THE RISE AND FALL OF FAMILY SUPPORT GROUPS

ISDD researchers set out reasons for adopting a sympathetic but questioning attitude to family support groups in the drugs field, looking first at limitations inherent in the conventional group, then describing some forms of practice that can serve as adjuncts or alternatives to these groups. What's needed, they way, is a wider 'menu' of options for different people in different situations.

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OVER THE LAST couple of years, media attention to family responses to drug problems (eg, BBC *Drugwatch* programmes) has come close to presenting one particular image of family groups as 'the answer'. But, like all good ideas, the family support group can be over-sold, and then there can be a negative reaction from those for whom the reality did not live up to the promise. This seems to have been the experience of many family members and professionals — although, for others, family and community groups retain much appeal.[1]

Many parents and other relatives of users simply don't want to spend a lot of time with others in the same position. This can be the case for several reasons. For example, some simply don't see the point. People with low expectations of life, which may well have resulted from experience, may continue to put their trust in professional help, even if repeatedly disappointed by services that fail to deliver. Those whose options are already limited by, for example, income, geography, age or absence of kin, sometimes don't feel able to help themselves any more than they are already doing. They believe professional help is the answer — indeed, the only answer — and so that is what they want.

Another reason for some parents' lack of enthusiasm for family support groups lies in their sense of stigma and shame on discovery of drug use within the family. This can occur in white and in ethnic minority communities. Contrary to the expectations and prejudice of many in the white community, who can all too easily fall into thinking some forms of drug use are somehow condoned in black and other ethnic communities, among these groups drug use may be regarded as particulary shameful. This is especially the case, of course, among Muslims but also in other religious communities, such as the black Christian churches.

Nor are these feelings confined to parents and other adults; they also extend to many young people. Many sections of British Afro-Caribbean and Asian youth are against or ambivalent about cannabis, and most are firmly against other forms of drug use, just as their parents are. In relation to Rastafarianism, it should be remembered that this belief is restricted to a small section of the Afro-Caribbean community in Britain, so a specifically religious rationale for smoking ganja, the 'sacred weed', is not available to most black youth.

Although it is dangerous to generalise about these and other ethnic groups, it is fair to say that for many parents in ethnic minority communities the fear of damaging the family reputation outweighs the perceived benefits of talking with other families about any drug problems. Talk will mostly remain within the extended family (even if some of its members are kept in ignorance so as not to upset them or precipitate a general family crisis).

Similar reservations abound in many white working class communities. It is perhaps only in the (predominantly white) middle classes that the *mea culpa* mode of public self-exploration and 'therapy' is widely practised. Working class people seem more likely to restrict their emotional exposure to close friends and family, and not to like 'blurting out' their secrets to 'a load of strangers'. They prefer to 'keep it in the family', or to take it to a professional who they believe will be discreet.

It is important to recognise that differences in ease of access to health and other services can be a factor behind different levels of enthusiasm for support groups among families of drug users. Social groups whose members have relatively poor access to professional help — perhaps because they live in an area where the NHS is stretched and do not know how to 'work the system', or lack the resources to 'go private' — are, in many circumstances, least enthusiastic about family support groups. This is because they get stuck at the point of seeking, but not getting, adequate help for the user from statutory and other professional agencies. People whose access to services is unsatisfactory may continue to be concerned with this question for a long time.

People more successful in obtaining for their drug using relative the kind of professional help they seek, are more likely to feel justified in giving themselves a bit of 'TLC' (tender loving care). They are thus more likely to find meaning in support groups which attempt to re-focus away from the drug user and to encourage relatives to explore their own needs. Those who command a higher level of resources are also better placed to make the practical arrangements (babysitting, travel, etc) which underpin regular attendance at support groups.

Exploring the alternatives

Neither of these responses — the focus on services for the user or the focus on the needs of the carer — is necessarily right or wrong. It's just that people in different circumstances are likely to construe their needs differently and to have different opportunities to satisfy them.

Some people find the group experience so valuable that other supports and services are seen as secondary; this is, for example, the experience of many Families Anonymous members. Others, however, have a variety of very understandable reasons for not going into a group — or, at

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least, not yet, or not as the primary strategy for dealing with the situation they face — but may still need support. On pages 10-11, we list some alternatives or adjuncts to the family support group which may be more appropriate for these people. Many of the examples are drawn from real life.

The first four options (page 10) still rely heavily on family resources. However, most people will probably initially seek help from professionals. The problem is that many generic professionals, such as GPs, find themselves as frightened and bemused by drug use as do parents. Others believe they are competent to help, but find that if they get a reputation for being helpful then they will be inundated with the clients turned away by their colleagues. Single-handed GPs are especially vulnerable to this.

Teamwork can lessen the burden, whether in general practice, social services casework or other professional areas. A facilitating element can be a counsellor and/or group-worker who works alongside a team of GPs or social workers, taking over some but not all of their drug-related caseload, and supporting them in developing their own ability to deal with drug-related problems. The counsellor might have a professional background and/or personal experience of drug/alcohol problems. S/he might well work with volunteers who might themselves go on to do the work on a paid basis.

Such a counsellor could then work with individuals, couples and other family and friendship groups in the first instance, going on to offer a wider support group to those who wanted it. Some support groups generated in this way would be short-term 'open' groups, with a changing membership made up of those needing the reassurance of just a few meetings with others in the same position. Some, but not all of these people would then make a transition to longer term, 'semi-open' or 'closed' groups, within which there would be more emphasis on deeper, therapy-type work. Even among those who do wish to try out a group, the needs vary considerably, and one person's 'really helpful' group is not necessarily another's.

This sort of attachment is just one of several models of 'working with families'. There are a number of other possibilities which can be placed alongside the all-purpose family support group. On page 11 we spell out some of these possibilities.

CONCLUSIONS: LET'S LOWER OUR EXPECTATIONS

■ The family support movement can be seen as one aspect of the broader movement for community or 'informal' care.[2] It draws together, in a sometimes uneasy alliance, people whose concerns are fiscal (saving money on state services), populist ('We the people are capable of doing things and taking the lead from professionals and the state') or born out of sheer desperation ('No one else is responding adequately to our crisis so we must').

■ The most coherent critique of this broader movement is undoubtedly feminist and it is clear that women do carry most of the burden.[3] By itself, this observation does not get us all that far, since we lack a strategy for making men take up a fair share of the support task or for making men and/or the state adequately support women who are carers. Additionally, we need to acknowledge that some women (and some men) discover their capabilities and strengths when faced with difficult situations. So any doubts about the 'fairness' of community care need to be placed alongside a sensitivity to the fact that there are potentially both costs and rewards for the carers.

■ An issue as important as fairness is that of the effectiveness of family support groups. We have argued that the prototypical family support group is but one of many forms of informal provision, suitable in some circumstances but not in others. On pages 10-11 we lay out a range of other forms of 'family responses', again suggesting what is effective in one situation will not necessarily be so in another. What is needed is a catholic 'menu' of possible community responses from which people can choose what suits them best. The conventional idea of the family support group is but one star in the firmament of responses to drug problems.

■ Getting comfortable within a group can be a major obstacle to people receiving the support they are looking for. Experience suggests groups can usefully offer a two-tier system, allowing newcomers initially just to see one or two regulars, have the space to talk about their problems, ask questions, decide what they want from the group, and so on, before entering the full group. Some people may not wish to join the larger groups and find they have got a lot of what they wanted from just chatting to one or two people in relative privacy. Most family members recognise it is perfectly OK for some people to only come to the group for a few weeks. A single appearance does not mean the group has 'failed' or that a heavier commitment should be extracted from newcomers or that those who attend only a few times should feel guilty — or that those who attend for a long time should feel inadequate. The important recognition is that both immediate needs and long term support requirements should be met — but the two are different and don't have to go together.

■ Groups can be very valuable for many people at different stages of responding to a drug problem in the family. But groups don't meet all of the needs of all of the people all of the time. This is because different people want different things. The implication is that those working with families should be responsive, innovative and practical, building upon the best features of community responses. If family support groups are falling from grace, it may be because — like the stock market — they were over-sold in the first place.

TURN OVER FOR ALTERNATIVES TO FAMILY SUPPORT GROUPS ▶

As one family worker recently said: "The numbers in our support group are dwindling. And when we ask around other agencies, they say the same thing. It is very difficult to keep support groups going . . . so now we are going out into the community more." Illustration from *Coping with a nightmare*, ISDD, 1987.

1. Coster G. "Family support groups". *Scottish Drugs Forum Bulletin*: 1987, no.4, p.4-5.
2. Walker A. "Enlarging the caring capacity of the community: informal support networks and the welfare state". *International Journal of Health Services*: 1987, *17* (3).
3. Finch J. "Community care: developing non-sexist alternatives". *Critical Social Policy*: 1984, *9*, p.6-18. But c.f. Walker A, *op cit*, p.377-8.
4. Malinowski A. "No free lunches: an experience in the use of volunteers". *Druglink*: 1986, *1* (3), p.14.
5. Walker A. *op cit*.
6. Glanz A. *et al*. "Findings of a national survey of the role of general practitioners in the treatment of opiate misuse: extent of contact with opiate misusers". *British Medical Journal*: 1986, *293* (6544), p.427-30.
7. On police conflicts, see Pearson G. *et al*. *Young people and heroin: an examination of heroin use in the north of England*. Aldershot: Gower Press, 1987, p.30.

ALTERNATIVES TO FAMILY SUPPORT GROUPS

On this page, some options that lean quite heavily on family resources. On the facing page, ways existing services could work more closely with families or families could influence the development of these services.

See pages 8-9 for a discussion of the role of family support groups

Option 1. Phone lines — building on existing networks

Option 1a: Ideal model. Emergency phone lines staffed by trained volunteers. The Samaritans may offer one model, providing both telephone and face to face contact. Existing general advice lines could be extended or refer people to a specialised line. Out-of-hours and weekend back-up could be provided by a system which diverts calls to a volunteer's number, ensuring coverage when family crises might most frequently occur but when most services are not available. Training and support should be available for the counsellors.

Option 1b: Ideal model. On-going mutual support phone networks. Many parents and other relatives and friends with phones who already know each other spend a considerable amount of time communicating on the phone. There seems no reason why people who do not know each other should not form such networks, once any immediate emergency has passed. There would be considerable advantages to this model in sparsely populated areas or where reaching a central meeting place would be difficult. People would technically be able to call anyone in the network at any time, though in practice certain restrictions and perhaps a rota might be advisable. There might well be advantages for those who would find it easier to talk in the emotional security of their own home, without the reciprocal 'facework' of face to face meetings. This offers an option that falls between emergency lines and groups that actually meet.

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.

Money implications. Relatively cheap — publicity, training budget, phone expenses.

Problems. Dependent on people having phones! Possession of a phone is income-related, and public phones are still frequently out of service. In any event, the sort of conversations that one wants to have around distressing issues — and the time they often take — make phoning from home highly desirable.

If the supportive network option allows anyone to call anyone else at any time, some people might get called upon a great deal more than others. This may be because they are good at befriending, which is the point of the exercise, but without some sort of rota the 'best' volunteers may burn out and drop out quicker than others.

On the bright side, this kind of service could be relatively easy to set up so long as the right kind of volunteer counsellors could be recruited. However, such schemes can be wasteful of human resources if volunteers just find themselves waiting around for calls that don't come.[4]

Option 2. Home befriending/ visiting

Ideal model. This could be a lay person visiting people affected by their own drug use or that of a friend or relative, along the lines of schemes such as Victims of Crime or AIDS 'Buddies'. Lay volunteers would need training and support and could be attached to a health centre, community centre or volunteer bureau. The service could extend beyond simply talking, to helping with practical things such as housework and shopping if family life has been disrupted by a drug-related problem. One example would be the family in which a single mother is trying to come off tranquillisers and needs not simply emotional support, but also helping out until she has got through the worst.

Ideally, a local professional or part-time paid worker (say 10 hours a week) could coordinate the scheme.

Example. A support group of volunteers in southern England is exploring these possibilities, with an advisory role played by the local drug education coordinator and an ISDD worker.

Money implications. Probably just seed money for initial publicity, funding for a part-time worker if no local professional could take on the coordinating role, and perhaps money for phone calls, an answer-phone service and stationery.

Problems. Would enough volunteers take on these quite onerous tasks? Would they be seen as competing with health visitors or others, even though these do not offer such a service?

Option 3. Home detoxification and exchange-an-addict schemes

Ideal model. Families quite often support by sharing the care and control of drug users, sometimes on a reciprocal basis: for example, arranging a car pick-up service to take kids to the clinic or probation office, reducing the chances of them running off and getting into trouble.

Only rarely will one family go so far as to 'take on' a drug user from another family and provide accommodation — especially when the user is trying to 'come off' drugs such as heroin. Yet there is a possibility that some families (and in this context we are really speaking particularly of mothers)[5] would find it less exhausting to cope with someone with whom they are not emotionally involved. It might be possible to encourage a pool of families to take in or exchange users coming off or trying to stay off. This might be a useful option for those who live in areas in which residential facilities are inaccessible for reasons of long waiting lists, distance or finance.

Example. Merseyside parents taking groups of kids to the acupuncture clinic and 'Doing a Geographical' — sending using kids away to relatives/friends in another area to 'stay off'.

Money implications. Contributions to ease financial strain caused by any extra needs that might arise; money for coordination — phones, etc; travel/petrol.

Problems. Difficult to organise and keep going once there is no longer a need for reciprocation because someone has 'recovered'.

Option 4. Lay staffed walk-in advice/referral service

Ideal model. Staffed by trained volunteers, such a service could offer flexible hours, partly dependent on volunteer availability. It need not offer 'professional' counselling but could be more of a befriending/ advice/reassurance/information/referral service.

Examples. This sort of volunteer service is running in a deprived East London borough, with a phone line and walk-in service sited in a health centre for one evening a week. Two months after opening, the service had attracted no custom, and although two lay staff had been on a training course, they were becoming dissatisfied at the lack of anything to do. Solvent- and drug-related problems were rife in the area, but the service could not plug into the potential demand for it.

Money implications. Funding for premises (may only be a small payment for use of community centre/church hall, etc); part-time coordinator; administration.

Problems. All volunteer schemes, require a major commitment. How much training should volunteers have relative to how many hours of voluntary work they are going to put in? It would be wasteful to expend a lot of training on someone who was only going to be involved for one or two hours a week and who may drop out of the scheme. Experience indicates that a service available only one or two evenings a week may not attract custom: people are unable to timetable their lives so they have problems or reach crisis points at those particular times.

Option 5. Innovations in generic social services

Ideal model. Field social workers might be expected to be well placed to pick up on local drug problems and associated family and community needs. 'Drugs' here will probably mean alcohol more often than illegal drugs. There may be cross-overs with health education officers and with health visitors, but perhaps Borough social services could establish Community Alcohol/Drugs Teams to work with those with a problem and their families.

Example. Judy Mews, a social worker with Southbank Social Services, has been redesignated to have specific responsibility for drugs work. The department has had a long-standing and good relationship with a local street agency and it was partly this relationship which led to the creation of the post and what has subsequently become a unit of up to five staff. The unit services an inter-agency working party which includes representatives of parents of drug users and aims to stimulate grass-roots responses. It also deals with those families and community groups which see local drug users as a threat to their own families.

Money implications. If such appointments can be shown to have a good chance of paying for themselves by enabling generic social workers to recognise and cope better with drug-related aspects of their casework, then the appointments can be argued for on grounds of likely cost-effectiveness.

Problems. Social services do not seem very interested in drug-related problems, preferring to refer them to specialists. Drugs work is often seen as diversionary of scarce resources and time, not worth the effort, and something to avoid. By contrast, problems associated with legal drugs — eg, alcohol-related problems linked to male violence against women and subsequent injury and/or homelessness — are more readily accepted as part of family case-work.

Option 6. Community education — languages and cultures

Ideal model. One under-developed approach involves working with community education teams and other non-drugs workers with a commitment to community outreach to make information available to different groups, emphasising what may be of specific importance to each group, and providing translation for those whose first language is not English. This can be a consciousness-raising exercise for groups that may otherwise have little or confused knowledge about drugs.

Example. A community education team, working with the Asian community in a metropolitan area, found alcohol (and, to a lesser degree, illegal drugs) to be a great concern. A working group was formed and identified the need for leaflets in the various Asian languages plus English as a first step in raising awareness, spreading information, and moving on to any further action that might later be identified. The working group, supported by the local drug education coordinator and an ISDD worker, have produced a draft leaflet.

Money implications. Where the appropriate teams/workers exist, statutory funding should be sufficient, though specific courses and other initiatives might seek joint funding from local government sources. However, the money required is not great and the number of people who can be involved is considerable.

Problems. It might be much easier to graft drugs initiatives onto existing information delivery systems than to build from scratch in areas with no previous commitment to community education. There can be an 'embarrassment of riches' in terms of involvement of local professionals, who may develop a keen interest once it is clear something is happening on their patch; this can lead the original movers to feel they cannot compete and should leave things to the professionals.

Option 7. Counsellor attached to a group practice of GPs

Ideal model. The counsellor would probably have some professional training. Most appropriately this service would cover tranquillisers, alcohol and smoking, as well as illegal drugs. Depending on local problems, the post could be part-time, with funding from the family practitioner committee.

The advantage of this model is that GPs are often the first port of call for family members seeking advice about drug problems.[6] The 'family doctor' is trusted and their accessibility would suggest general practices could do more to respond to drug problems and family concerns.

Example. Dr Help in an inner London borough is a GP who also prescribes on a 'maintenance' basis and runs a 'clinic' one afternoon a week. A drugs advice worker from a nearby street agency attends to offer a counselling service on those afternoons. Thus some drugs specialist counselling is made accessible through an 'ordinary' estate-based GP's practice.

Money implications. Not cheap. Gaining funding would require an FPC quite sympathetic to community-oriented initiatives.

Problems. Counsellors would find it easier to relate to one single practice or one group practice than to a number of separate GP practices. Single-handed GPs may themselves be irresponsible prescribers of tranquillisers. Working within the formal medical system may require a more 'professional' appointment.

Option 8. Family support and the criminal justice system

Ideal model. Generic services likely to come into contact with drug users — for example, police and probation — might offer opportunities for working back from the users to their families.

Examples. In Burnside in northern England, a probation officer alarmed at the number of young people with heroin problems also felt a service should be provided for parents, and set up a local families group. In a nearby metropolis, various probation officers have been supporting individual families in some cases, in others working with groups seeking services for family members with drug problems.

A future possibility might involve probation officers with an interest in drug problems and working around these issues in prisons. Such officers are likely to be working with clients who have caused some distress to their families. Their professional ideology dictates an interest in 'diversion' — keeping people out of prison. There may be scope for them to work with family groups so these groups can be supportive of the user on release from prison.

Problems. It is probably more realistic to see the probation service involved in this way than the police, not due to a lack of interest on their part, but because of the conflicts it would generate. Involvement in groups where revelations about relatives obtaining illegal drugs may be common would place police in a difficult if not wholly untenable position.[7]

Option 9. Public activism as a context for individual support

Ideal model. People come together to campaign around issues connected with drug abuse. These may be anything from poor housing or recreation facilities, which may be perceived as causative factors, to treatment facilities. Although the focus is on collective action, individuals often do get personal support from the resulting network of friendships.

Example. Residents on 'Tenantsrise' experienced a rapid build up of drug problems on their estate. They reacted with an equally rapid and public collective response, campaigning for improvements in policing and housing as well as in treatment services. The group successfully propelled professionals into action: in the process, families of drug users found strength in the network of neighbours arising from the activity.

Money implications. Publicity, phone, other minor expenses. Even if the group is successful in getting action in the form they want (eg, better housing, more police on the ground or a new medical service), they may not gain support for their own expenses as a pressure group.

Problems. May be difficult to initiate in areas with no history of collective action. Disagreements over priorities and how to proceed may lead to a hostile rather than a supportive atmosphere. Groups which try both to support individual members and to campaign may find difficulty in striking the right balance. The result may be frustration all round or even the break-up of the group.