal exposure to alcohol produces a range of morphological and cognitive–behavioural outcomes in the child, commonly referred to as foetal alcohol spectrum disorders (FADS). The term 'spectrum' highlights that the effects of prenatal exposure to alcohol exist on a continuum. Children severely affected by the exposure display a pattern of altered growth and morphogenesis, called foetal alcohol syndrome (FAS). FAS is characterised by prenatal and post-natal growth retardation, craniofacial anomalies, and abnormal brain function reflected by cognitive deficits and developmental delays.

In contrast, children on the moderate end of the spectrum show only some of the above features (Sampson et al., 1997), once referred to as having foetal alcohol effects, but now described as having alcohol-related birth defects (ARBD) or alcohol-related neurodevelopmental disorder (ARND). Sampson and colleagues (1997) reported that the majority of children with substantial prenatal alcohol exposure (about three times as many children as those with FAS), however, show features of foetal alcohol effects.

The cognitive and behavioural deficits resulting from FADS are the most noticeable and potentially the most devastating. The intellectual functioning, as assessed by intelligence tests, of children with prenatal alcohol exposure is consistently found to be deficient. There is also increasing evidence that this exposure is associated with: information processing and attentional problems – in particular, inattentiveness; deficits in specific cognitive abilities such as language, visual perception, and memory; and difficulty in performing tasks with increased complexity. Children with prenatal alcohol exposure have also been found to exhibit significant deficits in daily functional skills or adaptive behaviour, with deficits in socialisation becoming pronounced during adolescence (Kodituwakku, 2007).

Key point

Children who have experienced parental substance misuse and associated family problems may display a range of emotional and behavioural problems when they enter the care of their grandparents. This places greater demands on their carers and underscores the importance of providing specific support services for grandparents who take on this role.

6.5 Support needs of grandparents and other kinship carers

The general principle that children should remain within their birth families wherever possible has strong legislative support in both the United Kingdom (Barnard, 2003) and Australia. Further, the importance of ensuring that kinship carers are provided with the same support and services available to foster carers has been emphasised at the policy level, e.g. Australian Foster Care Association (2005). However, there has been very little systematic research around the needs of grandparents and other family members who provide full-time care of grandchildren. Nonetheless, the literature review above and a limited number of reports (e.g. Farmer & Moyers, 2005) highlight the importance of providing a range of support options and services for kinship carers generally, with some indications that grandparents have quite specific needs. The financial support offered to grandparents in Australia differs across jurisdictions and depends largely on the legal status of the caring arrangement. While more money does not necessarily solve all problems, it is self-evident that adding financial strain to a situation where there are already significant, and perhaps enduring, intergenerational emotional difficulties will make matters worse. Financial support that is equitable with foster carers and not linked to the legal status of the care arrangement appears warranted. However, additional services are required to help carers to understand and manage the difficult behaviours of their grandchildren. In their report, Farmer and Moyers (2005) provide a comprehensive list of services that would have assisted the kin carers interviewed in their study (see box below).

Services required to help grandparents and other kin carers

(adapted from Farmer & Moyers, 2005)

- assistance with contact issues when there are high levels of conflict with parents or other relatives
- individual help or training to understand and manage children's behaviour
- respite care to provide a break for carers who are under strain or caring for particularly challenging children
- financial help for activities for the children, for school uniforms etc.
- access to groups for those who feel isolated in their role
- counselling for the kin carer, especially surrounding issues of loss, grief and feelings of guilt
- recognition that many older carers already have significant caring roles in relation to their own partner and/or parent.

6.6 Existing services for grandparents

A search of literature databases did not identify any published evaluations of support services for grandparents caring for their grandchildren. Clearly this is an area that requires further research attention. There are, however, a small number of ongoing support programs and one-off projects in operation across Australia specifically designed to meet the needs of grandparents raising grandchildren.

6.6.1 Time for Grandparents program

The Time for Grandparents program, developed by the Seniors Enquiry Line in Queensland, offers grandparents and their children the opportunity to attend a two-day residential program. Separate programs are run for grandparents and for the grandchildren. The aims of the Time for Grandparents program are to provide the grandparents with:

- the opportunity to spend some time on their own while their grandchildren are being cared for and entertained by the children's program
- an opportunity to meet other grandparents who are in similar circumstances
- suggestions for coping in the role
- information on financial entitlements from Centrecare and family law matters
- information on grandparent support organisations operating in Queensland.

Grandchildren are provided with:

- the opportunity to participate in an exciting and challenging program of activities they may otherwise enjoy
- the opportunity to meet other children who are being raised by grandparents and to learn that their situation is not unique.

6.6.2 Grandparents Parenting Grandchildren project

The Canberra Mothercraft Society released a report on grandparents parenting grandchildren in 2006. The report, *Grandparents Parenting Grandchildren because of Alcohol and Other Drugs* (Baldock & Pettit, 2006), was based on a project funded by the National Illicit Drug Strategy – Strengthening and Supporting Families Coping with Illicit Drug Use. This project aimed to increase the visibility of grandparents who were raising their grandchildren because of the effects of alcohol and other drugs in the children's family of origin. Specific aims of the project were to help families by providing information on appropriate referral and services that could meet the specific needs of these carers, to identify the needs and aspirations of grandparents and grandchildren in relation to family issues due to alcohol and other drugs, and to enhance current services for grandparents by raising awareness, increasing understanding and providing information.

6.6.3 The Mirabel Foundation

The Mirabel Foundation, based in Victoria, provides specialist family support for children (aged 0–17 years) and their kinship carers who have been affected by substance misuse. A booklet published by the Mirabel Foundation, *'When the Children Arrive...'* (Rowe & Patton, 2004), is a valuable resource for kinship carers of children whose parents are unable to provide a home due to parental illicit drug use. The booklet aims to provide information and support for kinship carers or to direct carers to where they can find appropriate information or support. It includes advice on a number of difficult topics such as how to talk to children who have lost a parent to drug overdose and whether it is advisable to take children to their parent's funeral. There is advice on visiting parents who are in prison and the age at which it is appropriate to talk to children about substance misuse. In addition, the booklet includes some basic information on managing behavioural problems such as grief, bedwetting and sleeping difficulties. Finally, there is information on the law relating to the care of children, Centrelink and family assistance and contact details of support agencies relevant to grandparents raising grandchildren.

Key point

A number of resources have been developed for grandparents raising grandchildren. To date, the impact of these resources on the developmental outcomes of the grandchildren has not been systematically investigated.

6.7 Conclusions and recommendations

A significant number of Australian grandparents assume parenting responsibilities because of their own children's (or young person's) problematic substance misuse. This sub-sample of the population of family members requiring support to cope with a young person's substance misuse needs attention because of their specific needs. Many of these family members are likely to have their own personal support needs related to the young person's substance misuse (as described in Chapters 2 and 3), together with the additional support required to manage the stress of parenting young children. The parenting of these children is also complicated by the emotional and behavioural problems they frequently display because of the life events they have experienced.

Presently, no empirical research has investigated the efficacy of support and treatment options for this select group of family members. However, within the Australian context, some programs have been implemented.

It is recommended that support interventions for grandparents 'parenting' their grandchildren should include:

- support provisions directed towards assisting grandparents to meet their own psychosocial needs, as identified previously for family members of young people with a substance misuse problem
- counselling or support for the issues identified in this chapter relating specifically to grief and loss which may exist for these family members, and
- parenting skills training to manage the emotional and behavioural problems of the children in their care.

It is further recommended that policy makers address structural inequities that currently limit eligibility for some grandparents to access financial assistance and support services. All grandparents raising grandchildren, irregardless of the legal status of the care arrangement, should receive the same financial support as foster carers.

6.8 References

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