Familiar Drugs

Working Inclusively
With
Families About Drugs

Draft Document

KFx

Introduction

Familiar Drugs was originally written in December 2000. It was written as a discussion paper while I was working at the Inclusion Unit at Release. The aim of this and other pieces of work was to develop new strategies and models of inclusive work.

Familiar Drugs had a limited circulation and was well received by peers in the field. Unfortunately, the Inclusion Project at Release came to an end, and so there was never an opportunity to take this work forwards.

As there is still a shortage of literature on models of working with families about drugs, this paper still seems relevant.

The Inclusion project at Release sought to develop high quality drug strategies that reduce drug misuse and drug related harm amongst young people. To do this, we sought to develop strategies and resources for those who have the most contact with young people considered to be at high risk of problematic drug use.

Typically, this work involves "professionals," those who have contact with young people in a paid capacity. Much of our work is, therefore, with housing providers, social workers, educators in teaching and youth work settings, and similar fields.

However, we consider, as do the Government, that families have a crucial role to play in effective drug strategies. We have prepared this paper in order support the development of high quality, inclusive work with families.

This paper is very much a 'work in progress.' We are seeking to build links with groups and individuals who are undertaking work with families, with the aim of identifying innovation, highlighting successes, and disseminating good practice.

We plan to return to this paper in the future and use examples of practice in the field to augment this paper.

Who this paper is for:

This paper is intended to be a resource for people with an involvement in drug strategy, and those involved in work with families. This is clearly a very broad potential audience, and intentionally so. The paper highlights the wide and diverse nature of families and their equally wide spectrum of engagement with drugs.

As such, the paper should be relevant and useful to a very wide range of disciplines, including drug specialists, health, education and social services. At a strategy and commissioning level, the paper can act as a guide to the wide and diverse range of possible interventions that need to be developed. The paper looks both at the heterogeneous nature of the target populations and the wide range of models of work that can be implemented.

Many non-drug related agencies will find the report relevant too. A core theme within the report is ensuring that drugs education and support is made available through channels other than traditional drug services. So there is much here for professionals that have contact with families outside of drug settings.

The report is also intended to be of practical value to agencies and individuals who work at the 'coal-face.' The paper looks at what could be done to work more effectively with families on a day-to-day basis, drawing on up-to-date research and good practice.

Kevin Flemen
December 2002

This paper was originally release via the Inclusion Project, Release.

Chapter 1:
Context: Families, the National Strategy and Drugs

> *Families are at the heart of our society. Most of us live in families and we value them because they provide love, support and care. They educate us, and they teach us right from wrong. Our future depends on their success in bringing up children.*[1]

The publication of the Government paper *Supporting Families* in 1998 represented an important acknowledgement of the crucial role that families play in the development of young people. Coupled with this was the acknowledgement that families could also want and need support in meeting the challenges of contemporary society. Following the publication of *Supporting Families* came a raft of initiatives to provide this support to families as outlined below.

Government Initiatives to Support the Family

National Family and Parenting Institute:

The Government proposed the establishment of the the National Family and Parenting Institute to run from April 2001, with £2m of Government funding for the first three years. The Institute would "*provide guidance and develop more and better parenting support*."

Sure Start Programme:

A £540m initiative "*to help children in their early years grow up with the skills they need to make the most of school.*" Sure Start is to be targeted at parents in greatest need, "*particularly those facing linked problems such as poor educational achievement, health or housing, or unemployment."*

Parentline:

The telephone helpline, *Parentline*, is to receive over £1m over three years to develop and expand its advice and support services to parents.

Parenting Orders:

In addition to supportive and educational opportunities, more coercive measures were introduced to address problems within families. Parenting orders were introduced in the Crime and Disorder Act 1998. The Home Office guidance on Parenting Orders describes them as follows:

> *The parenting order can consist of two elements. The first element imposes a requirement for the parent or guardian to attend counselling or guidance sessions where they will receive help and support in dealing with their child…*
> *…the second element, which is discretionary, is requirements on the parent or guardian to exercise control over their child's behaviour.*[1]

In the pilot areas, some 284 parenting orders were made between 30th September 1998 and 31st March 2000. The Order became available nationally from 1 June 2000.[1]

The increased prominence given to family strategy by the Government reflects a growing awareness internationally of the importance of risk factors and protective factors that can influence young people's drug use, and the need for integrated strategies to address these factors. *Communities that Care*, an American programme

[1] Supporting Families:HMSO:1998:p4

of community regeneration, has been built on ideas around risk and protective factors developed by Professors Hawkins and Catalano in Seattle.[2]

Communitites That Care (UK), a national charity set up in the UK in 1998, aims to support the development of the programme in the UK. Fourteen projects have been initiated at the time of writing.[3]

Much of the direction and scope of *Inclusion's* work draws on this and related work and would envisage the ideas and initiatives explored in this paper being located within an integrated programme of work such as *Communities that Care.*

Families – The Drugs Context

Just as families play an important role in the overall development of young people, families also have a substantial impact on the drug 'career' of young people. The relationship between family function and drug use has been examined in a number of studies and was highlighted by the Government's ten-year drug strategy *Tackling Drugs to Build a Better Britain*, which noted "*Whatever other influences affect young people, the role of parents throughout this process is crucial."*[4]

More recently, the Drug Prevention Advisory Service (DPAS) published *Taking The Message Home*, an evaluation that explores the issues surrounding the engagement of parents in drugs prevention activities.[5]

The report reinforced the assertions made in the Government ten-year strategy, saying:

> *The Government's drug strategy suggests parents play a crucial role in influencing young people's drug use: this view is supported by the international research evidence, reviewed as part of this report. The relationship between parent and child has an impact not only on a young person's first use, but also on problematic use in later life.*[6]

The DPAS paper, *Taking the Message Home* is a significant piece of work, and represents essential reading for anyone interested or developing drug-related work with families. The aim of this paper, rather than revisiting areas already covered by *Taking the Message Home*, is to explore how to build on the successes identified by that, and other reports.

Taking the Message Home highlights the difficulty of reaching certain family groups, especially those considered "at risk." It warns:

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[2] Hawkins, Catalano and Miller: Risk and Protective Factor0s for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention: Psychological Bulletin *112*: pp64-105.
[3] Communities that Care (UK): A new kind of prevention programme: CtC:1997
[4] Tackling Drugs to build a better Britain:HMSO:1998
[5] Taking the message home: involving parents in drugs prevention: Velleman, Mistral and Sanderling:HMSO:2000
[6] Taking the Message Home: Briefing 5: DPAS:HMSO:2000

> *Those setting up projects should be aware that the parents whose families may be most at risk of problem drug use may be, also, the hardest to access…*[7]

It is with this difficult issue – developing strategies for working with families that are **inclusive** that we now must seek to engage.

[7] *op cit*: p40

Chapter 2:
The Scope of Drugs Work with Families

2.1 Who is family drugs work for:

"Family work" frequently, either tacitly or explicitly, becomes transformed into "parent work." The key outcomes of such work with parents have been summarised as:

- To make parents feel they know more about drugs
- To reassure parents about the dangers of drugs
- To make them feel more confident about their general parenting skills
- To reduce the numbers of young people experimenting with drugs
- To reduce the numbers of young people harming themselves through drugs.[8]

Taking the Message Home defined 'parents' in the study as "*people taking care of children in a personal as opposed to a professional role*." [*op cit*: p8]

Clearly parents are highly important and strategies rightly prioritise parents. However, this may mean that other family members, who could be making significant contributions or have significant needs, are neglected or excluded from provision.

One of the first challenges, therefore, in developing family services is to ensure that they are accessible to all family members, not solely parents. Organisations such as the Family Rights Group use an extended definition of family that includes "*not just birth parents and siblings, but also the extended family and significant friends."* Table 1 illustrates the range of family members whose needs should be considered in the development of family drug provision.

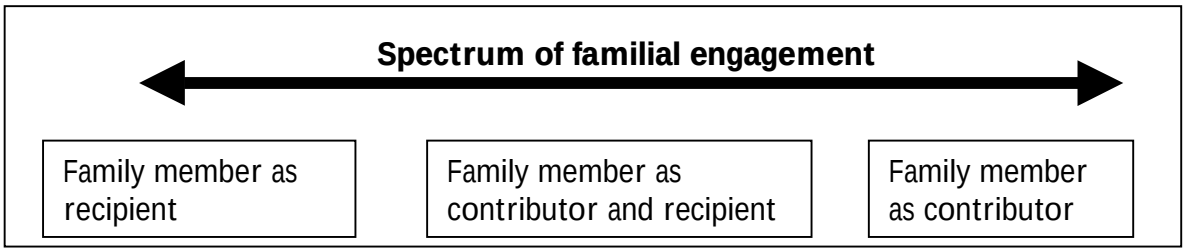
Table 1: **Who is "*Family Work" for*?**
• Mothers & Fathers • Step mothers & Step Fathers • Grandparents • Uncles and aunts • Foster carers • Younger & older siblings • Partners • Offspring • Significant friends

No single approach can succeed in reaching all family members, and so a number of approaches will need to be developed to respond to the needs of all family members. Some of these are explored below.

[8] Bridging the Gap: Shapiro, H: ISDD 1998

2.2 Family members: providers and receivers:

Just as families have a diverse membership, so too different family members will have different needs and different things to offer. Family work that solely views families as passive recipients of help may be failing to recognise the immense skills that families can bring to addressing drug use. Conversely work that views families as a conduit for information but fail to take on board the needs of family members in turn do these family members a disservice.



At one end of the above spectrum, family members are primarily recipients of a service; at the other end they may be primarily or exclusively providers of a service. Between these two poles is a range of positions within which family members may be both recipients and disseminators of advice information and support.

Family members as recipients:

Before starting to consider the role of families in educative, prevention or other settings, we should stress importance of and need for straight support services. Writers (Dorn *et al*: 1994, Higgins:1997) highlight the range of emotions that families, especially parents, experience on discovering the drug use of a family member. Higgins (1997) notes that "guilt, fear shame and anger were common responses on discovering their children's use."

Services therefore need to ensure that provision is in place that recognise and respond to the needs of family members themselves and do not solely view family members (typically parents) as a tool for drugs prevention (amongst children). Higgins stresses this point, saying "*most research is based on the assumption that parents are only a conduit for children…It does not take into account the individual needs of parents*." [9]

Example:
A father phones a telephone help-line. He needs support for himself as he is finding it hard to cope with his 23-year-old son's drug dependency.

Family members as recipients and contributors:

While recognising their need for support in their own right, this middle ground position also acknowledges the importance of family members as educators and supporters.

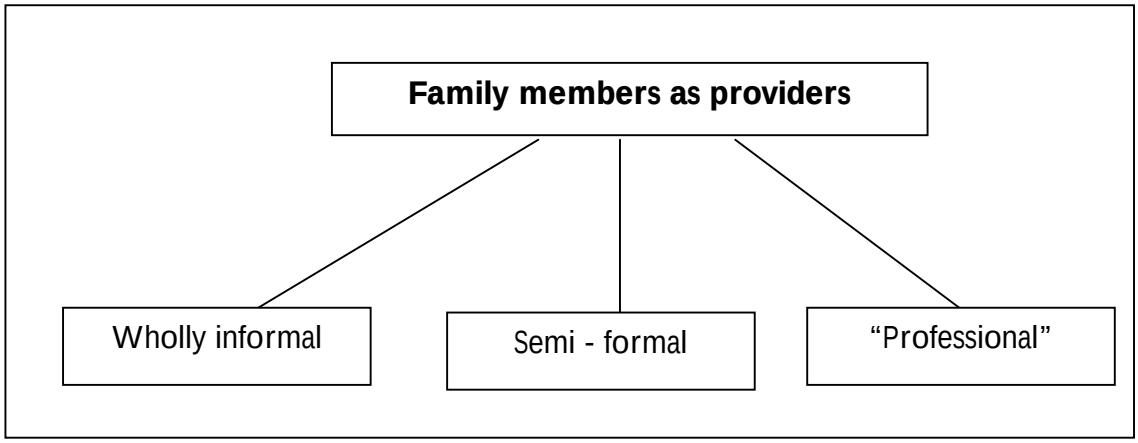
[9] Higgins: 1997: p6

Provision for this group needs to balance the needs of participants for support against the desire to equip them with the skills and knowledge to be effective educators and to make successful interventions.

Example:
A mother with twelve and fourteen year old sons is knows that the older son smokes cannabis. She is worried about this; she attends a drug workshop at a local school. She gets support and information that reduce her own worries; she also learns skills to talk to her younger soon about drugs.

Family members as providers:

The above considerations notwithstanding, the role of family members as providers of drug related interventions should also be noted. Broadly, this falls into three fields, as illustrated below:



Wholly informal:

Parents (or other family members) are seen as having a key role in educating their children about drugs. Through providing one-off or longer drug awareness and education sessions, parents can gain the skills, knowledge and confidence to work with their children about drugs.

Semi-formal:

Family members have a key role in delivering drug support or education, working in a voluntary capacity. This would typically follow a more extensive period of education and training. Family members may then in turn undertake peer-education, offer telephone support, one-to-one initiatives or deliver one-off drug education workshops.

Formal:

It is important not to lose sight of the fact that family members may also be professionals in their own right. In some cases, family-support initiatives that started

as informal or self-help groups make a transition to being funded, "professional" services. Elsewhere, it is likely to be the case that "concerned parents" are simultaneously "professionals," working in a variety of capacities, including working in education or drug settings.

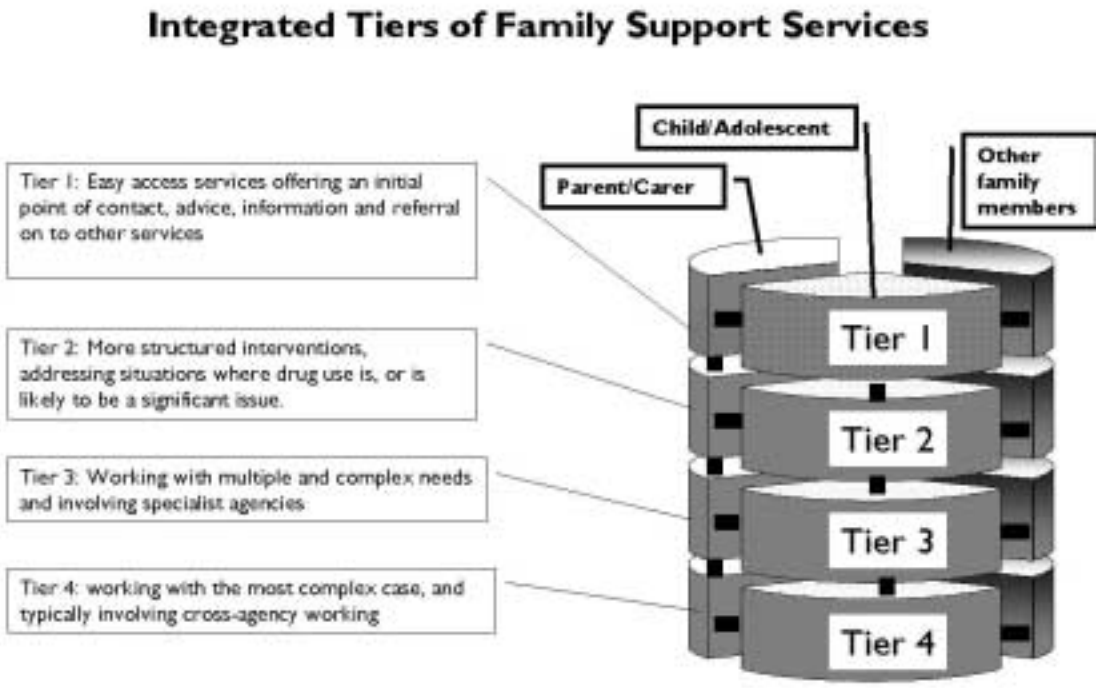
2.3 Tiers of Family Intervention – Matching Services to Need:

Drug-related initiatives have been extensively restructured to take account of the different needs of drug users. A tier-based approach was developed in the *Health Advisory Service*[10] report on substance misuse service for young people. Such a model has been extensively used and adapted in other setting, and can be usefully applied in the context of work with families.

This reflects a key recommendation of *Taking the Message Home*, which said:

> *We suggest that any local or national strategy attempting to involve parents in drug prevention should provide a balance between basic one-off awareness and information session, and longer, more intensive parenting focussed courses. A key strategic consideration is the gradient of risk.*[11]

The diagram below is intended to illustrate how a tier-based model of provision could be applied to family provision.



[10] Children and Young People – substance misuse services: Health Advisory Service: HMSO: 1996
[11] Velleman *et al: p42*

The above model builds on the tiers of provision envisaged by the *HAS* report, and envisages a model where this model is aligned to family drug education and prevention and to child protection processes as outlined by the Local Government Drugs Forum and SCODA in their guidelines for working with parents who misuse substances.[12]

Extensive consideration of child and adolescent services within the four tiers is provided by the *HAS* report. In the present context of whole family work, it is important to stress the need for, and the paucity of services aimed at children who are exposed to substance misuse within the family and the need to ensure that this is adequately addressed throughout child and adolescent services.

Similarly, the LGDF/SCODA guidelines offer an extensive commentary on the need to develop effective assessment and joint-working procedures to assess the needs of young people exposed to risk as a result of parental drug use. Reference to this document is essential for all professionals working with families experiencing problematic drug use.

When considering the provision of services for parents, carers and other family members, the application of tiers of services would be as follows:

Tier 1:
Tier 1 services are the most accessible and widely used services. In the context of work with families, these services would include many of the key tasks identified for Tier 1 services within the HAS report, but aimed at all family members rather than children and adolescents.
A key role for such services is to provide a first point of contact for family members who are concerned about drugs; where there is considered to be a low risk of drug-related harm, their role includes provision of information, advice and support in accessible and approachable environments. Where drug use is, or could be a more significant problem, Tier 1 agencies would make initial interventions, undertake brief interventions and refer on to more appropriate agencies. Tier 1 provision could include:

- One off drug awareness sessions
- Telephone help lines
- Work undertaken by police, social services, schools, GPs and other initial point s of contact.

Tier 2:
Where drug use within the family is already or is likely to be a more significant factor, more structured interventions may be required. Such services may be accessed directly, or via referral. Examples would include:

- Structured drugs awareness programmes
- Parenting skills courses
- Support groups
- Structured counselling provision.

[12] Drug Using Parents and their Children:LGDF/SCODA:1997

Tier 3:
Tier 3 services offer more specialised interventions. Such services would be needed where drug use is already a significant factor, or where there is a very high risk of drug related problems developing. Tier 3 services work with multiple and complex needs and frequently work across agencies. *HAS* Tier 3[13] identifies a number of interventions including

- individual counselling and psychotherapy,
- infectious disease advice,
- substitute prescribing and detoxification,
- family assessment and therapy.

Tier 4:
Working with the most complex cases, Tier 4 services are highly specialised and utilise intensive inter-agency cooperation. Where families required specialist interventions such as residential interventions for family members, removal of children into Local Authority Care or similarly complex situations.

[13] HAS:1996:p25

Chapter 3:
Models of family work:

There is a wide range of models of family provision, and these have been considered elsewhere (Shapiro, 1998; Velleman *et al* 2000.) Each has strengths and limitations, and different models will be more or less successful with family members. As such, it is desirable to ensure a range of models is available locally rather than placing reliance on any one model.

Examples:

3.1 Telephone helpline:

Telephone help lines are a much-used resource and can be highly useful as a tool for delivering support and advice. Some are run by well-resourced national charities; others are run by individuals out of home with little or no resources and, in a few circumstances, little or no training.

As such, the quality of help lines can vary dramatically. There may be a need to encourage providers of telephone advice services to join an organisation such as the Telephone Helpline Association.

Purchasers and service users should be able to ensure amongst other things that issues around confidentiality and record keeping are addressed, that providers have an understanding of child-protection issues, and that the providers have adequate levels of knowledge and the skills to provide a safe service.

Where resources allow, help lines can offer services outside office hours and some help lines do run 24 hours a day. Such services either require substantial resource commitments. It is important that, services are available at advertised times.

Help lines can either be publicised and operate on a national or a local level. Dorn *et al* make the following observation:

> *Other than the cost of long distance calls, there are no overwhelming reasons why emergency phone lines should not be national, but supportive phone networks would probably work best on a more local basis. Knowledge of the locality and proximity for visits where appropriate would be desirable.*[14]

It is important that help-lines, as with other services, are adequately publicised. Parents for Prevention in Birmingham looked in detail at parents' experiences of seeking help, and comments made by respondents shed important light on how helplines and other services may fail callers at a time of great stress and vulnerability.

- Only 6% of parents found it 'very easy' to find outside help; 43% found it 'quite difficult' and 30% found it 'very difficult.'
- The following observations were also made: 57% of callers got numbers from Yellow Pages but did not always get an appropriate agency on their first attempt;

[14] The Rise and Fall of Family Support Groups: Dorn, N, James, C & South, N:Druglink: Jan/Feb1998: pp8-10

- 22% had contact with up to 6 agencies before getting the help they wanted.
- 40% had seen leaflets/posters at some time but had not taken note of telephone numbers.[15]

In addition to the above points, help lines have the following advantages and disadvantages:

Advantages	Disadvantages
Accessible point of information at times of crisis	Less widely used outside of crisis; less useful as a tool for education or for pre-empting problems.
Phone lines can be used anonymously and so may be popular with people who feel unable to approach more 'public' services. This may make them more accessible to certain groups where presenting to a local service may not be possible, such as people in small communities or where drug use is stigmatised.	Telephone help lines require that those seeking help have access to a phone. This is not always the case, and reliance on public phone boxes is not always practical. There is a risk therefore that people on low incomes will have less access to such a service
Phone lines may be slightly less expensive to operate than other services; many phone help lines make use of trained volunteers. In addition, technology exists allowing calls to be automatically rerouted to an operative's home, reducing office or travel costs.	Unless phones utilise a freephone number, calls can become prohibitively expensive which again can reduce access to those on the lowest incomes. Most services will not phone back to mobiles; some mobiles cannot make free calls to freephone numbers.
Unlike other forms of provision, telephone helplines do not create additional transport costs or child care issues for family members and so may be more practical in some circumstances, especially where services are widely dispersed or where public transport is not widely available.	

3.2 Support Groups

AdFam produce a pack[16] on establishing and sustaining family support groups. This pack is essential reading for anyone interested in this area of work, and it would be redundant to revisit the pack here, save to highlights some salient points:
It is essential to ensure that a group is actually what is needed. This involves

- assessing local need,
- establishing aims and objectives,
- establishing an appropriate method,
- monitoring and evaluating the activities.

[15] The Needs of Parents: PFP: Birmingham: 1997
[16] Family Support Group Pack: Morgan, J: Adfam National: 1995

If it is established that support groups are considered to be an appropriate model, thought needs to be given to the type of group that is established, self help or support groups.

3.3 Self help groups and support groups:

Adfam distinguish between **self help groups**, which are "led by the members of the group themselves" and **support groups,** "which are led by a facilitator who is not a member of the group."[17]
The pack notes that there are advantages and limitations to both models. These are summarised below:

Advantages and disadvantages of models of Family Support Group[18]	
Advantages:	**Disadvantages**
Self help groups	
Empowering	Hearing about other people's drug problems can heighten anxiety
Members develop skills and abilities	Sharing negative experiences may make members more depressed and anxious.
Invaluable alternative for those nervous of "professionals	
Facilitator-led group	
Facilitator can maintain a more detached position, enabling group to work in a positive, constructive way.	Poor facilitation can deskill and disempower individuals and groups.
Facilitator can keep balance between sharing difficulties and dwelling on them too much	External facilitation may raise concerns around confidentiality.
Some people prefer there to be a designated group 'leader.'	
Leaves the group free from organisational and administrative concerns.	
Good facilitation can enable individuals to discover strengths, recognise and meet own needs.	
Facilitator can motivate the group through difficult times, and thus sustain it.	

3.5 One-to-one counselling

This is an important area, and one that warrants greater attention. Provision for family members often takes the forms outlined above: telephone helplines or support groups, or educational events of the sort considered below. However, family members may also want or need space to explore issues on an individual basis, face-to-face, and possibly over a number of sessions. Parents for Prevention (PfP) noted that:

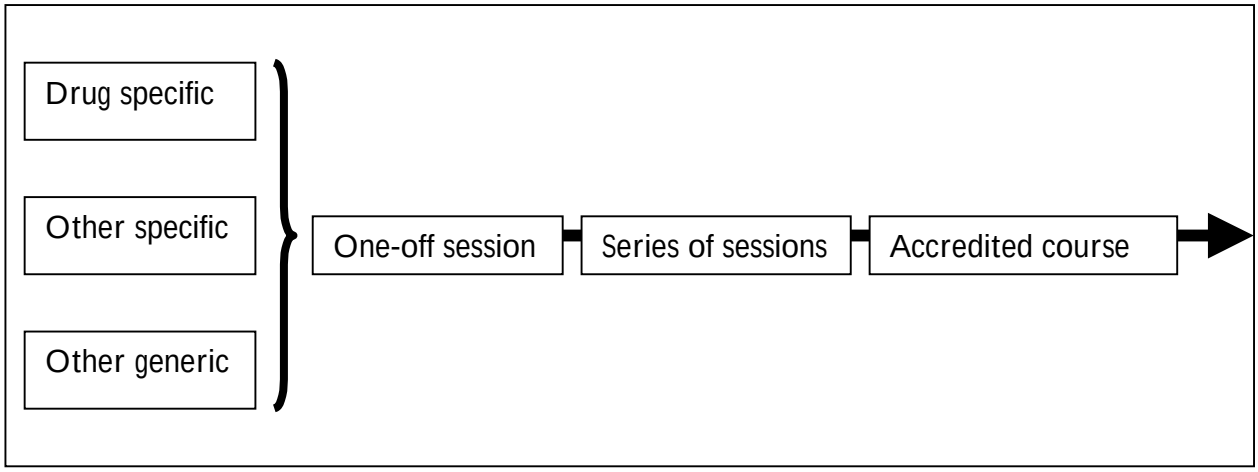
[17] Adfam: ibid: p11
[18] Adfam: ibid: p11-13

Most parents were eventually able to find support and reassurance over the telephone although this was limited (depending on the agency contacted) and did not fully meet the needs of those parents who wanted face to face contact.[19]

Such support may be offered as part of the existing provision of a local drug project or in other ways. For example, Parents for Prevention (Birmingham) offered "befriending support" to parents. This was delivered by the PfP co-ordinator and by trained volunteers. Other groups also offer one to one sessions, though these appear to be considerably less widespread than other initiatives. This is reflected in the literature which makes scarce reference to this area of work.

3.5 Education groups

Education sessions are a widely used vehicle for delivering drugs education to families. They can take a variety of forms, as illustrated below.



One-off events through to accredited courses:

One-off sessions are a popular delivery model. As mentioned in the consideration of family drug provision from a tiered approach, it is important to ensure that, in addition to Tier 1 level drug awareness sessions, there are also more structured education opportunities, especially for families at higher risk of drug related harm.

At the other end of the spectrum, some agencies put on longer structured courses that led to accreditation. Velleman *et al* note that the "*enormous sense of achievement"* engendered by successfully completing an accredited course needs to be offset against the fact that accreditation added to administrative demands and that "*the idea of accreditation could be initially off-putting…particularly with regards written work.*"[20]

[19] The needs of parents: Higgins, R: PfP: 1997
[20] Velleman et al: 2000: p24-25

Other specific and Generic courses:

For some people, references to 'drugs' in workshop titles or literature may be a reason for attending a session; for others it may be stigmatising or threatening. Some agencies therefore choose to locate drug awareness and education sessions within other, less "threatening" vehicles such as "*Coping with Teenagers*" courses. Other courses such as *Parenting Skills,* or workshops coping with truancy or offending were also perceived to be useful mechanisms for delivering drug information to parents.

3.6 Accessibility of sessions:

Whatever the actual format of sessions, it is important that they are accessible; the factors identified below may have an impact on the take-up of sessions.

Venues:

Access to venues represents an important issue. Access to a car, the cost of public transport and the safety and practicality of public transport may represent barriers to services, especially for people on low incomes and those in rural areas or areas with poor transport links.

Venues should be accessible by public transport. While it may seem obvious, ensuring that session times dovetail with transport provision is essential; not all participants have access to a car. Travel times routes and maps should be included with publicity. They should be designed in a way that makes them comprehensible by those unfamiliar with reading timetables or maps.

Where possible, it may be useful to have a small fund available to reimburse travel costs, so as to ensure people are not excluded by travel costs. Promotion of lift sharing schemes may be useful, though thought needs to be given to the safety and privacy of participants.

Wherever possible, they should be located in "neutral" territory. Some venues, such as schools or community centres on estates may discourage attendance from people from outside the area.

Home visits:

In some settings, and for some work such as on-going key work or support sessions, home visits may be welcomed by some, as being easier than attending drug projects, more discrete and easier to manage alongside other commitments such as child-care. However, some people also indicate that they would find such visits an unwelcome intrusion.

Childcare:

Parents and carers may find it difficult to attend sessions when they have child-care commitments. The provision of a crèche may help improve access to people with

such commitments. Parents have indicated in research that they dislike taking children to drug projects, and strategies suggested to address this include:

- home visits
- trained child care workers within projects
- sessions for parents with children only
- sessions within other arenas such as Family Health Centres.

Chapter 4
Strategies for Inclusion:

Interventions that educate or support families about drugs are clearly invaluable. Yet the available literature highlights, again and again, that such initiatives are not utilised by all family members, and tend to appeal to certain family and family members rather than others.

What follows is an exploration of possible strategies that may increase take-up and access amongst groups who may not, typically access family drug initiatives.

4.1 Whole-family strategies:

As discussed in earlier, "family" work often becomes "parent" work and in turn work with mothers or other women carers. While this aspect of work is clearly indispensable, we should not lose sight of other family members who could benefit from or contribute towards drug interventions.

Ensuring that organisation names are inclusive rather that exclusive:
Group names should encourage whole-family involvement rather than the participation of a narrow section. So organisation names that include "*family*" could prove more accessible than those that are titled "*parent*." Similarly, a group that has the word "*mother*" in the name will probably discourage the participation of fathers or other male carers.

4.2 Work with rural families:

Research evidence has repeatedly demonstrated that drug use is not exclusively an urban phenomenon but is also a concern, and indeed a growing concern, in rural communities.

Developing accessible and relevant responses with families in rural areas is an essential aspect of family drug provision, and one that brings with it some distinct challenges.

Henderson (1998) asserts that "*the principal distinguishing feature in undertaking drug prevention in rural areas is the marked reluctance to acknowledge drug misuse as a problem in rural areas.*"[21]

Allied to this obstacle, a number of other factors can inhibit work with rural communities.

Transport: lack of access to affordable, available public transport can make it difficult to attend meetings, drug education sessions or counselling sessions. While many people will have access to private transport, this is by no means universal. This

[21] Henderson, S: Drug Prevention in Rural Areas: HMSO: 1998

is especially pertinent for people who are unable to drive for health, alcohol or drug-related reasons or for those unable to afford private transport.

Solutions: It is important to ensure that the time and location of sessions maximises accessibility by public transport. Promotion of transport sharing arrangements or assisting with travel costs can also prove useful.

'Insiders' and 'Outsiders'

There is a tension between a clear desire for local services to be delivered by people who understand and have links with the local community. On the other hand, people encountering drug-related problems often wish to speak to people anonymously, and may find it hard to approach people they know personally, or are part of their local networks.

This tension creates a substantial challenge for providers of local services, and this is exacerbated by the difficulties of ensuring that workers in rural settings receive the support, supervision and back-up that is more readily available to workers in urban settings.

Solutions:

In *Drug Prevention in Rural Areas,* Henderson suggests locating drug prevention within a social and family context. She suggests that

> *This helps to overcome the fear of identification or stigma with having a drug problem, and capitalises on concerns more likely to be acknowledged such as: family problems, community safety, young people's alcohol consumption, and noisy or threatening public behaviour.*[22]

In addition, Henderson stresses the need for local involvement and ownership of strategies, including:

- Consulting with the "*widest possible number of local agencies and community organisations, not solely those with a drugs remit."*
- Ensuring the involvement of key "gate-keepers" who enjoy a good local reputation and can assist in getting results.
- Ensuring the involvement of local businesses and the local media.

The experience of the groups that fed in to *Drug Prevention in Rural Areas* highlighted the difficulties experienced by rural projects attempting to develop family drug projects, but als shows that it is possible to achieve positive outcomes.

4.3 Work with families from diverse ethnic groups:

Developing education and prevention strategies for families other than white western families is a substantial challenge, but one that must be addressed. Kamlesh Patel's paper *The Missing Drug Users*[23] should be required reading for all parties seeking to engage with the subject.

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[22] Henderson:*op cit:* p3

[23] The Missing Drug Users: Minority Ethnic Drug Users and their Children: Patel, K in *Substance Misuse and Child Care: op cit*

Key points that Patel makes in this paper include:

- Minority ethnic groups are not homogenous but hugely diverse. When considering the "Asian" community, for example, this covers some three different main religious groups, four generations, fifteen languages and several countries. Provision needs to recognise and respond to this diversity.
- Level of knowledge around exiting services is low.
- Research indicates that General Practitioners are an important point of contact for people encountering problems with drug use.
- There is a lack of staff within services who come from minority ethnic groups; this represents a barrier to services. Too often, where there are such staff, they lack sufficient support to work effectively.

Patel also crucially identifies the importance of drug awareness information to parents, in the context of working with South Asian families.

Patel makes a number of suggestions about how to take work forward; while these comments are made with regards Asian families, some of the points that he raises are also pertinent to other minority ethnic groups.

- There is a need for appropriate advice and information, particularly in respect of their own drug use (e.g. use of tranquillisers amongst South Asian parents.)
- Models of information delivery should take into account that not the entire target population can read or write in their mother tongue. The use of other media is suggested such as use of audiotapes, debates on Asian radio stations, and videotapes.
- Demographic profiling
- Planning and investing for the long-term,
- Developing local working partnerships, including important points of contacts such as General Practitioners. The importance of 'community leaders' is also noted, along with the caveat that they may be reluctant to acknowledge drug use is an issue within 'their' community.
- Outreach and community development strategy should be developed which work with the community rather than 'parachuting' workers in from outside.

4.3 Targeted work with fathers and other male carers:

At present, the bulk of this work aimed at parents place with mothers more than any other family members. For example, the single largest group of callers to the AdFam help line in 1997 was mothers, who made up 33% of all callers[24], while fathers made up only 6% of callers.

Similarly, Parents for Prevention, a Birmingham-based parent drugs initiative, recorded that 80% of their help-line callers were women (mothers, grandmothers, aunts and carers.)[25]

[24] AdFam National Newsletter: Summer 1998
[25] You Sow the Seeds of Hope…Mistral,W:1999

Different explanations have been offered by commentators for the lack of paternal involvement in drugs education, and it is a consistent trend identified both in the UK and internationally (e.g. Velleman, Mistral & Sanderling, 1999).

A volunteer worker at Parents for Prevention offered this explanation:

> *Because men…they don't like to admit it – that's what the wives say – they can't talk about it, they want to shut it out and go to work. But the mother react emotionally different…and women feel the guilt – they'll think somehow they've done something wrong.*[26]

But strategies for increasing the involvement of male carers in drugs work can and do work. Such strategies include:

- Undertaking drugs education settings in the workplace.
- Locating drugs education within more generic (and therefore less threatening) 'vehicles' such as general parenting sessions or non drug-specific work with fathers.
- Actively encouraging the participation of male carers through the literature and publicity material that is used and the places that events are promoted.

4.4 Provision for step-parents, single parents and divorced parents:

Family drugs provision needs to ensure that it is accessible to – and does not stigmatise, parents and carers coming from non-nuclear families. This consideration becomes increasingly important in the face of increasing social change. The National Strategy for Neighbourhood Renewal report on young people highlights these changes:

Changing Demographics in family structure
One in four children will have experienced parental divorce by the age of 16
40% of marriages are now likely to end in divorce
40% of marriages are now remarriages
20% of children live in loan parent families
1 in 12 children live in step-parent families

The National Stepfamily Association estimates that 18 million children and adults are involved in stepfamily relationships in the UK.
Given these figures, it is essential that family drugs work reaches birth parents and step-parents, and that it reaches both single parents and ex-spouses who still have contact with their offspring.

Strategies to achieve this could include:

- Ensuring that publicity and resource literature is accessible to and does not discriminate against parents and carers outside of nuclear families.

[26] ibid

- Ensuring that group facilitators and help line advisers are aware of and sensitive to lone, step and divorced parents.
- Ensuring that literature, workers and resources avoid adopting a culture of blame that suggests that family separation or being a single parent contributes to drug problems.
- Working in conjunction with marriage guidance services and lone-parent support groups to establish contact with lone parents, step parents and absent partners and encourage participation in drug related provision.

4.5 Parents and carers who are lesbians or gay men:

The existing literature does not suggest that there is a higher incidence of drug use or misuse amongst children who are brought up by carer(s) who are gay or lesbians. However, it is still important that such families have access to drugs awareness workshops, parenting skills courses *et cetera*. Given society's prevailing attitude to same-sex relationships – let alone same-sex parenting, there may be a reluctance on the part of lesbians and gay men who are parents or carers to attend generic workshops or classes. Strategies are needed to overcome this, which could include:

- Ensuring that workshop and seminar facilitators are trained to work effectively with issues around sexuality.
- Publicity for sessions through gay media and venues
- Locating such sessions with venues that are welcoming and safe for lesbians and gay men
- Public statements from groups and services that they actively challenge homophobia alongside other forms of discrimination.
- Development of literature and publicity that encourages participation of lesbians and gay men.

4.6 Fostering and Adoption:

At March 31st 1998, 53,700 children were looked after by local authorities. Of these children the majority, 35,200 were looked after in foster placements. Of these children and young people, a number will have entered the care system from families where substance misuse was a contributory issue. As such, these children may be at increased risk of problematic drug use themselves

Foster parents and carers and parents who adopt children should therefore also be considered a key group who should have access to support, resources and training so that they can make drug-related interventions.

- Some of this support could be offered via existing family education and support initiatives. Such initiative should strive to ensure, therefore that they are accessible and sensitive to the needs of fosterers or adoptive parents in the publicity material, literature and session content and facilitation that is used.
- More targeted provision exists, and should be expanded. This includes tailored in-house workshops for foster parents and adoptive parents in drugs and drug awareness, and access for such carers to support from bodies such as Social Services to offer guidance and assistance on tackling drug-related problems.

- This in turn means that local social services departments each need to ensure that the requisite level of skill is available to respond to the needs of foster parents and other carers.

4.7 Provision for both adult family members and child family members

Family support and assistance seems to work from the assumption that parents and carers need support or education as regards children and their drug use. This is of course an important aspect of this work, and needs to be addressed.

But frequently, young people are not the drug users in the family, but may be the family member who is exposed to drug use, is distressed by drug use and needs access to support, guidance and advice.

Child family members may be concerned by substance use on the part of primary carers or by other family members such as siblings.

It is difficult to gauge the extent of substance use within families, especially when we look beyond parental drug use and to drug use by siblings or other family members. Unless such use has come to the attention of statutory services, through the involvement of criminal justice or social service intervention, it is likely to go undetected and unrecorded. Where the nature and level of drug use within the family is such that the wellbeing of children could be affected, this would require interventions in line with guidelines from LGDF/SCODA[27] and in line with local Area Child Protection Committees.

Most children and adolescents are not exposed to high or chaotic levels of drug use within the family. But, using existing statistical sources, it is possible to start to gauge the proportion of young people exposed to some drug use within the family.

The British Crime Survey, which offers the most comprehensive examination and exploration of UK drug trends, does not currently assess family makeup in the survey. But looking at existing trends can give some indication of child exposure to substances within the family.

The table below looks at the proportion of respondents who had used in the past month, as recorded in the British Crime Survey, 1996.

	16-19	20-24	25-29	30-39
Males	23	24	13	6
Females	15	12	7	3
Anybody	19	18	10	5

The figures for usage in the last month are lower than figures returned for lifetime usage. However, in this setting they are more relevant. It gives some indication of

[27] Op Cit

the current extent of drug trends. It is important to stress that the bulk of this reported use relates to cannabis.

According to the Schools Health Education Unit over 60% of 14-15 year olds are "*fairly sure or certain*" that they know someone personally who uses drugs.[28] Again, it is important to note that a large proportion of these responses relate to cannabis use. Amongst 14-15 year old respondents, almost 80% of respondents who knew someone who takes drugs identified the drug in question as cannabis, compared to around 10% who knew someone who used heroin.

It is also important to note that this study does not ask respondents to identify who the user is; it may be friends, peers, siblings or an adult family member.

Given the lack of hard data on this area, it is difficult to make recommendations. However, some strategies, beyond the existing Child Protection guidelines, could include the following:

- Local or national surveys to gain an accurate picture of the nature and extent of drug use within families. This could be achieved through minor revision of existing research tools such as the SHEU questionnaire and the British Crime Survey.
- Local and National agencies are increasingly developing resources for children who have parents who use drugs and or alcohol. Lifeline and AdFam have developed such resources amongst others. Such resources should be made widely available, and similar resources available for young people concerned about sibling drug use.
- Identifying appropriate sources of information for young people who are concerned about drug use within the family; nationally, such agencies would include AdFam and Childline. In addition, local agencies working with families and young people should develop the capacity to work with young people encountering drug use within the family.

4.8 Active development of resources and services for Grandparents:

Grandparents can and should be able to play a pivotal role in drugs strategy. This has been amply demonstrated in research by Age Concern, cited in the Government consultation document "Supporting Families"

> *Most grandparents are already involved with the care of their grandchildren, A recent survey by Age Concern showed that 92% of grandparents have regular contact with their grandchildren. They are the most important source of day-care of children: 47% help look after their grandchildren.*[29]

The *Supporting Families* paper makes a number of commendable suggestions for ways of increasing the involvement of grandparents in aspects of family life, such as within

[28] Young People in 1997: Balding, J: SHEU:1998
[29] Supporting Families:HMSO:1999

schools, through Social Services where children need to be looked after by a local authority, and in housing and volunteering.

It would be appropriate to highlight drug use to this list. Grandparents who had the knowledge, skills and confidence to undertake drugs education with grandchildren would be a valuable resource.

Indeed, grandparents could prove more effective than parents in some situations. Even when parent-offspring communication is poor or non-existent, there is often still communication between grandparents and grandchildren. In such situations, grandparents would offer an indispensable role.

Supporting Families notes that "*where children have to be looked after by the local authority, a relative, especially a grandparent, may provide a very effective placement."*

This assertion should be as true when the child is using drugs as when they are not. But in order for this to happen, grandparents must have access to suitable training, support and resources.

Strategies to take this work forward could include:

- Ensuring that publicity material is accessible to grandparents. For example, information distributed through schools is less likely to reach grandparents.
- Ensuring that education or similar sessions take place in venues and at times that are accessible.
- Developing resources and literature that are accessible and relevant to grandparents.
- Developing strategies for workshops and training sessions in conjunction with local grandparents groups.
- Work with Social Services to enhance the role of grandparents as carers for looked after children.

4.9 'Child' age range:

When developing provision for parents and carers, it is essential to bear in mind that child age range is very wide. Currently much provision, especially structured provision, is quite narrow.

Much literature aimed at parents and carers is intended for people who have adolescent children. It assumes that parents want to be able to educate younger children about drugs, and deal with experimental drug use amongst teenagers.

There is of course a widespread need for such provision. However, there is also a need to recognise that many parents and carers have children in their twenties or thirties who use drugs, and those parents also need access to services, to support and to resources. Of 237 parents consulted for a report by *Parents for Preventio*n for

the Birmingham DAT, the age range of the "child" discussed by concerned parents was 10-42 years.[30]

AdFam recorded the following distribution of callers to their National Helpline between January and December 1997:

- 33% of calls concerned people under 18 using drugs
- 54% of calls concerned people aged 18-25 using drugs.[31]

When commissioning or developing family work it is important to ensure, therefore that:

- A balance is struck between education and prevention strategies for parents and carers of younger children, and provision for parents of older children and parents of adults.
- That agencies are clear that they work with parents of adolescents or work with parents who have children of all ages.
- That publicity material, publicity strategies, resources, literature and workers are appropriate and accessible to parents of children of all ages. For example, drugs education or support opportunities promoted via schools will have a low take-up rate amongst parents of post-school age children.

4.10 Spectrum of drug related-issues:

Just as a drug-using child may be young or old, so too there is a broad spectrum of drug related behaviour that parents and other family member may encounter. The table below is intended to illustrate the diverse range of drug use that family members maybe confronting, and needing support about.

- Not using
- Contemplating use/suspicions of use
- Using – recreational/infrequent
- Using – regular/non-problematic
- Using – regular/problematic
- Using – Chaotic
- Using – involved with services (criminal justice/treatment etc)
- Ex-user

The development of family drug initiatives needs to be able to work across this spectrum of drug use. As discussed elsewhere in this paper, such provision would reflect the tiers of provision identified by the Health Advisory Service and elsewhere.[32] While such tiered provision requires more resources, it ensures that the different needs of participants are effectively met.

[30] The Needs of Parents: Higgins,R: Parents for Prevention:1997
[31] AdFam National Newsletter: Summer 1998
[32] Children and Young People Substance Misuse Services: The Substance of young needs: Health Advisory Service: 1996

As with other aspects of family work, the need for publicising and recruiting family members to services needs to reflect the diverse nature of drug use that family members do encounter.

4.11 Family Members as a support for treatment:

Family members could play a pivotal role in supporting other family members who are engaged with treatment services. Typically, this does not happen to any great extent. In part this is because services, especially drug services operate from a position of confidentiality and so discourage disclosure of information, including information to family members.

What limited research there is available (e.g Toumbourou, 1994) suggests that there are significant benefits to involving parents or other family members in the treatment process, and that outcomes for some patients can be improved by such family involvement.

It would be of great benefit if this area of work were explored in greater detail in the UK.

Chapter 5:
Targeting families 'at risk.'

5.1 Risk and Protective factors

Over the past few years, research has increasingly demonstrated that some groups of young people are more likely than others to develop problematic drug use. A variety of risk factors have been identified as increasing the likelihood of problematic drug use. In turn, researchers have identified protective factors that reduce the likelihood of problematic drug use in later life. Some of the key variables are outlined in the table below:[33]

Risk Factors Related to Problematic Drug Use		
Environmental variables:	**Individual variables**	**Family Factors**
The law and societal norms	Physiological factors	Family attitudes to substance use or misuse
Extreme economic deprivation	Genetic Factors	Use of substances by parents
Neighbourhood disorganisation	Psychological Factors	Poor and inconsistent family management practices
Substance availability	Early and persistent behaviour problems	Family conflict
	Academic problems	
	Low commitment to school	
	Early peer rejection	
	Alienation	
	Association with peers who use drugs.	
	Early onset of drug or alcohol use	
Protective Factors		
Positive Temperament		
Intellectual Ability		
A supportive family environment		
A social support system that encourages personal effort		
A caring relationship with at least one adult		

The identification of risk factors should be useful in allowing resources to be targeted at those young people who are most at risk of developing problematic drug use.

[33] Adapted from HAS:1996: p28

Family drug strategies need to ensure therefore that they reach the families of young people who have exposure to multiple risk factors.

However, research indicates that it is the very parents and other family members of the most 'at risk' families who have the least engagement with family drug initiatives.

In his very useful overview of parental drug education and prevention *Bridging the Gap*, Harry Shapiro notes:

> *The literature indicates that the majority of those who actually attend programmes are often white middle class women whose children do not have a drug problem – the "worried well."*[34]

This point is reinforced by the DPAS paper, which observed:

> *Projects did work with those from deprived areas, yet workers were aware that in many instances they were unable to assess or meet the needs of the poorest, least educated more marginalised parents. Despite the efforts of project workers these parents did not attend school events and did not respond to discussion opportunities. While the research literature indicates that the children of these parents were at risk of later drug problems, accessing them would have required greater resources and a more specific focus.*[35]

What follows is an attempt to identify some of the barriers that restrict access to family drug initiatives and to start exploring strategies that could overcome those barriers.

5.2 Risk group: young people in families where drug use is present or where parents hold pro-drug attitudes:

A number of studies have looked at the significance of family drug behaviour. The key findings of this research are summarised below:

Parental and sibling alcoholism/use of illicit drugs increase risk of alcoholism, drug use initiation, drug abuse in children. *(Cotton, 1979; Goodwin 1985; Cloninger et al, 1985; Johnson et al, 1984; Kandel et al., 1978; McDermott, 1984)*
Drug salience in the household best predictor of children's expectations to use and actual use of alcohol, tobacco and marijuana. *(Ahmed et al, 1984)*
Parental modelling directly related to friend's use of drugs which in turn was related to adolescent subject's substance use. (Hansen et a, 1987)
Oldest brother and parents each had an independent effect on younger brother's use. Both drug modelling and drug advocacy by older brothers had independent effects and interacted with parental drug use to provide a risk/protective effect.

[34] Bridging the gap – engaging parents in drug education and prevention: Shapiro, H: ISDD: 1998
[35] Velleman, Mistral&Sanderling: Taking The message home:HMSO:2000

(Brook et al., 1988)
Perceived parent permissiveness toward drug, alcohol use more important than actual parent drug use in determining adolescent drug, alcohol use. *(McDermott, 1984; Hansen et al, 1987; Barnes&Welte, 1986; Jessor et al, 1980)*[36]

Recent research highlights the extent to which family substance misuse is a key factor in child protection cases. Research undertaken by workers in Bolton requested data from all Area Child Protection Committees (ACPCs) on the number of children on the child protection register or in the looked after system, where parental drug use was recognised as a contributory factor. They reported that:

> *Whilst expecting a limited response, those ACPCs that did return questionnaires were generally unable to provide the information requested. Those ACPCs who were able to provide the relevant information indicated that there was a link between parental drug misuse and issues of neglect and emotional abuse for the families that they were working with.*[37]

Implications:

Family drug behaviour would appear, therefore to have a significant impact on drug use amongst young people.

- Parental use is an important factor; this use ranges from heavy end, problematic, dependent or chaotic use through to controlled, recreational and infrequent use.
- Parental attitude to use is as significant, if not more significant than actual parental use.
- The attitudes or use of substances by other family members, notably older siblings, is an important factor.

Given the importance of family drug use on determining adolescent drug use, it is important that thought is given to reaching and working with parents who use drugs or who are tolerant of drug use.

Barriers and solutions:

In order to work successfully with parents who use drugs, strategies need to overcome the numerous and substantial barriers that can restrict uptake of drug education and prevention initiatives.

The barriers to service will of course vary from parent to parent, according to the nature and extent of the drug, and according to the nature and format of the drug-related initiatives available.

Parents as users:

For some parents, there may be a reluctance to acknowledge that there is a need to attend. White (1998) argued that "*many parents will have used drugs themselves and so,*

[36] cited in Hawkins, Catalano & Miller: Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention: Psychological Bulletin 112, No1, 64-105:1992

[37] Substance Misuse and Child Care: Harbin F & Murphy M (eds):Russell House Publishing: 2000

rather than ignoring the problem, they think that there isn't a problem."[38] This may be especially applicable to parents who who use drugs recreationally, and so perceive their drug use to be unproblematic.

Watson and Elliot (1999) looked at this issue from the perspective of parents who were used drugs was more problematic, and explored their engagement with services in relation to their drug use. They found that 40 out of the 52 drug-using parents that they interviewed were not in contact with any services in relation to their drug use.

Respondents identified the following factors as factors that delayed or prevented contact with services or that made them less open with workers.[39]

- Fears about children being taken into care
- Fears about anonymity and confidentiality
- Time constraints
- Workers' attitudes
- Wanting something other than methadone
- Rules and regulations
- Unnecessary intrusion into family life
- Workers' knowledge and skills
- Time between initial contact and first appointment
- Fears about developing a 'dual' habit.

Strategies:

As discussed previously, clear guidelines and procedures need to be established in line with the LGDF/SCODA guidelines to assess and intervene when parental or other drug use within the family creates child protection issues. But outside of these extreme situations, there is still a clear need to develop strategies to work with parents and carers whose use, though less serious, still creates potential risk for children and other family members.

Publicity:

The promotion of events in an "anti drug" context may discourage the participation of current or ex drug users. We would encourage the use of titles, names and images that would not deter attendance by people who themselves use or have used drugs.

Models:

It would be useful to explore which models of delivery are most effective for working with parents who are users. It seems likely that short presentations to large groups, though usefully anonymous, will be least useful in addressing the needs of attendees who themselves use drugs.

[38] White, K: Ostriches, owls and all points in between – Involving parents in drug education: Druglink: 1998

[39] Watson & Elliot: Salford University: 1999

It also seems likely that such large groups would be the least comfortable arenas for users to disclose or discuss their own use, especially if such disclosure would bring opprobrium from the rest of the group.

Facilitation:

The nature and skills of the facilitator will be an important factor in encouraging attendees to explore their own drug use and attitudes to drugs. Where the facilitator is an 'authority figure' – from the police or social services for example, then disclosure and discussion about attendees drug use is again less likely to be forthcoming. This is not to say that such providers should not facilitate groups; rather that thought should be given to the development of additional provision that would encourage the participation of current drug users and ex users.

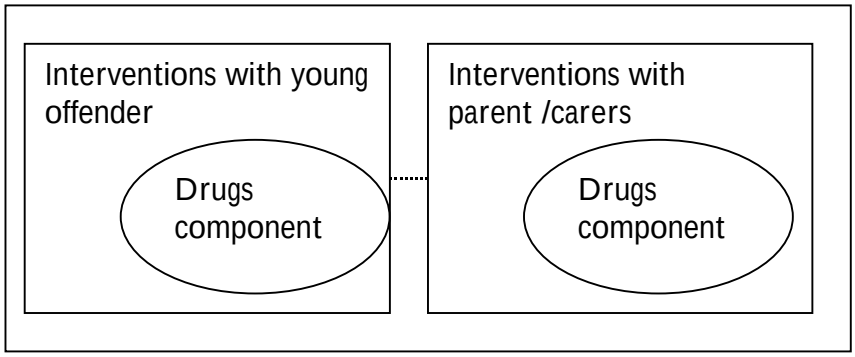
5.2 Other "at risk" groups:

The following groups of young people are also considered to be 'at risk' of problematic drug use:

- Young people who are homeless or vulnerably housed
- Young people in care and care leavers
- Young people who are excluded from school or truanting
- Young offenders
- Young people with mental health problems.

Provision for both young people and, where possible their families, would therefore reach groups encountering multiple risk factors.

An example of this is illustrated below, using the example of work with youth offending, which would equally applicable where a parent was the subject of a Parenting Order.



Parents and carers seeking to address offending behaviour may well also be encountering drug use. If they are not at present, there is an increased risk that they will do so at a later date. By ensuring that offending-related provision also has a drugs component, it is possible to address both areas of concern within the one provision.

Such a model could similarly be applied to other 'high risk' groups such as groups working with parents, carers or families of young people with Mental Health problems.

Schools, school excludees and truants:

Young people who are excluded from school or who truant are considered to be a key 'high risk' group. It is therefore especially important to ensure that they – and in turn their parents or carers can access drug-related advice, information and prevention strategies. In turn, this group may be especially 'hard-to-reach' with these strategies.

The publicity and delivery of drug education sessions is frequently undertaken via school. Letters for example may be sent from school and sessions may be held within school settings, outside of school hours.

This approach has both strengths and limitations. Its greatest strength is that it is an approach that reaches school-age children. However it does have some limitations.

Such an approach cannot reach the parents of school-age children who are excluded or self-excluding from school. Additional measures, such as ensuring that events are organised for and literature is disseminated via pupil-referral units would be required to ensure that these families were reached.

Parents and carers who themselves did not enjoy school, or were excluded from school may in turn be less enthusiastic about attending school-based drugs sessions, as they may not feel comfortable in such settings. The use of non-education settings may be more appealing.

Parents and carers of young people perceived to be 'troublemakers' at school may be reluctant to attend school based sessions for fear of being scapegoated by other parents. Again, the choice of venue and the skills of the facilitator will be important factors here.

Conclusion:

As we stated at the start, this is very much a 'work in progress.' There is already much innovative, successful and though-out work with families already taking place both here and abroad.

However, there is much still that could be done, and this paper is intended to start exploring that potential. When we return to this paper, we hope to be able to illustrate how different initiatives have successfully met the challenges outlined here.

Written by Kevin Flemen: January 2001