Measuring the impact: An independent evaluation of the work of Family Support Link.

And to assess the improvements in health and wellbeing for family members affected by another's substance use.

family support link

Supporting families' in Northamptonshire affected by another's substance misuse

Registered Charity Number 1119358

Commentary by **Julia Feazey**
Chief Executive of the Family Support Link

In the Charity Sector, there are a vast number of organisations who provide help and support to individuals and families.

At Family Support Link (F.S.L), our mission is to empower families harmed by the use of substances to regain control and lead happier, healthier lives.

Founded in 2007 by Sandra McDermott, who needed support in managing her loved one's drug/alcohol use. Unable to find the support she needed locally, it became obvious that there was a need for an organisation that could help and support families who were having to cope with the stress, and strain caused by a loved one's drug/alcohol use. Keen to support others, she set up a small charity to offer support to others.

As a locally based charity helping families across Northamptonshire, F.S.L is one of the few charities in the United Kingdom that supports families impacted by another's substance use FSL. provides outcomes led interactive therapy based on the stress-strain coping-support model (SSCS) developed by Orford, Copello, Vellemen & Templeton (2010). F.S.L has continued to grow, and its mission remains at the core of all its decisions and services. As an estimate, since F.S.L was formed, it has helped in excess of 4,500 individuals and families across Northamptonshire.

In November 2016, the Senior Leadership Team took a decision that, although for many years, we were getting positive feedback from the people we helped, it was time for F.S.L to apply a more critical analysis and evaluation of how effective we were in delivering the interactive therapy and look to ask the people we were supporting and helping what they thought of F.S.L.

So, we commissioned Helen Pearson, an expert in Social Research with experience working with substance use services and also a member of the addiction and the family international network to independently undertake this evaluation with objectives to: -

1. Examine the value and effectiveness of the service F.S.L provides
2. Inform the practice of FSL

The period of evaluation would take place from 1st April 2017 to 31st March 2019 with anticipated publication of the final evaluation report in mid-2020. Unfortunately, as with many things, this was delayed due to the COVID pandemic but, as you will see, the Report is comprehensive in its content and research as well as being concise in its findings and observations.

A Report of this nature helps all of us at F.S.L to understand more about ourselves and the work we undertake to help families.

As CEO, I am drawn to a number of issues:

1. Clients' mental wellbeing at the initial measurement showed that more than 85% scored under the median norm for England, and 43% were in the lowest decile. Mental wellbeing improved during the initial six sessions and continued improving dramatically after clients had completed their time with Family Support Link, evidencing that the support is life changing.

2. Client's feedback shows the positive impact of the support they have received on their lives, reading their comments, and hearing the desperation that they felt and the relief at having found us is humbling.

3. The impact to the family and its functioning due to the problematic substance use of a family member/loved one is far reaching and devastating. This evaluation and report evidence just how all aspects of a family's lives are impacted and the positive difference that support makes.

4. It shows that, affected family members are ordinary people faced with the task of coping with stressful life circumstances and that behind every one of these statistics is an individual or family.

As the Chief Executive of F.S.L since 1st January 2020 following the retirement of Sandra, I can only thank Helen for her hard work that went in to producing this Report.

I wish to personally give my thanks to Sandra who had the drive and ambition to see what a difference Family Support Link would make to families in Northamptonshire. I also wish to thank all of the staff and volunteers both past and present; every one of them has made a positive lasting difference to many families lives. Lastly, to the Trustees of F.S.L who provide me with the support and governance of a Charity which as this Report shows is making a tremendous contribution to not only many families but communities in Northamptonshire.

If I had one wish, it would be that others could benefit from what Family Support Link are doing in other parts of the UK where it is needed.

Foreword by **Vivienne Evans OBE**

Chief Executive of ADFAM

Families affected by substance misuse are hidden in plain sight; they are an unrecognised section of society, often stigmatised and isolated.

Our You Gov poll discovered that as many as 5 million people in this country are adversely affected by a loved one's drug or alcohol problems.

Support for these families is unfortunately few and far between, yet, as Family Support Links report, so clearly demonstrates, it is vitally needed. We need this kind of evidence of the benefits that support for families can bring so we can continue to campaign to ensure that these families will no longer be neglected.

Family Support Link is a prime example of the ambition and effectiveness of an organisation dedicated to working with families affected by substance misuse, and a blueprint for other organisations to aspire to. We need Family Support Links in every area of the country.

Family Support Link demonstrates how positive outcomes can be achieved in the face of societal and financial challenges. We are pleased to have them as a partner and collaborator.

Vivienne Evans OBE
Chief Executive
ADFAM
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Abbreviations

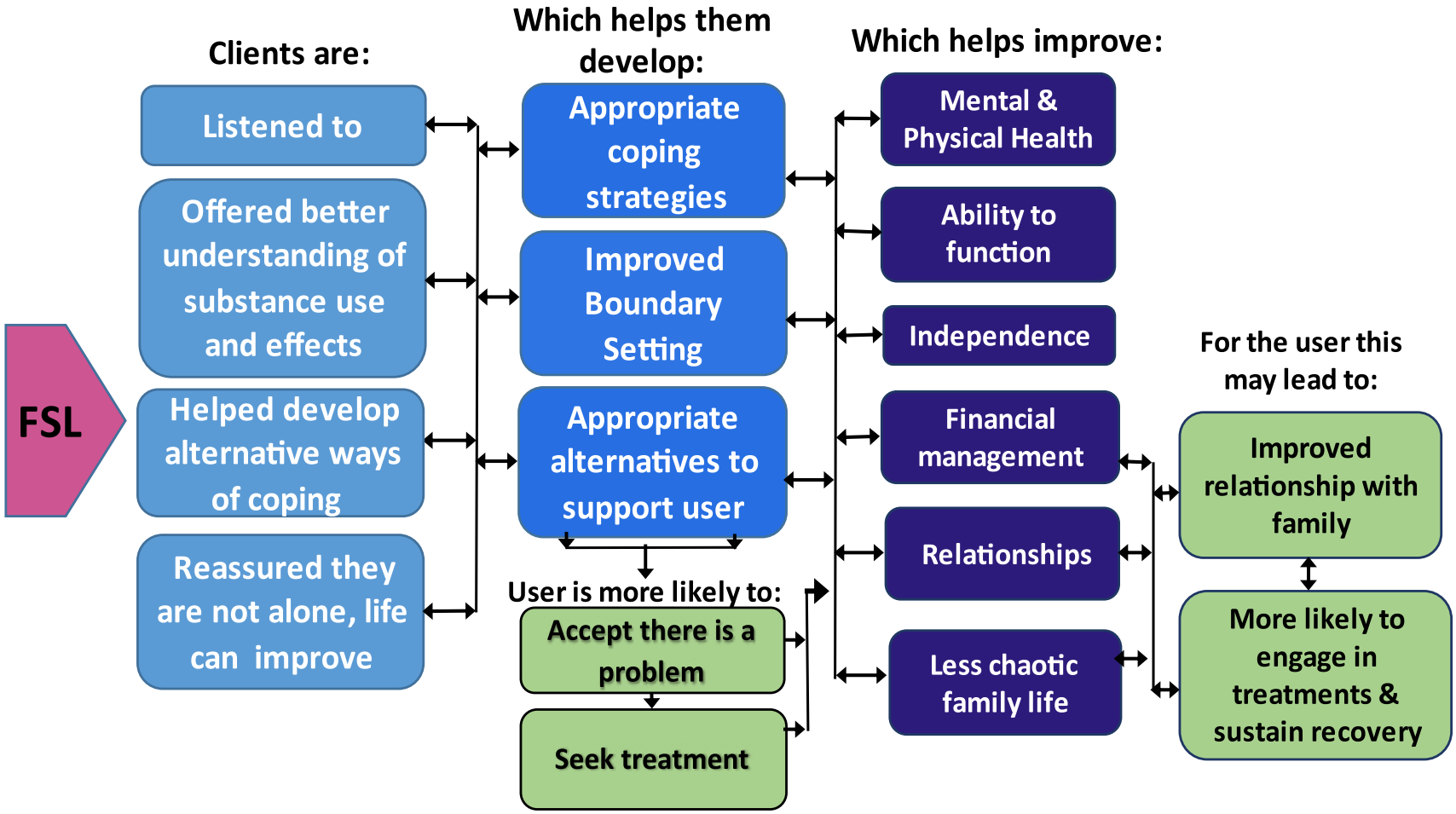
5-step	The 5-step method, based on the stress-strain-coping-support of model
AFM	Affected Family Member
Caseworker	Family worker, working with affected family members
F.S.L.	Family Support Link
FMQ	Family Member Questionnaire or SQFM(AA) (Short Questionnaire for Family Members (Affected by Addiction) developed by AFINet-UK
On Entry	Family Member Questionnaire Initial measure, taken on second visit to F.S.L.
Peer	People with the same lived experience
P-I	Post-intervention
Problematic use	Any substance that causes problems for others.
Second measure	Family Member Questionnaire Second measure, taken after six sessions
SSCS	Stress-Strain-Coping-Support
SU	Substance User
Support Group	Peer group, led by a Family Support Link member
SWEMWBS	Short Warwick/Edinburgh Mental Wellbeing Scale

The Seven Key Findings

1. Clients attending Family Support Link (F.S.L.) were from some of the most chaotic families in Northamptonshire, presenting with multiple complications and hardships. Clients were from families that had been affected by the substance use of a family member.
2. Mental wellbeing improved during the six sessions, and continued improving dramatically after clients had completed their time with Family Support Link
3. The stress-strain-coping-support model was appropriate, and the fidelity of the work of Family Support Link in their application of the 5-step method was successful in enabling clients to recognise the effectiveness of more appropriate coping methods, thus decreasing stress and reducing symptoms of strain.
4. Participants reported improvement in coping with their situation and their lives, particularly an increased ability to set and keep boundaries. They indicated that improved knowledge and understanding of substance use helped them and their families better manage the circumstances surrounding substance use.
5. The post-intervention study showed stress and strain continued to improve, and coping strategies continued to become more appropriate.
6. Practitioners were seen to be highly effective, being both trained and expert by experience. Clients reported that caseworkers' lived experience was a major factor in helping them address their problems.
7. AFM attending support groups found them a useful source of knowledge, understanding, support and hope. Groups served as a context to Family Support Link services, as well as being complementary to the one-to-one sessions, important as the client transitions from the service.

Benefits for family members accessing family support link

Figure 1. Benefits for Family members accessing Family Support Link



Adapted from Rattenbury, E. & Kempton, O. (2012)

Abstract

Problematic substance use by an individual is often highly destructive to their family, disturbing and damaging healthy family functioning.

The aim of this evaluation was to determine the extent to which Family Support Link (F.S.L.) delivered support in line with best practice, and to assess the improvements in mental wellbeing for family members affected by another's substance use.

In 2017 F.S.L. commissioned an evaluation of their work. Data concerning social issues experienced by F.S.L. clients were obtained on the first visit. Measures of stress, strain, coping and support were obtained using the Family Member Questionnaire which was administered to 147 clients on the second visit, and again five sessions later. At the same time wellbeing of F.S.L. clients was evaluated using the Shorter Warwick and Edinburgh Mental Well-Being Scale.

Very significant improvement was observed for mental wellbeing and across stress, strain and coping domains. Improvement continued to be highly significant on the follow-up.

The findings from this study demonstrate that participation in the Family Support Link programme can help clients cope better with the substance use of a family member, as indicated by the reduction in stress and symptoms of strain, and in dysfunctional strategies such as emotional reactive behaviour, or tolerating substance use and thereby effectively endorsing problematic behaviour.

Background

Family Support Link (F.S.L.) is a registered charity based in Northamptonshire, working with both adults and children affected by a family member's substance use.

It is a family focussed, community-based, needs-led organisation, working with AFM (Affected Family Members) of all ethnic groups and religions across the county. In addition to a structured programme F.S.L. provide interactive, telephone, and peer group support, for both adults and children. Working in partnership with other professionals, statutory bodies, and the community, F.S.L provides referral routes for families, carers and other agencies. It has a small core staff, and a growing group of local volunteers. Families are involved in the design and development of the service; F.S.L. hold consultation days every year to ensure they are meeting the needs expressed by families.

Family Support Link aims to reduce the physical, psychological, and emotional harm caused by living with a person who has problematic behaviour associated with drinking or drug use problems. They provide specialist emotional and social support to help an AFM understand the addiction, explore ways of improving relationships and learn skills and strategies for coping effectively, in order to feel more in control of their lives. The aim of the intervention was to help clients develop resilience and improve their wellbeing without directly trying to control or influence their relative's behaviour.

The guiding principle behind F.S.L.'s practice is that family members are victims that deserve the right to a 'normal' life. F.S.L. provides outcomes led interactive therapy based on the stress-strain coping-support model (SSCS) developed by Orford, Copello, Vellemen & Templeton (2010). AFM suffer strain induced stress in the form of physical and/or psychological ill-health. Appropriate coping strategies and good social support help ameliorate stress and symptoms of strain. This model views family members as ordinary people faced with stressful life circumstances, it works with affected family members as clients independently of whether or not their relative is making changes.

The evaluation was supported by Northamptonshire Public Health.

1. Context

1.1. Living with a Substance User

For a family, there are three elements:

1. The family member's substance abuse problem,
2. Living with the substance user, and
3. Dealing with the consequences of the substance user's addiction.

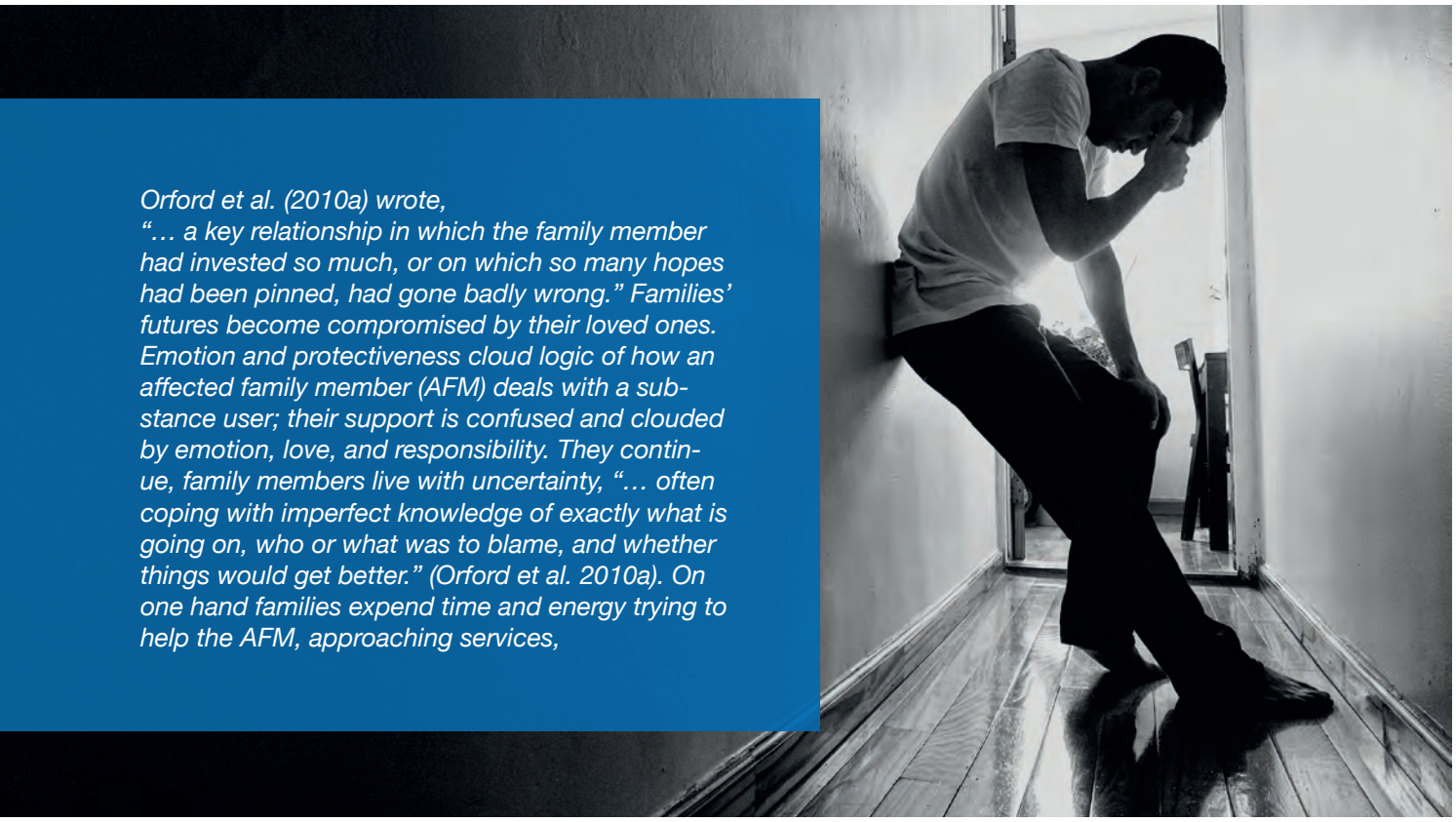
One of the roles of F.S.L. is helping clients disaggregate the substance use, its treatment, the interactions with the affected family member (AFM), and in helping identify resources to help manage the consequences of the addiction.

Family members are interdependent, what affects one family member affects other family members. While the drug/alcohol use is worrying, even devastating, for families, it is the behaviour of the substance user (SU) that is ultimately destructive. Disagreement and conflict become common, exacerbated by substance use.

A SU creates tensions and conflict. and poses dilemmas about how to cope with the SU's behaviour and its effects (Orford et al. 2010a), they pose a threat to the happiness, productivity and even the existence of the family. Substance use manifests over time and problems escalate. A SU becomes dominated by the substance, often leading to abusive behaviour. In turn the family becomes focussed on the SU.

Almost all AFM report being manipulated, lied to, coerced, and blamed for issues associated with the substance use (McDonagh et al.2019). Typically, communication between the family and SU deteriorates; often into a pattern of blackmail, or aggression, where the family becomes the victim (Daley 2013). The SU frequently becomes the focus of family attention and resources to the detriment of other family concerns. Velleman et al. (2005) argue that in some families the dynamics are so dysfunctional that they can result in permanently unresolved conflicts, denial, break-down of open communication and mutual caring, which could then be another trigger for substance abuse.

Orford et al. (2010a) wrote,
"… a key relationship in which the family member had invested so much, or on which so many hopes had been pinned, had gone badly wrong." Families' futures become compromised by their loved ones. Emotion and protectiveness cloud logic of how an affected family member (AFM) deals with a substance user; their support is confused and clouded by emotion, love, and responsibility. They continue, family members live with uncertainty, "… often coping with imperfect knowledge of exactly what is going on, who or what was to blame, and whether things would get better." (Orford et al. 2010a). On one hand families expend time and energy trying to help the AFM, approaching services,



1.2. The Stress-Strain-Coping-Support Model

The Stress-Strain-Coping-Support model (SSCS) developed by Orford, Copello, Velleman and Templeton (Orford et al. 2010b) derives from the premise that affected family members are ordinary people faced with the task of coping with stressful life circumstances. The model rejects the idea that families, or individual family members, are the cause of the loved one's addiction.

It recognises that substance-related problems are stressful for family members, and that stress induced strain may affect their health. It provides a theoretical framework to examine the impact of a relative's substance misuse on family members' wellbeing and adjustment to stressors (Orford, Copello, Velleman, & Templeton, 2010; Velleman & Templeton, 2003).

Interventions involving family members have often been intended to persuade the SU to accept treatment, the SSCS model concentrates on individuals and families in their own right. The central precept is that people facing such conditions have the capacity to cope with them, much as one would attempt to cope with any difficult and complex task. It encompasses the idea of being active in the face of adversity, of effective problem solving, of being an agent in one's own destiny, and of not being powerless.

Family members face dilemmas in coping, but appropriate coping strategies and good social support help ameliorate stress and symptoms of strain. (See Section 5.1.1 intervention analysis, 5.2.1 for post-intervention analysis, and Appendix 2 for FMQ questions)

1.3. Stress

Families living with a SU have complex issues; problems with mental health, domestic abuse and debt are not uncommon. McCann et al. (2017) wrote, "Affected family members experienced wide-ranging harms, which affected their emotional, social and financial well-being, safety and family dynamics, and instilled a persistent sense of fearfulness and hopelessness about the future." SUs live an exposed life, vulnerable to other substance users and gangs, families live in constant apprehension of hearing the SU has been attacked.

Many AFM feel themselves to be responsible for the substance use of their family member, and guilt compounds the stress. AFM attending F.S.L. come from some of Northamptonshire's most damaged and chaotic families, those with the most complex problems. In many cases there are children living with, or affected by, the substance use.

Growing up in such families may substantially affect their future health and their life. The Stress/Impact construct in the Family Member Questionnaire is made up of subscales encompassing 'worrying', and 'active' elements. Worrying strain is exemplified by concerns about finances, the SU's appearance or self-care and the effect on the clients own social life. Active strain is characterised by quarrels, threats and family occasions being upset.

(See Section 5.1.1 intervention analysis, 5.2.1 for post-intervention analysis, and Appendix 2 for FMQ questions).

1.4. Strain

AFM may be under considerable stress, and are at risk of experiencing strain on their physical and mental wellbeing, which can include, depression, decreased self-esteem, substance use disorders, or psychosomatic symptoms. (Orford et al. 2010a; Orford et al. 2010b; Orford, et al. 2013; Ray, et al. 2007; Velleman & Templeton, 2003). These in turn effect work performance, parenting skills, and finances.

The strain construct in the FMQ has two subscales, psychological and physical. Psychological symptoms include worrying, being irritable and persistent recurring thoughts, physical symptoms include inability to concentrate, sleeplessness, and feeling weak.

1.5. Coping

Families approach living with the SU using a variety of coping strategies as they try to deal with the difficult situation. Analysis by Orford et al. (1998, 2002, 2005) found three factors underlying coping; engaged, tolerant/inactive, and withdrawn. Engaged coping has since been broken down into emotional, and assertive.

Engaged emotional or reactive coping (referred to as reactive in the rest of this document) describes reacting to a SU by arguing, becoming emotional, or continually checking up on him/her. It is dysfunctional because it increases stress for both the SU and AFM, while rarely improving the situation for either.

Engaged assertive or proactive coping, (referred to as proactive in the rest of this document), relates to attempts by AFM to discuss and clarify the expectations of SU contributions to the family, and confirm that the AFM will no longer cover for him/her. Most AFM already use this strategy to a greater or lesser extent. It may, however, result in conflict with the SU, and hence lead to AFM resorting to dysfunctional reactive methods.

Tolerant coping strategies prolong the status quo; the AFM supporting the SU by excusing, and covering up, even buying drugs or drink for them. It is usually seen by AFM as caring and keeping the family going by avoiding trouble. It is dysfunctional because it is effectively endorsing substance misuse. It also implies that the SU is the centre of attention, with the AFM subservient and unable to develop his/her own life. Orford et al. (2001) suggests that tolerant coping develops through the sense that one is powerless to change the situation. AFM are usually aware, however, of the negative consequences for the SU and for the family. It has been recognised that tolerant coping has particularly bad effects on health (Orford 2001).

Withdrawal coping strategies enable family members to pay attention to their own needs, and to distance themselves from the misusing relative (Orford, Velleman, et al. 2010; Orford et al.2013). The family need to reassert themselves as having worth in their own eyes and in the eyes of the SU. Individuals need to rediscover their own identity, rather than it being subsumed into the role of a carer.

It shifts the focus away from the SU and allows a family to function independently. A strategy of withdrawal may be difficult for a SU to accept because he/she no longer commands the centre of attention, and consequently may feel rejected.

It appears that there is no universally appropriate coping strategy to ameliorate the effects of stress. Families may find some ways of coping to be more useful than others; using different forms of coping strategies as appropriate in different situations (Orford et al. 2010a, Orford, Copello, et al.2010b; Orford, Velleman, et al.2010). Often AFM are aware that some coping methods are dysfunctional, but patterns of interactions and behaviours within the family, become habitual, and destructive, contributing to the anger and resentment of family members.

1.6. Support

Walsh (1993) wrote that interdependence is central to human functioning. Families with a substance user may feel responsible, and shamed by the SU's behaviour. This associative stigma isolates and inhibits them from bringing home friends or attending social occasions because of fear of shame and embarrassment (Tamutiene & Laslett 2016, Park S. & Park K.S. 2014). This limits the contact and support families might usually call on from extended family, neighbours, friends, or organisations; which makes both daily living more difficult, and profoundly affects mental health. Jetten and Haslam (2017) wrote that:-

"belonging to stigmatized groups, and being exposed to stigma and discrimination on this basis, is a particularly toxic threat to positive health and wellbeing."

Stigma is viewed as a major obstacle to support seeking and behaviour change (Wilson 2014). Some AFM coming to F.S.L. feel that painful feelings cannot be expressed because they are 'unacceptable'. Emotional support, good information and material help, encourages coping efforts and contributes to health. (Orford et al. 2010). Being supported and encouraging family members to make contacts outside the home increases potential sources of support as well as deflecting attention from, and reducing the influence of the user.

1.7. Wellbeing

Wellbeing consists of two key dimensions, feeling good and functioning well. It encompasses interrelated components, understanding, a sense of self-efficacy, and self-esteem. It also implies a sense of confidence and an ability to manage problems, all of which promote optimism. Higher levels of optimism have been related to better subjective wellbeing in times of adversity, appearing to improve resilience to stressful life (Carver, Scheier, & Segerstrom, 2010), and has been linked with better and more constructive coping strategies; (Assad et al. 2007). Wellbeing interacts with resilience.

Resilience has been described as the ability to overcome problems, to anticipate and cope with crises, and recovery (Aguirre, B.E. 2006). Resilience and coping are related constructs. Coping refers to the set of cognitive and behavioural strategies used by an individual to manage the demands of stressful situations, whereas resilience refers to adaptive outcomes and psychological adjustment in the face of adversity (Riley, J.R and Masten, A.S. 2005). Employing appropriate coping methods increases feeling of efficacy and self-confidence.

1.8. Five-Step

AFM arrive at Family Support Link (F.S.L.) when they have reached a crisis. The 5-step intervention, developed by Copello et al. (2000a, b) is a brief, 5-step, psychological intervention based on the SCSS model. It is a systematic and collaborative method for helping people to explore their own values and motivations, and how these may be served by either remaining in the status quo, or altering elements of their own behaviour. The five steps consist of;

- listening non-judgmentally,
- providing relevant information,
- exploring ways of coping,
- discussing social support, and
- establishing the need for further help.

As used by F.S.L. 5-step utilises motivational interviewing techniques to help AFM work through ambivalence and commit to change (Miller and Rollnick 2002).

Keyworkers at F.S.L. are trained in the 5-step method, and are 'experts by experience'. Empathy helps clients feel that they can confide without being stigmatised, and provides an example of people who have survived the experience. Lundahl et al. (2010) wrote that the use of empathy, helping clients feel understood, and increasing rapport, reduces the likelihood of resistance to change, and allows clients to explore their inner thoughts and motivations.

Instead of implying that, 'I have what you need', 5-step communicates, 'You have what you need.' It is important that it is the client, rather than the practitioner, who identifies and verbalises the arguments for change; when people justify their own behaviour, they are more likely to initiate and follow through change (Groskova, 2010, Hettema et al. 2005).

AFM are encouraged to recognise their own self-worth and right to a 'normal' life independent of the SU; a vital step towards setting boundaries. Being able to say "No" to the SU, and meaning it, is important, both for the AFM and SU, it means that the SU is no longer the dictator and pivot of the AFM's existence. Setting boundaries includes being able to say, 'You will not talk to me like that.', or 'If you do that, I will call the police', or 'No, I will not give you money'. Boundary setting, however, is consensual, not only the instigator, but the object must agree those rules.

The SU may not accept the boundaries, which must keep being enforced; it takes confidence and persistence to change. Supporting client's self-efficacy and encouraging a client's confidence in their ability to modify behaviour is critical to successful change. Self-confidence and self-esteem, as well as the growing understanding that they are not responsible for the SU's substance use, help the AFM begin to restore social connections.

1.9. Support Groups

(see Section 7 for analysis, and Appendix 3 Group Feedback)

As well as one to-one interactive work F.S.L. offers the opportunity to attend weekly support groups. Support groups work by emphasizing the inherent expertise derived from group members' own lived experience, with members fulfilling dual roles of peer and expert.

Members are simultaneously providers and consumers of support, and they profit from both roles—their self-worth is raised through altruism, and hope is instilled by their contact with others who have overcome problems similar to their own (Yalom & Leszcz 2005). Support groups focus on enhancing coping and adaptation, with improved quality of life as an outcome. Yalom and Leszcz contend that the most powerful and most unique benefits of group therapy were that clients interact openly with others, observe others, and get feedback from others in order to identify, understand, and change their own maladaptive patterns of behaviour.

Yalom (1985) defined eleven therapeutic factors, which can be defined as a series of mechanisms in groups that bring about changes:-

"altruism, group cohesiveness, universality, interpersonal learning, imparting information, catharsis (ventilation), identification (imitative behaviour), self-understanding, the instillation of hope, and existential factors (taking personal responsibility for actions)".

Social factors are not specifically identified by Yalom, but for AFM, who have become isolated, support is a major factor in change.

A cohesive group is one in which all members feel a sense of belonging, acceptance, and validation. Humans have an instinctive need to belong to groups. The group setting provides a safe and supportive environment for members to share their experiences. In conditions of acceptance and understanding, group members are more inclined to express, explore, and to develop relations with others. Recognition of being in the same unpleasant situation as other people removes a member's sense of isolation, and validates experiences.

Catharsis is the experience of relief from emotional distress through the free and uninhibited expression of emotion. When members tell their story to a supportive audience, they can obtain relief from chronic feelings of shame and guilt. (Yalom & Leszcz, 2005). The group is a place where members observe the coping strategies and perspectives of other group members and where members can help each other through support, or perception.

Members are inspired or encouraged by observing improvement of others, who have overcome problems similar to their own (Yalom & Leszcz, 2005). Sharing perceptions can lift self-esteem by gaining a sense of value and significance, and help develop more adaptive coping styles and interpersonal skills. (Yalom & Leszcz, 2005). Support may consist of verbal comments or consist of listening and nodding, on occasion offering a tissue when a member is reduced to tears, or even offering to be at the end of a phone. Support and hope keep clients attending.

1.10. Value

The value to a family, and to an individual's wellbeing, of being able to function better, is incalculable, the main value was for the clients and substance users themselves. In monetary terms the SROI ratio calculated by Rattenbury E. & Kempton, O. (2012).

Using figures taken from the Adfam family intervention report, calculated a return of investment of £4.71 for every £1 invested in family support services., the return to the state was in the region of £1.88 for each £1 spent, the highest outcome values being from reduced health costs and wellbeing benefits for family members.

Table 1. F.S.L. Helping Families to Stand on Their Own

F.S.L. Helping Families to Stand on Their Own

	Resilience			Wellbeing			
Important outcomes	Taking control and being able to set boundaries	Better relationships	Understanding triggers and consequences of substance use	Increased self-esteem and confidence	Ability to use problem solving skills	Optimism and motivation	Improved health (physical and mental)
Enablers ***(Internal and External)***	Experienced staff who understand service users' circumstances	Appropriate access to support provided by external agents	Feeling secure that support in in place through 1-1 and telephone support	Dependable, consistent and reliable staff who deliver on commitments	Recognition, and taking ownership responsibility and control of their situation	Helping people make informed choices	Ensuring other agencies are aware of the need for support

How F.S.L. Achieve Delivery

Working 1-1 with clients, Helping:	to understand that there is hope	to realise they themselves are able to make meaningful changes	to set small incremental and achievable goals	to set realistic expectations about progress	to work towards achieving improved social norms
Group work. Opportunities to:	meet other people - social support	learn from others with similar problems	share own experiences	help others by advice or support	
Practical Help	informing and helping clients claim appropriate benefits	encouraging activities outside the immediate family.	helping clients to take steps to improve their own physical and mental health (G.P., nutrition, exercise)	helping people into employment or education.	by referring to appropriate agencies
Within F.S.L.	training staff	frequent meetings with caseworkers to discuss client progress and problems	frequent meetings with caseworkers to ensure their own problems are addressed. *(practical, physical, and mental).*	holding consultation days for clients, to ensure awareness of their concerns.	obtaining quarterly feedback from clients.
Externally:	working alongside other agencies	providing training to other agencies			

Adapted from Rattenbury, E. & Kempton, O. (2012)

2. Aims and Objectives.

This research aims to evaluate the adult service provided by F.S.L. over two-years, 1st April 2017 to 31st March 2019, with a post-intervention survey in July 2019.

Aims:

- To assess the outcomes of the F.S.L. intervention and to examine whether the F.S.L. intervention had made significant difference to the family burden, coping mechanisms and wellbeing of AFMs.
- To examine the functioning of F.S.L. led peer groups.
- To identify social issues that affect AFM clients of F.S.L.

Objectives:

- To provide an unbiased account of the efficacy of the F.S.L. intervention in modifying AFMs' coping behaviour and decreasing burden on the family, using the Family Members Questionnaire (FMQ); a widely used tool to assess the efficacy in terms of the stress, strain, coping, and support model developed by Orford et al. (2010b).
- To investigate the mental wellbeing of clients, and whether this had improved between initial and second measures. Mental wellbeing will be measured using the Shorter Warwick and Edinburgh Mental Wellbeing Scale (SWEMWBS), a validated and widely used tool. Measures of wellbeing for the initial measure, and that at the second measure, will be compared with the published SWEMWBS Norms for England.
- To investigate the relationship between the change in mental wellbeing, as shown in the SWEMWBS, and the change in the FMQ scores for Stress, Strain, Coping Support between the initial measure, those at the second measure, and post-intervention.
- To compare measures of wellbeing for the initial measure, that at the second measure, and post-intervention, with the published Norms for England.

3. Research Method

Measures and Procedure:

There was four elements to this evaluation.

- The quantitative outcome measures from the stress-strain-coping-support Family Member First Questionnaire (FMQ) measuring outcomes from the intervention, second visit and after five further sessions, and for post-intervention respondents. (Second visit rather than on entry for administrative reasons).
- Quantitative data concerning mental wellbeing using the Shorter Warwick and Edinburgh Mental Wellbeing Scale (SWEMWBS), for both the main evaluation cohort, and for the post-intervention respondents.
- Qualitative data about F.S.L. supported groups.
- Social issues data
- Feedback from clients.

Stress-Strain-Coping-Support

Systematic monitoring of interactive work is carried out using the Family Member Questionnaire (FMQ) developed by Orford et al. (2010), which measure stress, strain coping and support, developed specifically to evaluate the 5-step model, it is peer reviewed and used throughout the world. This helps assure the fidelity of the work as well as allowing overview of an AFM's progress.

The quantitative data used in this evaluation were collected by F.S.L., initially on the second visit (not the first as in other studies), and subsequently five sessions later. Timings were approximate because for clients with less pressing problems appointments were fortnightly, and because on occasion appointments were missed or cancelled. A post-intervention survey of clients who had exited from F.S.L. took place in July 2019,

Wellbeing

At the same time as the FMQ, clients completed the Shorter Warwick and Edinburgh Mental Health Wellbeing Scale (SWEMWBS). This has been academically validated (Ng Fat et al. 2017) and is widely used in educational establishments, hospitals and care homes throughout the UK and Europe. It was specifically designed to measure the feeling and functioning aspects of positive mental wellbeing.

The strengths include the ability to identify "people's functioning, social relationships, sense of purpose" and "feelings of happiness". As the majority of clients were female the SWEMWBS Norms for England values for women were used for comparison with F.S.L. clients' wellbeing, although there was "negligible difference" between norms for men and women (Ng Fat et al. 2017)).

Group data

F.S.L. group meetings were attended over a period of a year, in more than one location, providing qualitative data. Consent was obtained from clients who agreed to the anonymised data being used for evaluation. Although the smaller group had no problems with recording discussion, the larger group decided that it would hamper individuals' experience of the group to record proceedings, so notes were transcribed after each meeting. Extracts from these notes and recordings were analysed, using client's comments, to illustrate Yalom's therapeutic factors.

Social Issues

Social data concerning the family and SU were collected on the second visit, although some clients declined their data being used in the evaluation, and others declined to answer individual questions. In total there were 184 people who complete the social survey and gave permission for their anonymised data to be used.

Statistical Analyses

There were 229 clients who initially consented to the evaluation, but only 189 completed the second questionnaire, and of these several had a number of omissions. It was decided to use only the 147 for whom there were complete data for both questionnaires.

In July 2019 these 147 were asked to complete a post-intervention survey, there were forty-nine respondents (33%), the mean response rate for such surveys is 32%.

Quantitative data were analyzed using excel to produce mean, standard deviation, confidence intervals and charts for all FMQ and mental wellbeing data. SPSS was used to calculate significance for difference in variable values for repeated measures, using the Wilcoxon Signed Rank test for repeated measures, and the Mann Whitney U test used to calculate differences between populations. Correlations were calculated using Spearman's Rank Order Correlation (2-tailed, which does not presuppose the direction of the relationship).

The confidence level in this report is calculated at 95%

Consent

Consent was obtained on entry from the 147clients whose data were used in this evaluation, and from the forty-nine who responded to the post-intervention analyses.

Consent was obtained from group members who contributed to the group analyses and those who gave feedback.

- Data concerning referrals is in the public domain.
- Consent was given by clients who completed social demographic data.
- All data were anonymised.

4. Demographics

Data were taken from the referral forms and data collected by F.S.L.
(Also see Appendix 1. F.S.L. Active Clients and Referrals and Completions/Discharges)

Number of Active Clients: Referrals and Completions

Table 2: Number of Active Clients, Referrals and Completed Discharges Active and Referred
1st April 2017 to 31st March 2019

F.S.L. Clients, Referrals and Completions	Active Clients	New Referrals	Completed-Discharged
Total	519	214	408

There were also 127 (31%) referrals where the AFM did not engage at all, withdrew voluntarily, or dropped out, one moved out of county. There were seven cases (2%) where the referral was withdrawn and 57 (14%) inappropriate referrals. An inappropriate referral can relate to an AFM who is themselves substance using, or an AFM who is referred to F.S.L., but where there are other higher priority issues ,and where it might be more appropriate to refer the AFM to another agency (for instance Mental Health Services). The client is not rejected, F.S.L. keep in touch and when appropriate the AFM is able to return.

F.S.L. do not discharge clients until it is mutually agreed that they no longer benefit from the service. Attendance at support groups may be offered as way forward for clients whose one-to-one sessions have reached a stage where less intensive support is indicated.

Clients are welcome to attend support groups at any stage, and for some it is an introduction to F.S.L. Clients may choose to attend as long as they feel it is helpful, in some cases altruistically to help other people understand they are not powerless and there is hope.

Of the 408 discharges between 1st April 2017 and 31st March 2019 there were 206 (51%) successful completions, six whose family member had died (2%), and four no longer attending because their family member was in recovery (1%) one moved out of county

Of the 408 discharges, 38% of AFM were discharged within 3 months, and 58% within six months. A three-year assessment of adult client service showed that following exit from the service, although it was available, 82% of these clients did not return to the service within 6 months of leaving.

Gender

The majority of referred, and of active clients, were female (82/83%).

Table 3. Gender, AFM Active and Referred 1st April 2017 to 31st March 2019

Gender	Active clients *(n=519)*	Percentage Active Clients	New Referrals *(n=214)*	Percentage New Referrals
Male	93	18%	68	17%
Female	426	82%	327	83%
Total	*519*		*395*	

Ethnicity: Active F.S.L. Clients and Referrals

Table 4. Ethnicity of AFM Active and Referred 1st April 2017 to 31st March 2019.

Ethnicity	Active clients *(n=319)*	Percentage Active Clients	New Referrals *(n=214)*	Percentage New Referrals
White British	202	63%	124	58%
Other White	9	3%	8	4%
White Irish	3	1%	1	1%
Bangladeshi	2	1%	2	1%
Indian	2	1%	1	1%
Other	2	1%	2	1%
Other Mixed	2	1%	1	1%
White and Asian	2	1%	2	1%
Caribbean	1	0.3%	0	0.0%
Chinese	1	0.3%	0	0.0%
Other Asian	1	0.3%	1	0.5%
Other Black	1	0.3%	1	0.5%
White and Black Caribbean	1	0.3%	1	0.5%
Not Stated	90	28%	70	32%

The ethnicity of referrals were not significantly different from active clients, although 'White British' made up the majority of AFMs attending F.S.L. (61%), and slightly fewer of those referred (56%). There were a considerable number of other ethnic groups represented.

Age Range of AFM Attending F.S.L. Active and Referred

Nearly half (49%) of active F.S.L. clients were aged fifty-five or over, and a quarter (25%) were 65 or over. There were slightly more active clients in the older age groups than were referred (45% referred were aged fifty-five or over).

Table 5. Age Range of AFM Active and Referred 1st April 2017 to 31st March 2019

Age Range	Active clients *(n=319)*	Percentage Active Clients	New referrals *(n=214)*	Percentage New Referrals
18-24	11	3%	6	3%
25-34	36	11%	24	11%
35-44	53	17%	35	16%
45-54	64	20%	54	25%
55-64	72	23%	48	22%
Sixty-five & over	83	26%	47	22%
Total	*319*		*214*	

Figure 2a. Age Range of AFM Active and Referred 1st April 2017 to 31st March 2019.

Age range of Referrals and Active Clients 01/04/2017 to 31/03/2019

A family member is likely to seek help when the stress is maximised. This may be related to the time the family member had been misusing substances, and thus to the age and family status of the AFM.

Relationship of AFM to Substance User (n=188) Active and Referred Clients 1st April 2017 to 31st March 2019

Table 6: Relationship of F.S.L. Client to Substance User. Responses of Active Clients 1st April 2017 to 31st March 2019

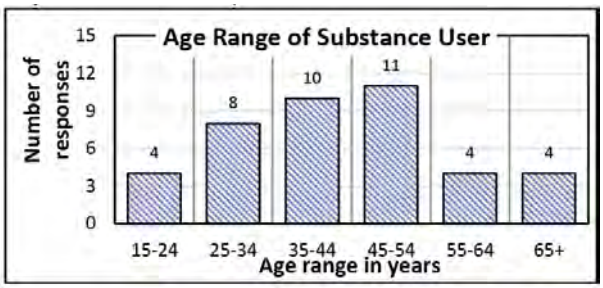
Relationship to Substance User *(n=188)*	**Count**	**Percentage**
Parent	94	50%
Child	13	7%
Partner/Spouse	60	32%
Friend/Concerned Other	1	1%
Other Family	20	11%

The majority (50%) of F.S.L. clients were parents of the SUs with spouse/partners making up another 32% of the respondents.

Age Range of Substance User on Entry (Responses of Active Clients 1st April 2017 to 31st March)

Figure 2: Age range of Substance User, Responses of Active Clients 1st April 2017 to 31st March 2019

Age range of SU *(n=42)*	**Count**	**Percentage of responses**
15-24	4	9%
25-34	8	18%
35-44	11	25%
45-54	10	23%
55-64	5	11%
65+	4	9%



Only 21% of AFM clients volunteered the age of the SU. The substance users for whom we have age data were considerably younger than of the AFMs attending F.S.L. The majority (50%) being aged between 35 and 55, many were adult children of AFM.

User's Substances of Choice

Table 7. User's Preferred Substance

Substance *(n=184)*	**Count**	**Percentage**
Drugs	69	38%
Alcohol	70	38%
Drugs & Alcohol	30	16%
Prescription Medication	2	1%
Drugs & Prescription Medication	4	2%
Alcohol & Prescription Medication	3	2%
Alcohol, Drugs, Prescription Medication	4	2%

Substance User's current treatment status (at start of F.S.L. intervention)

Table 8. Substance User's Treatment Status

Treatment status *(n=180)*	Count	Percentage
In treatment	80	44%
In detox/rehab	4	2%
Not in treatment	92	51%
Drug free/sober	4	2%

5.1 Family members questionnaire april 2017 to april 2019

(See Appendix 2, Family Member Questionnaire (FMQ) for Questions.)

Significance

n.s indicates there is no significance found.

p≤0.05 indicates less than or equal to five chances in 100 that the result is incorrect (i.e., 95% likelihood it is correct).

p≤0.01 indicates less than or equal to one chance in 100 that the result is incorrect (i.e., 99% likelihood it is correct).

p≤0.001 indicates less than or equal to one chance in 1000 that the result is incorrect (i.e., 99.9% likelihood it is correct).

p≤0.000 virtually no chance that this result is incorrect (1 in 10,000 i.e., 99.99% likelihood it is correct).

5.1 1 Stress - Impact on family

(See Context 1.3. Stress, and Appendix 2 for questions.)

The stress construct in the Family Member Questionnaire represents the impact of living with an SU. It consists of worrying stress (finances, social life, and appearance of SU) and active stress (quarrels, threats and upsetting family occasions).

Table 9: Stress: Comparison of Overall Stress; Mean Scores for Initial and Second Measure (n=147)

Initial Measure		Second Measure			
Mean Conf int	Std.Dev	Mean Conf in	Std.Dev	Mean Improvement	Significance.
9.44 ±0.70	4.38	7.56 ±0.77	4.79	1.87	*p≤0.01*

Scored out of 18: 0 =no impact, 18 =very stressful

Stress; Worrying and Active subscales

Table 10: Stress sub-scales, Worrying and Active means Initial and after Second measure (n=147)

Types of Stress		Stress Initial Measure		Stress Second Measure			
		Mean Conf.int.	Std.Dev	Mean Conf.int	Std.Dev	Mean improvement	Significance.
Worrying		5.59 ±0.39	2.38	4.56 ±0.78	2.743	1.03	*p≤0.01*
Active		3.85 ±0.44	2.7	3.01 ±0.55	2.574	0.85	*p≤0.01*

Worrying stress and active stress were both scored out of 9, 0= no stress, 9= stress very high

The mean scores for both worrying and active stress were very significantly improved between the initial and second measurement. Some 16% reported no stress for the second measure. Over 50% of respondents improved their stress scores between the initial and second measures.

Table 11: Stress: Initial and Second Measure, Number of Responses by Score (n=147)

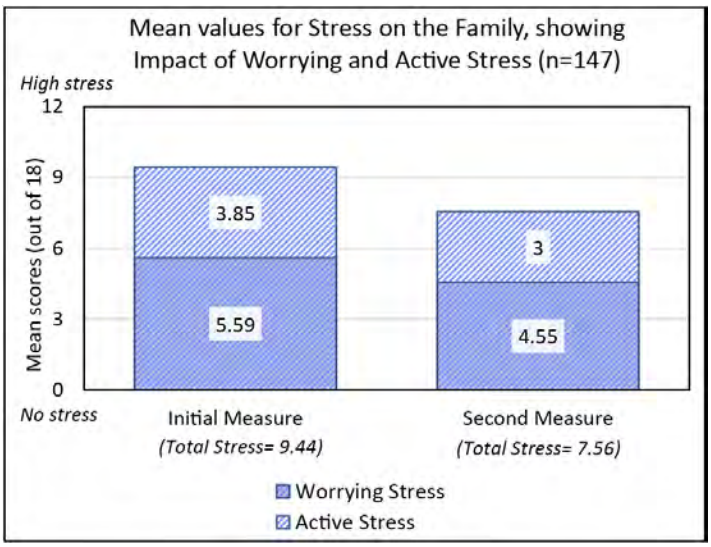
	Worrying		Active	
	Initial Measure	Second Measure	Initial Measure	Second Measure
0=no stress	3%	9%	9%	16%
1	4%	12%	12%	22%
2	5%	18%	18%	11%
3	8%	14%	14%	12%
4	10%	12%	12%	2%
5	13%	10%	10%	1%
6	22%	6%	6%	3%
7	10%	5%	5%	2%
8	14%	6%	6%	1%
9=high stress	12%	9%	9%	0%

Table 12: Comparison of Stress Scores; Initial to Second Measure, Improved, Unchanged or Deteriorated, by Percentage of Responses (n=147)

Types of Stress	Improved	Unchanged	Deteriorated
Worrying	55%	16%	29%
Active	56%	16%	27%

Figure 3: Contribution of Worrying and Active Stress to Overall Mean Stress Score (n=147)

Mean values for Stress on the Family, showing Impact of Worrying and Active Stress (n=147)



Initially the mean for worrying stress was higher (5.59) than for active stress (3.85), appearing to be more of a problem for clients than active concerns. On the second measure the reported stress was highly significantly improved, both for active and worrying stress.

5.1.2 Strain

(See Context 1.4. Strain, and Appendix 2 for FMQ questions)

The strain an AFM was under was exhibited by the symptoms with which they present. This construct is divided into psychological symptoms and physical symptoms. Psychological symptoms include worrying, being irritable and persistent recurring thoughts. Physical symptoms include inability to concentrate, sleeplessness and feeling weak.

Table 13: Comparison of Strain Symptoms; Mean Scores for Initial and Second Measures (n=147)

Strain Symptoms Initial Measure		Strain Symptoms Second Measure			
Mean Conf.int	Std.Dev	Mean Conf.int	Std.Dev	Mean Improvement	Significance.
8.05 ±0.45	2.80	6.86 ±5.4	3.36	1.19	*p≤0.01*

Scored out of 12: 0 = no symptoms, 12 = symptoms very troubling

Symptoms of Strain: Psychological and Physical sub-scales

Table 14: Comparison of Symptoms of Strain, Initially and after Six Sessions; Mean, Std.Dev. Improvement in mean score and significance: by question (n=147)

Types of Strain	Initial Measure		SECOND MEASURE			
	Mean	Std.Dev	Mean	Std.Dev	Improvement	Significance.
Psychological	4.64 ±0.21	1.31	4.02 ±0.28	1.71	0.62	*p≤0.01*
Physical	3.41 ±0.32	1.77	2.84 ±0.32	1.94	0.57	*p≤0.01*

Table 15: Strain: Initial and Second Measures, Percentage of Responses by Score (n=147)

Sum of three questions	**Psychological**		**Physical**	
	Initial Measure	Second Measure	Initial Measure	Second Measure
0=no symptoms	0%	3%	5%	18%
1	2%	7%	9%	18%
2	5%	7%	19%	16%
3	13%	21%	17%	12%
4	23%	19%	20%	18%
5	22%	12%	20%	10%
6=high symptoms	35%	30%	18%	12%

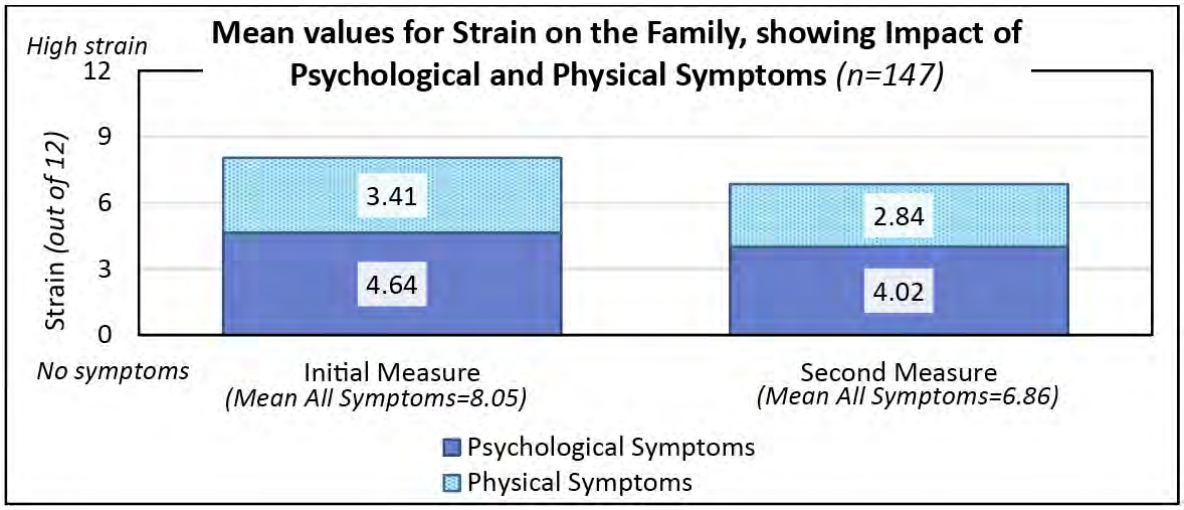
The mean for psychological strain was reported as being higher than physical symptoms, with over a third (35%) reporting the highest possible scores. Both the psychological and physical mean scores improved highly significantly between the two measures, and this was reflected in the number of those reporting improvements.

Table 16: Strain Score Entry to Six Session Measurement, Improved, Same or Deteriorated, by Percentage of Responses (n=147)

Types of Strain	Improved	Unchanged	Deteriorated
Psychological Symptoms	48%	26%	27%
Physical Symptoms	46%	27%	27%

Figure 4: Contribution of Psychological and Physical Symptoms to Overall Mean Strain Score (n=147)

Mean values for Strain on the Family, showing Impact of Psychological and Physical Symptoms (n=147)



Psychological strain interacts with physical strain (being able to sleep better for instance), and improvement in both was highly correlated.

Psychological strain reported to case workers during their first one-to-one session was higher for many AFM than the FMQ mean scores would indicate.

5.1.3 Coping Strategies

(See Context 1.5. Coping, and Appendix 2 for FMQ questions)

The coping construct consists of engaged coping, tolerant coping and coping by withdrawal. Engaged coping is sub-divided into two scales, reactive/emotional, and assertive/proactive. This gives four measures:

- Engaged Emotional = Reactive, reacting to SU by arguing, getting moody or watching very movement
- Engaged Assertive = Proactive, attempting to clarify expectations and confirm that excuses are not acceptable
- Tolerant, prolongs the status quo.
- Withdrawn, withdrawing attention from the user to AFM and family's own needs.

Table 17: Coping Strategies; Mean, Std.Dev. and Significance and Improvement Between Initial and Second Measure (n=147)

Coping Strategies	Initial Measure		Second Measure			
	Mean Conf.int	Std.Dev	Mean Conf.int	Std.Dev	Improvement in means	Significance
Reactive Coping	5.22 ±0.39	2.43	4.43 ±0.43	2.674	0.80	*p≤0 .01*
Proactive Coping	5.42 ±0.46	2.84	5.27 ±0.43	2.69	0.15	n.s.
Tolerant Coping	3.14 ±0.45	2.76	2.37 ±0.39	2.44	0.78	*p≤0.01*
Withdrawn Coping	4.46 ±0.41	2.52	4.84 ±0.41	2.51	0.39	n.s.

Each scored out of 9, 9=using this strategy, 0=not using.

The significant **(p≤0 .01)** improvement in the mean scores for reactive and tolerant coping indicated less use of these dysfunctional approaches.

Table 18: Coping Strategies: Initial and Second Measure, Percentage of Responses by Question **(n=147)**

Strategy Score *(Sum of relevant three questions)*	Reactive		Proactive		Tolerant		Withdrawn	
	Initial Measure	Second Measure	Initial Measure	Second Measure	Initial Measure	Second Measure	Initial Measure	Second Measure
0 (Never)	1%	5%	3%	5%	23%	32%	7%	6%
1	5%	9%	9%	7%	12%	13%	5%	4%
2	6%	15%	7%	5%	12%	16%	13%	10%
3	18%	15%	11%	14%	17%	12%	14%	12%
4	10%	12%	7%	9%	5%	10%	8%	9%
5	14%	10%	11%	12%	9%	3%	15%	15%
6	13%	9%	11%	11%	5%	7%	14%	17%
7	9%	7%	13%	12%	7%	2%	9%	10%
8	12%	8%	4%	14%	3%	3%	10%	9%
9 (Often)	12%	10%	24%	13%	5%	2%	4%	8%

Table 19: Coping: Initial to Second Measure, Percentage Improved, Unchanged or Deteriorated (n=147)

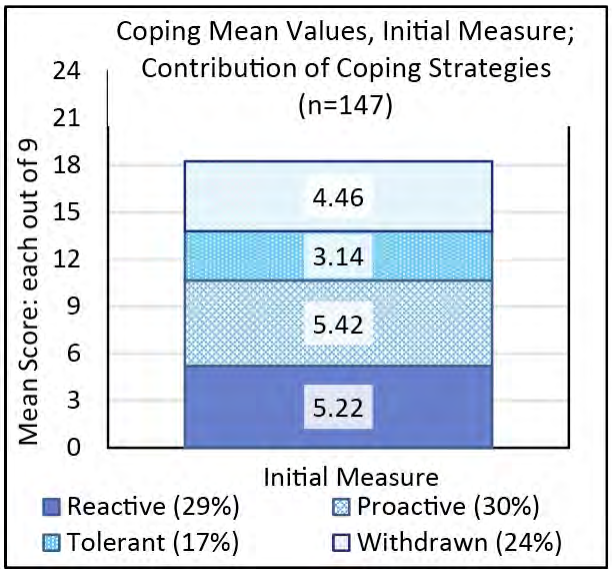
Coping Strategy	Improved	Unchanged	Deteriorated
Reactive Coping	52%	16%	32%
Proactive Coping	44%	12%	44%
Tolerant Coping	48%	27%	25%
Withdrawn Coping	48%	19%	33%

Coping; Contribution of the Various Strategies, Initial and Second Measures

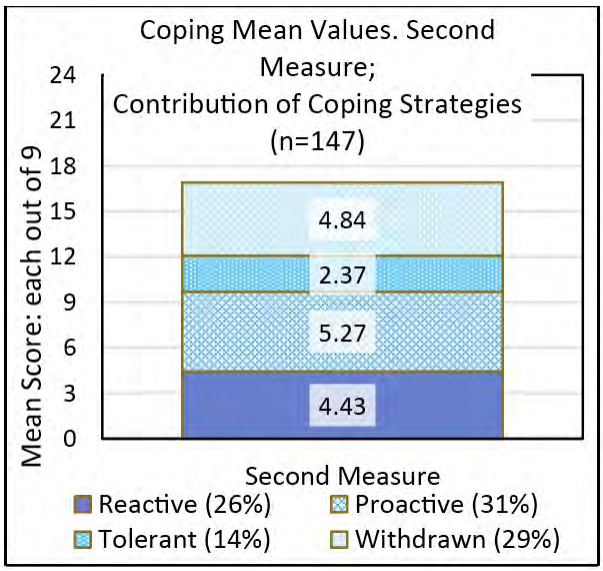
Coping; Contribution of the Various Strategies, Initial and Second Measures

Figure 5: Mean Values for Coping Showing Distribution of types of Coping, Initial and Second Measures (n=147)

Coping Mean Values, Initial Measure; Contribution of Coping Strategies (n=147)



Coping Mean Values. Second Measure; Contribution of Coping Strategies (n=147)



Although some 23% of the cohort initially responded that they 'never' facilitated or excused the SU's substance use, the majority of clients use a mixture of all four approaches as seems appropriate. The mean for dysfunctional strategies fell from 8.37 to 6.08 between the two measures, at the same time the mean for more constructive approaches rose from 9.88 initially to 10.12. Mean scores for dysfunctional approaches made up 46% of initial, but only 40% of the second measures, while measures for proactive and withdrawn strategies formed 54% initially, and 60% of the total at the second measure.

The mean score for reactive coping, was highly significantly improved at the second measure (4.43) with more than half (52%) of AFM reporting an improvement. Initially only 1% of clients responded to all three questions that they 'never' (score=0) used reactive approaches, while 12% utilised this approach 'often', for all three elements. This had improved on the second measure with 5% responding to all three questions 'never' and only 10% 'often' (score=9). As a proportion of coping strategies, reactive approaches initially contributed 29%, but had improved at the second measure, falling to 26%.

The mean for proactive strategy, where the AFM made clear to the SU that their behaviour was not appropriate, was identified as having the highest mean score initially (5.42) as well as for the second measure (5.27) and it was a slightly higher proportion of the whole at the second measure (30% initially, 31% on second measure). Although the difference in mean scores was not significant, only 3% of respondents initially and 5% at the second measure responded for all three questions that they 'never' used proactive coping strategies. The number reporting that they 'often' used them for all three questions (score=3, for all three questions) fell from 24% to only 13% at the second measure. The total of responses, however, where at least two of the questions scored 'often' rose from 4% to 14%.

The mean score for tolerant strategies fell from 3.14 initially to 2.37 at the second measure. Initially some 23% of respondents 'never' excused, covered up or were complicit in helping the SU obtain drink/drugs. This rose to 32% at the second measure. Tolerant coping made up 17% of initial coping scores, but this had reduced to 14% on the second measure, and although 27% reported no change, 48% reported an improvement. As 23% initially reported that they never tolerated or facilitated substance use no change was a positive result.

There was not a significant increase in mean scores for withdrawn coping, although it contributed a greater proportion of the whole at the second measure (29%, improved from 24%). Although the difference in means were not significant some 48% reported an improvement.

Table 20 Relationship Between Coping Strategies: Initial and Second Measure (Spearman's Rank Order Correlation, r_s)

Coping Measure Initial Measure *(n=147)*		Reactive Coping	Proactive Coping	Tolerant Coping
Proactive Coping	Correlation Coefficient,	0.534		
	Significance. (2-tailed)	*p≤0.000*		
Tolerant Coping	Correlation Coefficient,	0.448	0.350	
	Significance. (2-tailed)	*p≤0.000*	*p≤0.000*	
Withdrawn coping. *(negatively scored)*	Correlation Coefficient.	-0.020	-0.031	0.062
	Significance. (2-tailed)	n.s.	n.s.	n.s.

Coping Second Measure *(n=147)*		Reactive Coping	Proactive Coping	Tolerant Coping
Proactive Coping	Correlation Coefficient, r_s	0.518		
	Significance. (2-tailed)	*p≤0.000*		
Tolerant Coping	Correlation Coefficient, r_s	0.533	0.499	
	Significance. (2-tailed)	*p≤0.000*	*p≤0.000*	
Withdrawn coping. *(negatively scored)*	Correlation Coefficient, r_s	-0.054	-0.061	-0.045
	Significance. (2-tailed)	n.s.	n.s.	n.s.

(A positive correlation suggests that variables were both high, or both low, a negative correlation is an inverse relationship, the higher one variable, the lower the other).

There was a highly significant relationship between proactive and reactive coping strategies. There was also a highly significant correlation between tolerant and reactive, and between tolerant and proactive coping.

The relationship between reactive proactive and tolerant coping was highly significant for both the initial and the second measure, although the correlation for proactive and tolerant was stronger at the second measure.

Some level of withdrawn coping was utilised by most respondents, but there was no significant relationship between withdrawn coping and other coping strategies.

5.1.4 Family Burden

(See Context 1.1. Living with a Substance User, and Appendix 2 for FMQ questions)

Family burden was calculated by totalling the stress, strain, reactive coping, and tolerant coping to give an overall score for problems relating to the SU.

Family Burden: Mean and Standard Deviation; Initial and Second Measures

Table 21: Family Burden; Improvement Between Initial and Second Measure, Mean, Std.dev. and Significance; (n=147)

	Initial Measure		Second Measure			
Family Burden	Mean Conf.int	Std dev	Mean Conf.int	Std dev	Difference in Mean	Significance.
	25.85 ±3.63	12.37	21.22 ±3.89	13.26	4.63	*p≤0.01*

Scored out of 30, 0= no burden 30= high burden

Table 22: Variables Comprising Family Burden; Mean Values: Initial and Second Measures (n=147)

	Initial measure	Second measure
Stress	9.44	7.56
Strain	8.05	6.86
Reactive coping	5.22	4.43
Tolerant coping	3.14	2.37
Burden	25.85	21.22

Table 23: Family Burden Score: Initial to Second Measure, Deteriorated, Unchanged or Improved, by Percentage of Responses (n=147)

	Improved	Unchanged	Deteriorated
Family Burden	64%	3%	33%

Family burden was highly significantly improved between the initial and second measure. This was reflected in the number who reported improvement (64%) compared with the number whose scores deteriorated (33%).

Pressures on a family reflect the chaotic nature of living with the SU, as well as the AFM's own reactions and concerns, it would be unrealistic to expect the burden for all AFM to have improved.

5.1.5: Social Support

(See Context1.6 Support, and Appendix 2 for FMQ questions)

Social Support Sub-Scales, Helpful informal, Helpful Formal and Unhelpful Informal

Table 24: Social Support Subscales: Helpful Informal, Helpful Formal and Unhelpful Informal; Mean, Std.Dev. and Significance: Improvement Between Initial and Second Measure (n=147)

	Initial Measure		Second Measure			
	Mean Conf.int	Std.Dev	Mean Conf.int	Std.Dev	Improvement in mean	Significance.
Helpful Informal *unhelpful=0, helpful=9*	6.11 ±0.35	2.71	6.07 ±0.44	2.71	-0.06	n.s.
Helpful Formal *unhelpful=0, helpful=9*	5.60 ±0.53	3.28	7.93 ±0.3	1.84	2.33	*p≤0.01*
Unhelpful Informal *helpful=0, unhelpful=9*	2.80 ±0.43	2.68	2.5 ±0.41	2.55	2.31	n.s.

Table 25: Social Support Subscales; Percentage of Responses Initial and After Six Sessions (n=147)

Strategy Score	**Helpful Informal**		**Helpful Formal**		**Unhelpful Informal**	
(sum of relevant three questions)	**Support**		**Support**		**Support**	
	Initial Measure	Second Measure	Initial Measure	Second Measure	Initial Measure	Second Measure
Never=0	6%	3%	12%	1%	28%	31%
1	1%	3%	4%	1%	14%	10%
2	5%	3%	5%	1%	12%	14%
3	6%	11%	12%	1%	12%	15%
4	5%	7%	7%	1%	6%	10%
5	12%	8%	2%	2%	7%	5%
6	15%	18%	8%	9%	9%	4%
7	12%	7%	10%	9%	5%	3%
8	10%	10%	5%	16%	5%	5%
Often=9	28%	29%	35%	59%	2%	2%

Table 26: Support Score: Initial to Second Measure, Percentage of Responses Improved, Unchanged or Deteriorated (n=147)

	Improved	Unchanged	Deteriorated
Helpful Informal Support	39%	25%	35%
Helpful Formal Support	57%	29%	14%
Unhelp Informal	42%	22%	36%

The mean for helpful informal support was relatively high initially (6.11), indicating that for the majority of AFM there was support from family and friends. Although informal helpful support was not scored as highly at the second measure the difference was not significant.

Formal support increased very significantly, with 59% of AFM indicating they 'often' (score 9) appreciated the support and helpful information of caseworkers.

Initially most AFM rated informal unhelpful support low (i.e., there was relatively little unhelpful informal support). Some 28% initially reported friends or family 'never' (score 0) made unhelpful or nasty comments about the SU, or that they did NOT deserve help; and only 2% who rated this 'often' on all three questions. There was no significant change over the period, some 42% indicated that this had improved, although 36% that it had deteriorated. Mean scores show that it had improved over five sessions to the second measure, but not significantly.

5.1.6 RELATIONSHIPS BETWEEN STRESS, STRAIN, COPING STRATEGIES AND SUPPORT

Correlations Between Improvements in Stress Strain, and Coping Strategies

Table 27: Relationship Between Improvement in Coping and Improvement in Stress and Strain Sub-Scales

	Improvement in Stress		Improvement in Strain	
Improvement in:	**Worrying**	**Active**	**Psychological**	**Physical**
Reactive Coping	.518	.494	.384	.332
Significance	p≤0.000	p≤0.000	p≤0.000	p≤0.000
Proactive Coping	.257	.214	.249	.148
Significance	p≤0.001	p≤0.01	p≤0.001	p≤0.05
Tolerant Coping	.399	.416	.381	.395
Significance	p≤0.000	p≤0.000	p≤0.000	p≤0.000

Improvements in reactive and tolerant coping strategies were very highly significantly correlated with improvements in stress and strain at the ***p≤0.000*** level. Proactive coping improvement, although significant, was less strongly associated with improvement in stress or strain. The improvement in withdrawn coping had no significant relationship to any improvement in stress or strain suffered by AFMs.

Correlation of Improvement in Social Support, Stress and Strain,

Table 28: Correlations between Improvement in Helpful and Unhelpful Social Support and Improvement in Stress and Strain Subscales (n=147)

	Improvement in Stress		Improvement in Strain	
Improvement in:	**Worrying**	**Active**	**Psychological**	**Physical**
Helpful Informal Support	0.096	0.002	0.345	0.095
Significance	n.s.	n.s.	p≤0.001	n.s.
Helpful Formal Support	0.082	0.044	0.063	0.061
Significance	n.s.	n.s.	n.s.	n.s.
Improvement in Unhelpful Informal Support	0.172	0.255	0.184	0.225
Significance	p≤0.05.	p≤0.005	p≤0.05	p≤0.01

(Helpful informal and formal support and withdrawn coping area all negatively scored)

Improvement in Informal helpful support in and in psychological symptoms was significant at the ***p≤0.001*** level, but other relationships for helpful support were not significant. The mean for improvement in unhelpful informal support was relatively low (n.s.), improvement was, however, significantly correlated with improvement in worrying stress ***(p≤.0.05)***, active stress ***(p≤0.005)***, psychological ***(p≤.0.05)*** and physical strain ***(p≤0.01)***.

Table 29: Correlations between Improvement in Helpful and Unhelpful Social Support and Improvement in Coping Strategies (n=147)

Improvement in:	**Improvement in Reactive Coping**	**Improvement in Proactive Coping**	**Improvement in Tolerant Coping**	**Improvement in Withdrawn Coping**
Helpful Informal Support	0.082	0.113	0.117	0.178
Significance	n.s.	n.s.	n.s.	p≤0.05
Helpful Formal Support	0.117	0.0723	0.111	0.208
Significance	n.s.	n.s.	n.s.	p≤0.05
Improvement in Unhelpful Informal Support	0.144	0.09	0.270	0.035
Significance	n.s.	n.s.	p≤0.000	n.s.

Withdrawn coping strategy improvement was related to improvement in helpful informal support and with helpful formal support ***(p≤0.05)***. Improvement in tolerant coping was very significantly correlated with improvement in unhelpful support ***(p≤0.000)***.

5.1.7 MENTAL WELLBEING

(See Context 1.7. Wellbeing, and Appendix 2 Family Member Questionnaire)

Table 30: Comparison of Wellbeing; Initial Mean Scores and At the Second Measure (n=147)

Mental Wellbeing Initial Measure		**Mental Wellbeing** Second Measure			
Mean Conf.int	Std.Dev	Mean Conf.int	Std.Dev	Difference in mean	Sig.
19.32 ±0.57	3.56	20.77 ±0.7	4.33	1.45	*p≤0.01*

(Five items, each scored 1-7. Total scored out of 35: 7=very poor, 35=very good)

Table 31: Wellbeing Score Entry to Six Sessions, Improved, Same or Deteriorated, Percentage by Number of Responses (n=147)

	Improved	Unchanged	Deteriorated
Wellbeing	59%	11%	30%

Shah et al. (2018 p5) used a difference of 2.77 as being a statistically meaningful change at the individual level. On this basis nearly a third (31%) of individual respondents indicated significant meaningful improvement during the five sessions although 14%, indicated that wellbeing had significantly deteriorated.

Table 32: Wellbeing, Number of Respondents whose Wellbeing (SWEMWBS) scores had changed significantly.

(n=147)	Number	Percentage
Significantly Improved	46	31.3%
Significantly Deteriorated	20	13.6%

Table 33: Number of Respondents Compared with Centiles for England (n=147)[1]

Centiles for England	Initial Measure		Second Measure	
Bottom 10% of English Population	79	53.7%	51	34.7%
11th to 15th Centile	13	8.8%	15	10.2%
16th to Median	37	25.2%	51	34.7%
Median to 85th Centile	15	10.2%	21	14.3%
86th t0 90th centile	1	0.7%	1	0.7%
Top 10% of English Population	2	1.4%	8	5.4%
Percentage at or below the 50th Centile of English National Norms	**129**	**87.7%**	**117**	**79.6%**

At the initial measure some 87.7% of SWEMWBS scores were below the median Norm for England (23.21) and 53.7% in the bottom decile. At the second measure the scores had improved highly significantly, only 80% were below median, and 35% in the bottom decile. While there was very significant improvement over three quarters of AFM remain below the median normal score for England.[1]

Figure 6: Mental Wellbeing Scores, Percentages of Respondents Compared with the National Centiles for England, Initial and Second Measure(n=147)

Mental Wellbeing; Percentages of Respondents compared with the National Centiles for England, Initially and Measure after Six Sessions (n=147)

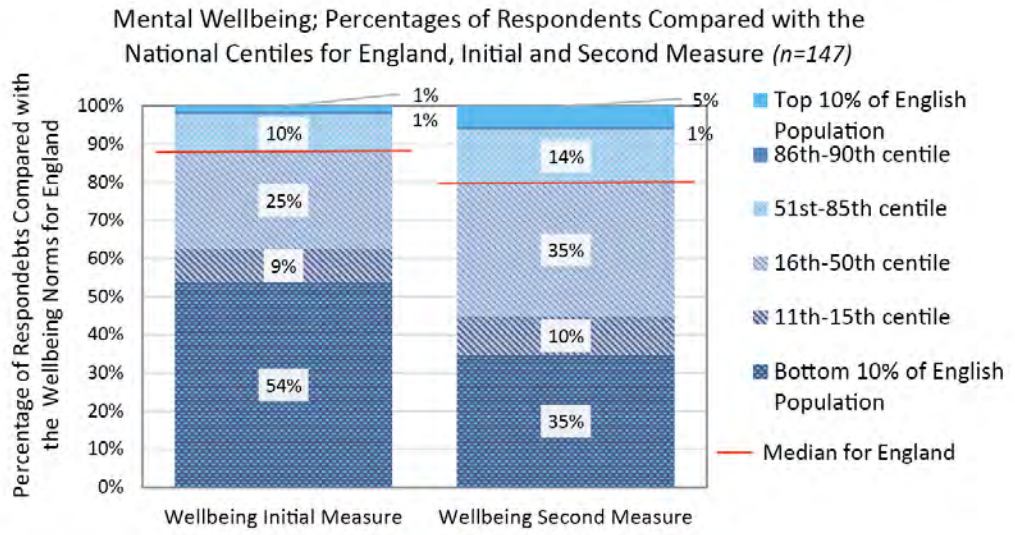
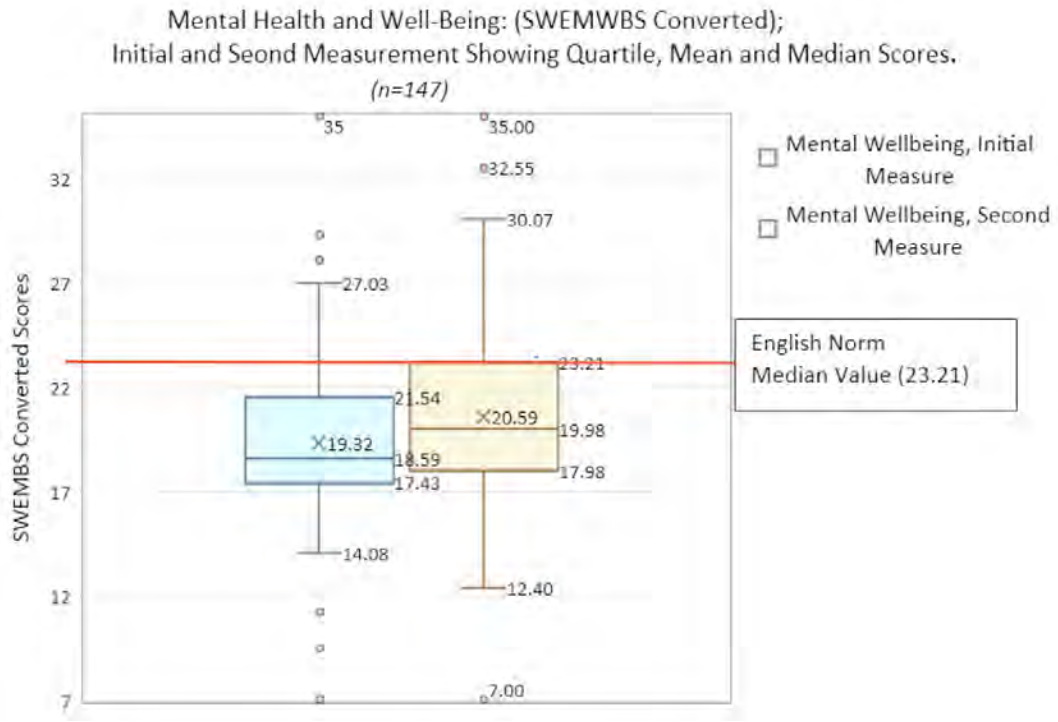


Figure 7: Mental Wellbeing. Box and Whisker Chart for Initial and Second Measure Scores, showing Quartile, Mean and Median Scores. (n=147)

Mental Health and Well-Being: (SWEMWBS Converted); Initial and Second Measurement Showing Quarile, Mean and Median Scores.



10th =18.59	15th =19.25	50th =23.21	85th =27.03	90th =28.13

5.1.8 MENTAL WELLBEING CORRELATION WITH STRESS, STRAIN, COPING STRATEGIES AND SOCIAL SUPPORT

(See Appendix 2 for SWEMWBS and FMQ questions.)

Table 34: Correlation of Wellbeing with Stress and Strain; Initially and after Six Sessions (n=147)

Correlation (Spearman's rho, r_s)	Stress		Strain	
	Worrying	Active	Psychological	Physical
Initial Measure	-0.175	-0.297	-0.387	-0.404
Significance	*p≤0.05*	*p≤0.000*	*p≤0.000*	*p≤0.000*
Second Measure	-0.466	-0.379	-0.442	-0.624
Significance	*p≤0.000*	*p≤0.000*	*p≤0.000*	*p≤0.000*

All stress and strain measures were inversely related to wellbeing, although initially the correlation for worrying stress and wellbeing was only significant at the ***p≤0.05*** level, at the second measure the correlation became very highly significant ***(p≤0.000)***. All other stress/strain variables were very highly significantly inversely related to wellbeing ***(p≤0.000)***.

Table 35: Correlation of Wellbeing with Coping Strategies; Initial and Second Measures (n=147)

Correlation (Spearman's rho, r_s)	**Reactive**	**Proactive**	**Tolerant**	**Withdrawn** *(negatively scored)*
Initial Measure	-0.245	-0.268	-0.264	0.407
Significance	*p≤0.001*	*p≤0.001*	*p≤0.001*	*p≤0.000*
Second Measure	-0.360	-0.154	-0.342	0.291
Significance	*p≤0.000*	*p≤0.05*	*p≤0.000*	*p≤0.000*

Initially responses show that wellbeing was very highly inversely correlated with reactive, proactive, and tolerant coping ***(p≤0.001)***. and positively ***(p≤0.000)*** with withdrawn coping. The relationship was still apparent in the second measure, although the significance of the correlation for proactive coping dropped to ***p≤0.05***.

Correlation of Wellbeing with Social Support; Initial and Second Measure

Table 36: Correlation of Wellbeing with Coping Strategies; Initially, and at the Second Measure (n=147)

Correlation (Spearman's rho, r_s)	**Helpful Informal**	**Helpful Formal**	**Unhelpful Informal** *(negatively scored)*
Initial Measure	0.165	0.293	-0. 067
Significance	*p≤0.05*	*p≤0.000*	*n.s.*
Second Measure	0.302	0.058	-0.225
Significance	*p≤0.000*	*n.s.*	*p≤0.01*

Initially helpful support, both informal ***(p≤0.05)*** and formal ***(p≤0.01)***, was significantly correlated with wellbeing, but unhelpful support was not significantly related. At the second measure helpful informal support was correlated with wellbeing at the ***p≤0.01*** level, while unhelpful informal support was significantly inversely correlated ***(p≤0.01)*** the more unhelpful informal support, the lower the wellbeing score. There was no significant relationship between wellbeing and helpful formal support at the second measure.

Correlations of Improvement in Stress, Strain, Coping and Support with Improvement in Wellbeing

Improvement in:		Improvement in SWEMWBS	
		Correlation	Significance
Stress	Worrying	0.3122	$p \leq 0.005$
	Active	0.2161	$p \leq 0.05$
Strain	Psychological	0.3321	$p \leq 0.0000$
	Physical	0.4139	$p \leq 0.0000$
Coping	Reactive	0.2843	$p \leq 0.0005$
	Proactive	0.1351	n.s.
	Tolerant	0.3246	$p \leq 0.0001$
	Withdrawn	0.3826	$p \leq 0.0000$
Support	Helpful Informal Support	0.0491	n.s.
	Helpful Formal Support	0.2220	$p \leq 0.01$
	Unhelp Informal Support	-0.0229	n.s.

The improvement in most variables are at very significantly correlated with improvement in mental wellbeing.

Active stress improvement is correlated at the ***$p \leq 0.05$*** level

There is no significant relationship, however, between improvement in mental wellbeing and improvement in informal helpful, or unhelpful support. Nor is there any significant correlation between in the improvement in proactive coping and mental wellbeing.

5.2 Post-Intervention

In June 2019 there was an opportunistic opportunity to follow up AFM who had completed the intervention (i.e., exited by mutual consent). These AFMs were asked to complete a further questionnaire over the phone. As this was a snapshot some respondents had left F.S.L. only a few weeks, while others had exited up to two years previously. Forty-nine completed questionnaires were analysed.

The Mann-Whitney test was run to check whether initially the post-intervention respondents differed from the original cohort. Each variable showed a non-significant difference except those of social support. Initially social support was very significantly lower for the post-intervention cohort, compared with the main evaluation cohort. Other variables were not significantly different initially.

5.2.1 Stress: Post-Intervention

(See Context 1.3. Stress, and Appendix 2 for FMQ questions)

Table 37: Impact on the Family, mean values for Post-Intervention Respondents; Initial, Second, and Post-Intervention Measures (n=49)

	Respondents Initial Measure *(Post-Intervention Respondents)*		**Respondents Second Measure** *(Post-Intervention Respondents)*		**Post-Intervention Measure**		**Mean Improvement**		
	Mean Conf.int	Std. dev	Mean Conf.int	Std. dev	Mean Conf.int	Std. dev	Initial to Second Measure	Initial to Post-Intervention	Second Measure to Post-Intervention
Stress	9.59 ±1.28	4.47	6.29 ±1.28	4.45	3.37 ±1.34	4.79	3.31 *p≤0.01*	6.22 *p≤0.01*	2.92 *p≤0.01*

Stress sub-scales: Post-Intervention

Table 38: Impact on the Family. Mean Values for Post-Intervention Respondents; Initial, Second, and Post-Intervention Measures (n=49)

	Respondents Initial Measure *(Post-Intervention Respondents)*		**Respondents Second Measure** *(Post-Intervention Respondents)*		**Post-Intervention Measure**		**Mean Improvement**		
	Mean Conf.int	Std. dev	Mean Conf.int	Std. dev	Mean Conf.int	Std. dev	Initial to Second Measure	Initial to Post-Intervention	Second Measure to Post-Intervention
Worrying	5.71 ±0.72	2.52	3.90 ±0.77	2.69	1.84 ±0.78	2.71	1.82 *p≤0.01*	3.88 *p≤0.01*	2.06 *p≤0.01*
Active	3.88 ±0.78	2.72	2.39 ±0.64	2.21	1 .53 ±0.65	2.27	1.49 *p≤0.01*	2.35 *p≤0.01*	0.86 *p≤0.05*

Figure 8: Comparison on Worrying and Active Impact on the Family for Post-Intervention Respondents; Mean Scores for Initial, Second, and Post-Intervention Measures showing Contribution of Worrying and Active Stress (n=49)

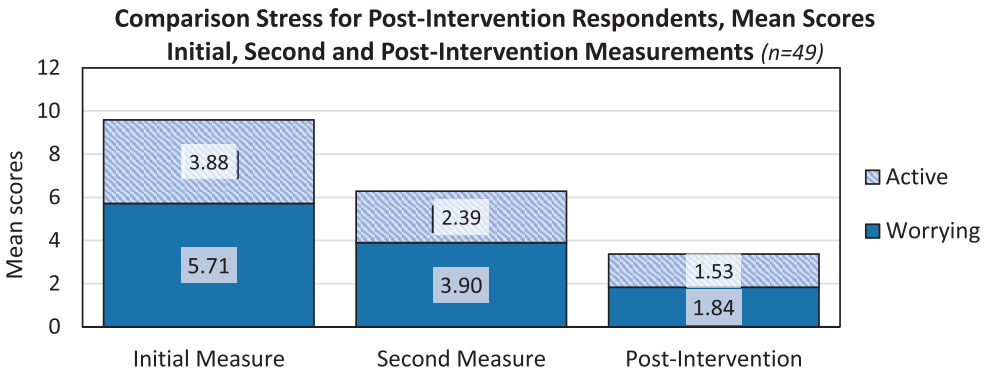


Table 39: Worrying and Active Stress, Second Measure to Post-Intervention; for Post-Intervention Respondents, Improved, Unchanged or Deteriorated, by Percentage of Responses (n=49)

Individual's Change Between Second Measure and Post-Intervention	Improved	Unchanged	Deteriorated
Worrying	61%	18%	20%
Active	51%	24%	24%

Initially stress, neither worrying nor active, was significantly different from the main evaluation cohort, and similarly, at the second measure, was very significantly improved. Post-intervention means showed very significant improvement compared with the second measure. This was reinforced by the percentage of clients who responded that stress had improved between the second measure and post-intervention.

5.2 2 Strain: Post-Intervention

(See Context 1.4. Strain, and Appendix 2 for FMQ questions)

Table 40: Strain, Mean, and Difference In Mean for Initial, Second and Post-intervention Measures.(n=49)

	Respondents Initial Measure *(Post-Intervention Respondents)*		**Respondents Second Measure** *(Post-Intervention Respondents)*		**Post-Intervention Measure**		**Mean Improvement**		
	Mean Conf.int	Std. dev	Mean Conf.int	Std. dev	Mean Conf.int	Std. dev	Initial to Second Measure	Initial to Post-Intervention	Second Measure to Post-Intervention
Strain/ Symptoms	8.59 ±0.71	2.56	6.10 ±0.93	3.33	1.78 ±0.69	2.45	2.49 *p≤0.01*	6.82 *p≤0.01*	4.33 *p≤0.01*

Strain Sub-Scale Mean Scores: Post-Intervention

Table 41: Strain Sub-Scales, Psychological and Physical Symptoms of Strain for Post-Intervention Respondents. Mean for Initial, Second and Post-intervention Measures (n=49)

	Respondents Initial Measure *(Post-Intervention Respondents)*		**Respondents Second Measure** *(Post-Intervention Respondents)*		**Post-Intervention Measure**		**Mean Improvement**		
	Mean Conf.int	Std. dev	Mean Conf.int	Std. dev	Mean Conf.int	Std. dev	Initial to Second Measure	Initial to Post-Intervention	Second Measure to Post-Intervention.
Psych.	4.92 ±0.32	1.16	3.55 ±0.50	1.77	0.96 ±0.42	1.51	1.37 *p≤0.01*	3.96 *p≤0.01*	2.59 *p≤0.01*
Physical	3.67 ±0.49	1.74	2.55 ±0.51	1.8	0.82 ±0.29	1.04	1.12 *p≤0.01*	2.86 *p≤0.01*	1.73 *p≤0.01*

Figure 9: Strain, Mean, and Difference in Mean for Initial, Second and Post-Intervention Measures (n=49)

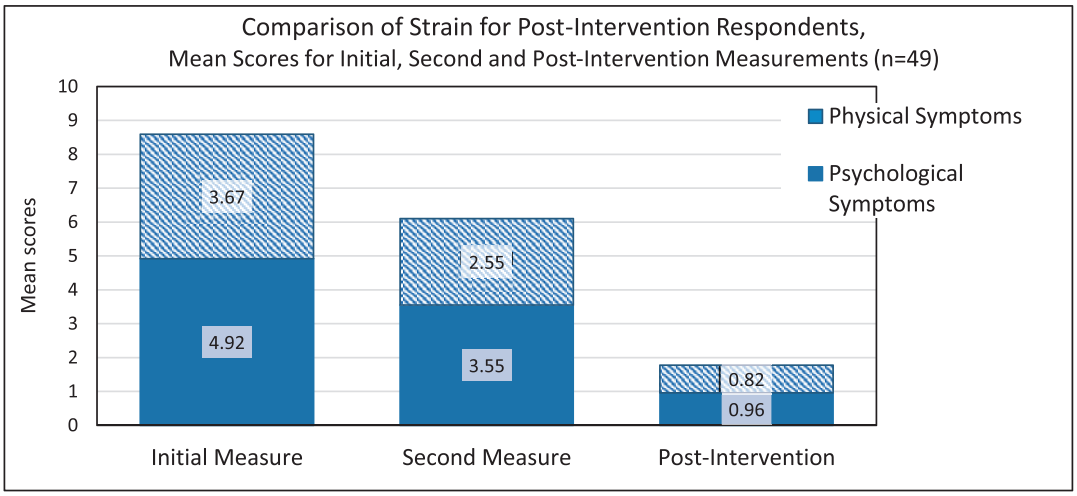


Table 42: Strain Symptoms, Second Measure to Post-Intervention, Improved, Unchanged or Deteriorated, by Percentage of Responses (n=49)

Individual's Change Between Second Measure and Post-Intervention for Post-Intervention Respondents	**Improved**	**Unchanged**	**Deteriorated**
Psychological	84%	6%	10%
Physical	69%	14%	16%

Initially the mean stress scores for post-intervention respondents were not significantly different than for the main evaluation cohort, and similarly, improved very significantly at the second measure.

5.2.3 Coping: Post-Intervention

(See Context 1.5 Coping, and Appendix 2 for FMQ questions)

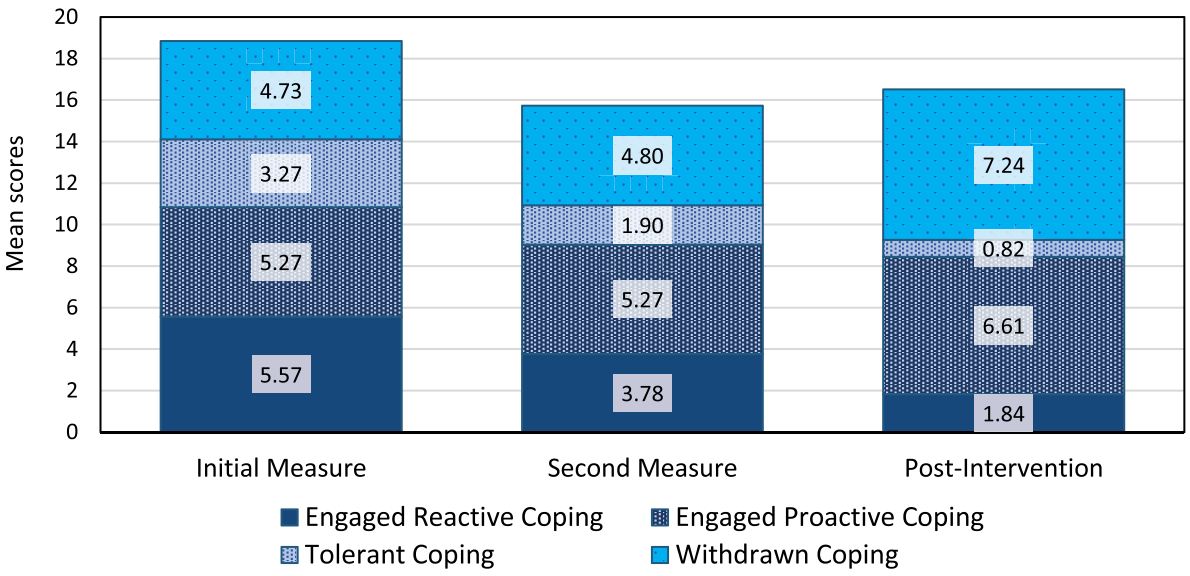
Table 43: Coping Strategies for Post-Intervention Respondents; Mean of Initial, Second and Post-intervention Measures (n=49)

	Initial Measure *(Post-Intervention Respondents)*		**Second Measure** *(Post-Intervention Respondents)*		**Post-Intervention Measure**		**Mean Improvement**		
	Mean Conf.int	Std. dev	Mean Conf.int	Std. dev	Mean Conf.int	Std. dev	Initial to Second Measure	Initial to Post-Intervention	Second to Post-Intervention
Reactive	5.57 ±2.34	2.34	3.78 ±0.73	2.64	1.84 ±0.6	2.13	1.8 *p≤0.01*	3.73 *p≤0.01*	1.94 *p≤0.01*
Proactive	5.27 ±0.79	2.82	5.27 ±0.73	2.60	6.61 ±0.85	3.04	.00 n.s.	-1.35 *p≤0.05*	-1.35 *p≤0.05*
Tolerant	3.27 ±0.75	2.69	1.90 ±0.67	2.40	0.82 ±0.42	1.5	1.37 *p≤0.01*	2.45 *p≤0.01*	1.08 *p≤0.05*
Withdrawn	4.73 ±0.66	2.35	4.80 ±0.74	2.63	7.24 ±0.67	2.41	0.06 n.s.	2.51 *p≤0.01*	2.45 *p≤0.01*

Table 44: Coping Strategies; Second to Post-Intervention Measures, Improved, Unchanged or Deteriorated by Percentage of Respondents (n=49)

Coping Strategies Change Second to Post-Intervention	**Improved**	**Unchanged**	**Deteriorated**
Reactive	67%	12%	20%
Proactive	33%	8%	59%
Tolerant	49%	33%	18%
Withdrawn	76%	6%	18%

Figure 10: Comparison of Coping Strategies Used by Post-Intervention Respondents; Mean Scores for Initial, Second, and Post-Intervention Measures (n=49)



For post-intervention respondents the initial mean for reactive and tolerant coping was slightly higher, and mean proactive coping slightly lower than for the main cohort (n.s.). At the second measure post-intervention respondents showed that reactive tolerant and withdrawn coping were improved. The post-intervention measure shows reactive, tolerant and withdrawn coping strategies were very significantly improved. The mean improvement for proactive coping was significantly lower ***(p≤0.05)***, however, compared with initial measures I continued to be a strategy adopted by the majority of respondents.

Table 45: Coping Strategies used by Post-Intervention Respondents; Proportions Initially, At the Second Measure, and Post-Intervention, by Percentage of Respondents (n=49)

Coping Strategy	**Initial Measure** *(Post-Intervention Respondents)*	**Second Measure** *(Post-Intervention Respondents)*	**Post-Intervention Measure**
Reactive	30%	24%	11%
Proactive	28%	34%	40%
Tolerant	17%	12%	5%
Withdrawn	25%	30%	44%

The dysfunctional proportion of the coping construct was considerably less at the second measure than the initial measurement. Initially dysfunctional elements of the coping strategy comprised some 47% of the whole. The post-intervention data shows that only 16% were still resorting to these methods, while proactive and withdrawn strategies make up 84% of the total.

Some 39% of post-intervention respondents report that they never resort to reactive strategies, compared with 2% initially. It was particularly encouraging that by the second measure 73% of post-intervention AFM reported not endorsing substance misuse by giving money to the SU, clearing up after them or covering up the results of the substance use.

5.2.4: Burden on the Family: Post-intervention

Family burden is calculated as the sum of stress, strain, reactive coping and tolerant coping.

Initially the stress, strain and coping variables that comprise the family burden construct, were not significantly different from the main evaluation group. When combined, however, the initial burden measure for post-intervention was initially significantly worse.

Table 46: Improvement in Variables Comprising Family Burden for Main Evaluation Cohort and Post-Intervention Respondents; Initial and, Second Measurements. (n=49)

Improvement Initial to Second measure	**Stress**	**Strain**	**Reactive Coping**	**Tolerant Coping**	**Burden**
Main evaluation cohort *(n=147)*	1.88	1.19	0.79	0.77	4.63
Post-intervention *(n=49)*	4.3	3.49	1.79	1.37	8.96
Significance difference between the two cohorts	n.s.	n.s.	n.s.	n.s.	*p≤0.01*

Table 47 Overall Burden, Comparison of Mean Burden Mean Scores for Post-Intervention Respondents; Initial, Second, and Post-intervention Measures. (n=49)

	Initial Measure *(Post-Intervention Respondents)*		**Second Measure** *(Post-Intervention Respondents)*		**Post-Intervention Measure**		**Mean Improvement**		
	Mean Conf.int	Std. dev	Mean Conf.int	Std. dev	Mean Conf.int	Std. dev	Initial to Second Measure	Initial to Post-Intervention	Second Measure to Post-Intervention
Burden	27.02 ±2.73	9.75	18.06 ±2.94	10.5	11.16 ±4.17	14.9	8.96 *p≤0.01*	25.18 *p≤0.01*	15.22 *p≤0.01*

Table 48: Comparison of Variables Comprising Family Burden for Post-Intervention Respondents; Mean Scores; Initial, Second, and Post-intervention Measures (n=49)

Family Burden Variables	**Initial Measure** *(Post-Intervention Respondents)*	**Second Measure** *(Post-Intervention Respondents)*	**Post-Intervention Measure**
Stress / Impact *(max score=18)*	9.59	5.29	3.37
Symptoms *(max. score=12)*	8.59	5.10	1.78
Reactive Coping *(max score=9)*	5.57	3.78	1.84
Tolerant Coping *(max score=9)*	3.27	1.90	0.82
Family Burden	27.02	18.06	7.80

Figure 11: Comparison of Family Burden for Post-Intervention Respondents (Impact, Symptoms, Reactive Coping and Tolerant Coping Methods); Mean Scores; Initial, Second, and Post-intervention Measures

Comparison of Helpful Informal, Helpful Formal and Unhelpful Informal Support for Post Intervention Respondents; Mean Scores: Initial, and Post Intervention Measures (n=49)

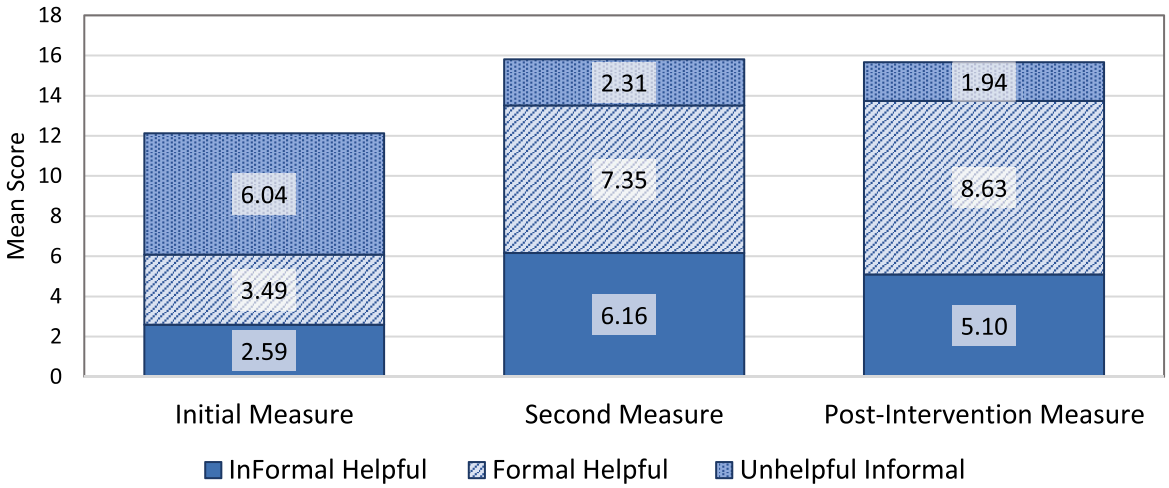


Table 49: Burden Score Second to Post-Intervention; Improved, Unchanged or Deteriorated for Post-Intervention Respondents, by Percentage of Responses (n=49)

Individual's Change Between Second Measure and Post-Intervention	Improved	Unchanged	Deteriorated
Burden	69%	6%	24%

The difference in the post-intervention means between the initial and second measure was very significant, and was again very significantly improved post-intervention with 69% of post-intervention respondents responding that their problems had reduced between the second measure and post-intervention.

Table 50 Correlation Between Improvement in Coping Strategies Post -Intervention, Second to Post-Intervention Measurements

Improvement in:	Improvement in Reactive Coping	Improvement in Proactive Coping	Improvement in Tolerant Coping
Proactive	0.386		
Significance	*p≤0.01*		
Tolerant	0.598	0.336	
Significance	*p≤0.01*	*p≤0.05*	
Withdrawn	0.275	0.229	0.203
Significance	n.s.	*ns*	*ns*

5.2.5 Social Support: Post-Intervention

(See Context 1.6. Strain, and Appendix 2 for FMQ questions)

Initially for the post-intervention cohort the mean showed significantly different values when compared with the main evaluation cohort. There was very significantly less informal or formal helpful support, and significantly more unhelpful support. By the time of the second measurement both cohorts had similar mean scores and there were no significant differences in support between the two cohorts at that stage.

Table 51: Comparison of Support for Main Evaluation Cohort with Post-Intervention Cohort

	Main Cohort Initial Measure		Post-intervention Respondents; Initial Measure		Difference	Main Cohort Second Measure		Post-Intervention; Second Measure		Difference
	mean	std. dev.	mean	std. dev.	Difference sig	mean	std. dev.	mean	std. dev.	Difference sig
Helpful Informal	5.11	2.73	2.59	2.72	3.52 *p≤0.000*	6.07	2.71	5.16	2.69	-0.09 n.s.
Helpful Formal	5.60	3.21	3.49	3.0	2.11 *p≤0.000*	7.93	1.83	7.35	2.45	0.58 n.s.
Unhelpful Informal	2.80	2.63	6.04	2.81	-3.24 *p≤0.000*	2.57	2.55	2.31	2.37	0.26 n.s.

Table 52: Helpful Informal, Helpful Formal and Unhelpful Informal Social Support Subscales for Post-Intervention Respondents; Mean, Std.Dev. and Significance, Improvement Between Initial, Second, and Post-Intervention Measures(n=49)

	Initial Measure *(Post-Intervention Respondents)*		**Second Measure** *(Post-Intervention Respondents)*		**Post-Intervention**		**Mean Improvement**		
	Mean Conf.int	Std. dev	Mean Conf.int	Std. dev	Mean Conf.int	Std. dev	Initial to Second Measure	Initial Measure to Post-Intervention	Second Measure to Post-Intervention.
Helpful Informal	2.59 ±0.75	2.7	6.16 ±0.75	2.69	5.10 ±1.04	3.73	3.57 *P≤0.000*	2.51 *p≤0.01*	-1.06 *p≤0.05*
Helpful Formal	3.49 ±0.84	3.0	7.35 ±0.69	2.45	8.63 ±0.27	0.98	3.86 *P≤0.000*	5.14 *P≤0.000*	1.29 *p≤0.05*
Unhelpful Informal	6.04 ±0.78	2.8	2.31 ±0.66	2.37	1.94 ±0.72	2.56	3.73 *P≤0.000*	4.10 *P≤0.000*	0.37 n.s.

All support improved highly significantly between the initial and second measures. Helpful informal support fell significantly post-intervention ***(p≤0.05***), although helpful formal support improved (p≤0.05). Informal unhelpful support did not improve significantly between second and post-intervention measures

Figure 12: Comparison of Helpful Informal, Helpful Formal and Unhelpful Informal Support for Post-Interventional Respondents

Comparison of Helpful Informal, Helpful Formal and Unhelpful Informal Support for Post Intervention Respondents; Mean Scores: Initial, Second and Post Intervention Measures (n=49)

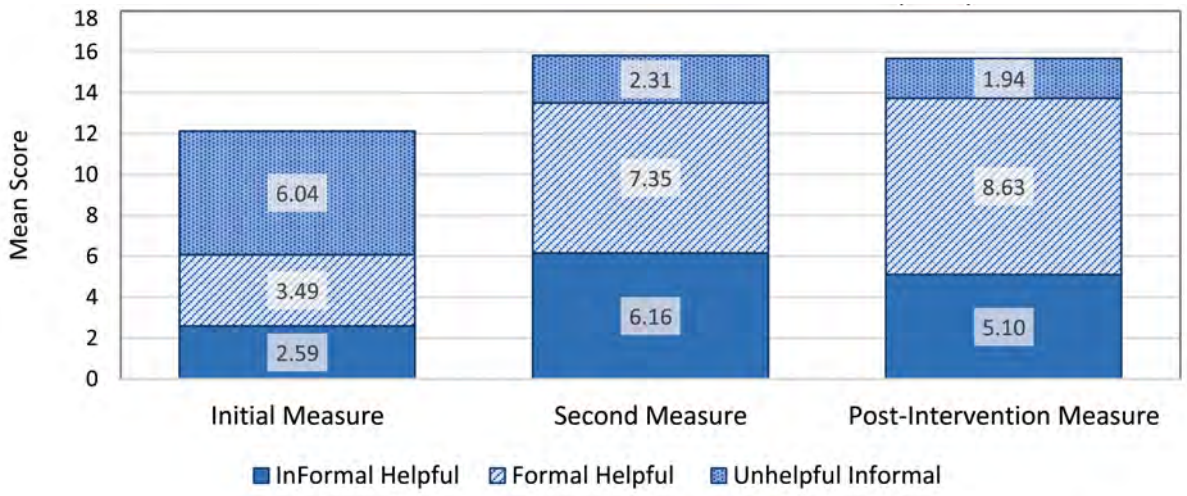


Table 53: Social Support for Post-Intervention Respondents; Initial to Second Measure, Improved, Unchanged or Deteriorated, by Percentage of Responses (n=49)

Individual's Change Between Second Measure and Post-Intervention *(n=49)*	**Improved**	**Unchanged**	**Deteriorated**
Informal Helpful	41%	16%	43%
Formal Helpful	43%	49%	8%
Informal Unhelpful	47%	18%	35%

POST-INTERVENTION CORRELATION OF IMPROVEMENTS IN STRESS STRAIN COPING AND SUPPORT

Table 54: Correlation of Improvement in Stress, Strain and Coping Strategies Between the Second and Post-Intervention Measures

	Improvement in Stress		**Improvement in Strain**	
Improvement In:	**Worrying**	**Active**	**Psychological**	**Physical**
Reactive Coping	0.728	0.778	0.681	0.634
Significance	*p≤0.000*	*p≤0.000*	*p≤0.000*	*p≤0.000*
Proactive Coping	0.255	0.376	0.362	0.394
Significance	n.s.	*p≤0.01*	*p≤0.01*	*p≤0.005*
Tolerant	0.577	0.604	0.568	0.701
Significance	*p≤0.000*	*p≤0.000*	*p≤0.000*	*p≤0.000*
Withdrawn	0.556	0.378	0.415	0.337
Significance	*p≤0.000*	*p≤0.01*	*p≤0.01*	*p≤0.05*

Improvement in proactive coping was not significantly correlated with improvement in worrying stress, and withdrawn coping improvement was only correlated with physical symptoms at the ***p≤0.05*** level. All other relationships were significantly correlated at least at the ***p≤0.01*** level. Improvement in dysfunctional strategies were correlated particularly strongly ***(p≤0.000)*** with all stress and strain improvement.

Table 55: Correlation of Improvement in Stress Strain and Support Between the Second and Post-Intervention Measures

	Improvement in Stress		Improvement in Strain	
Improvement In:	**Worrying**	**Active**	**Psychological**	**Physical**
Informal Helpful Support	0.359	0.247	0.24	0.283
Significance	*p≤0.05*	n.s.	n.s.	*p≤0.05*
Formal Helpful Support	0.232	0.196	0.189	0.061
Significance	n.s.	n.s.	n.s.	n.s.
Informal Unhelpful Support	0.147	0.129	0.084	0.206
Significance	n.s.	n.s.	n.s.	n.s.

Improved helpful informal support was significantly related to worrying stress and physical symptoms at the ***p≤0.05*** level. There were no other significant relationships.

Table 56: Correlation of Improvement in Stress Strain and Coping Strategies Between the Second and Post-Intervention Measures

	Improvement in Coping			
Improvement In	**Reactive**	**Proactive**	**Tolerant**	**Withdrawn**
Informal Helpful Support	0.165	-0.062	0.309	0.355
Significance	n.s.	n.s.	*p≤0.05*	*p≤0.05*
Formal Helpful Support	0.147	-0.231	0.051	0.342
Significance	n.s.	n.s.	n.s.	*p≤0.05*
Informal Unhelpful Support	0.210	-0.016	0.290	0.115
Significance	n.s.	n.s.	*p≤0.05*	n.s.

5.2.6 Mental Wellbeing Post-Intervention

Table 57: Wellbeing for Post-Intervention Respondents; Mean, Std.Dev. and Significant. Improvement between Initial, Second and Post-Intervention Measures (SWEMWBS converted scores) n=49

	Initial Measure *(Post-Intervention Respondents)*		**Second Measure** *(Post-Intervention Respondents)*		**Post-Intervention**		**Mean Improvement**		
(n=49)	Mean Conf.int	Std. dev	Mean Conf.int	Std. dev	Mean Conf.int	Std. dev	Initial to Second Measure	Initial to Post-Intervention	Second Measure to Post-Intervention.
Mean SWEMWBS Converted scores	19.25 ± 0.58	3.57	21.40 ± 0.72	4.42	25.27 ±1.46	5.23	2.15 *p≤0.000*	7.02 *p≤0.000*	4.87 *p≤0.000*

Wellbeing improved very highly significantly ***(p≤0.000)*** not only between the initial and second measurement, but again at post-intervention.

Table 58: Wellbeing (SWEMWBS) Score for Post-Intervention Respondents; Initial, Second and Post-Intervention Measures, Improved, Unchanged or Deteriorated, by Number of Responses

Wellbeing, Individual's Change Between Measures *(Post-Intervention Respondents)*	**Improved**	**Unchanged**	**Deteriorated**
Initial to Second Measure	65.3%	6.1%	28.6%
Initial to Post-Intervention Measure	73.5%	12.2%	14.3%
Second to Post-Intervention Measure	73.5%	2.0%	24.5%

The majority of respondents (74%) improved their mental wellbeing between second and post-intervention, although for 25% it had deteriorated. Compared with the initial measure, however, 73% improved, while only 14% reported wellbeing as having deteriorated.

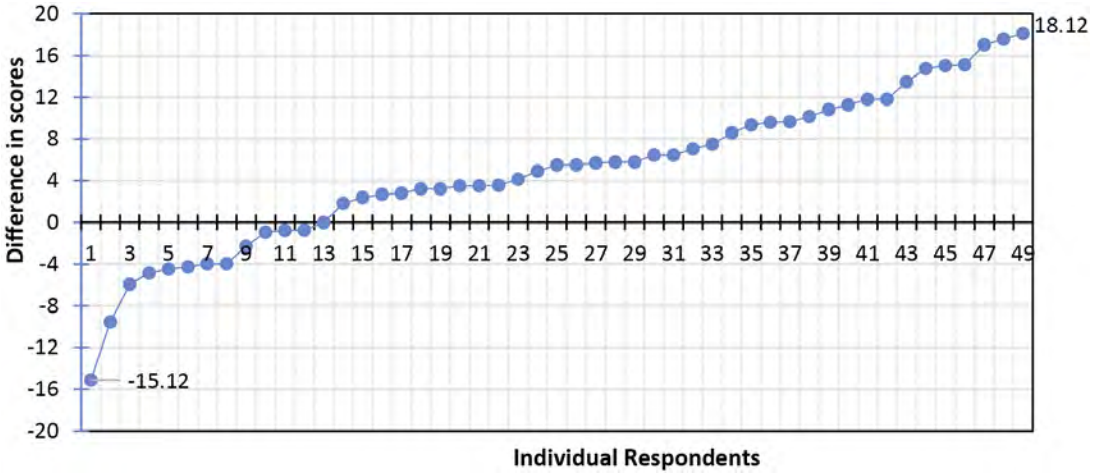
Table 59: Wellbeing (SWEMWBS) Meaningful Change in Individual Wellbeing for Post-Intervention Respondents; for Initial, Second and Post-Intervention Measures, Improved or Deteriorated. By Percentage of respondents

Wellbeing Individual's Significant Change between Measures *(Post-Intervention Respondents) (n=49)*	**Improved**	**Deteriorated**
Initial to Second Measure	44.90%	14.30%
Initial to Post-Intervention Measure	69.40%	8.20%
Continued change Second Measure to Post-Intervention	67.35%	16.33%

Using the 2.77 difference in SWEMWBS score identified by Shah et al. (2018) as being meaningful at the individual level, 33 (67%) of these post-intervention respondents had meaningful positive improvement between the second and post-intervention measures, although for 8 (16%) it had deteriorated. Compared with the initial measure, however, 69% improved, while only 8% reported wellbeing as having deteriorated.

Figure 13: Difference: Initial and Post-Intervention SWEMWBS scores for Post -Intervention Respondents

Difference between SWEMWBS Initial and Post Intervention Scores by Respondent (n=49)



Comparison with National Norms for England

Table 60: Comparison with National Norms

Compared with the Norms for England	Initial Measure *(Post-Intervention Respondents)*	Second Measure *(Post-Intervention Respondents)*	Post-Intervention
Bottom 10% of National Population	27 (55%)	15 (31%)	2 (4%)
11th-15th centile	4 (8%)	3 (6%)	8 (16%)
16th-50th centile	12 (24%)	21 (43%)	4 (8%)
51st-85th centile	5 (10%)	4 (8%)	18 (37%)
86th-90th centile	0 (0%)	1 (2%)	2 (4%)
Top 10% of National Population	1 (2%)	5 (10%)	15 (31%)
Below Median Norm for England (23.21)	**88%**	**65%**	**29%**

Figure 14: Percentages of Respondents Scoring in 10th, 15th and 85th Centile Bands of Wellbeing (SWEMWBS) National Norms, Initial, Second, and Post-intervention Measures (n=49)

Mental Wellbeing, Percentages of Respondents compared with the National Norms for England; Initial, Second and Post Intervention Measures (n=49)

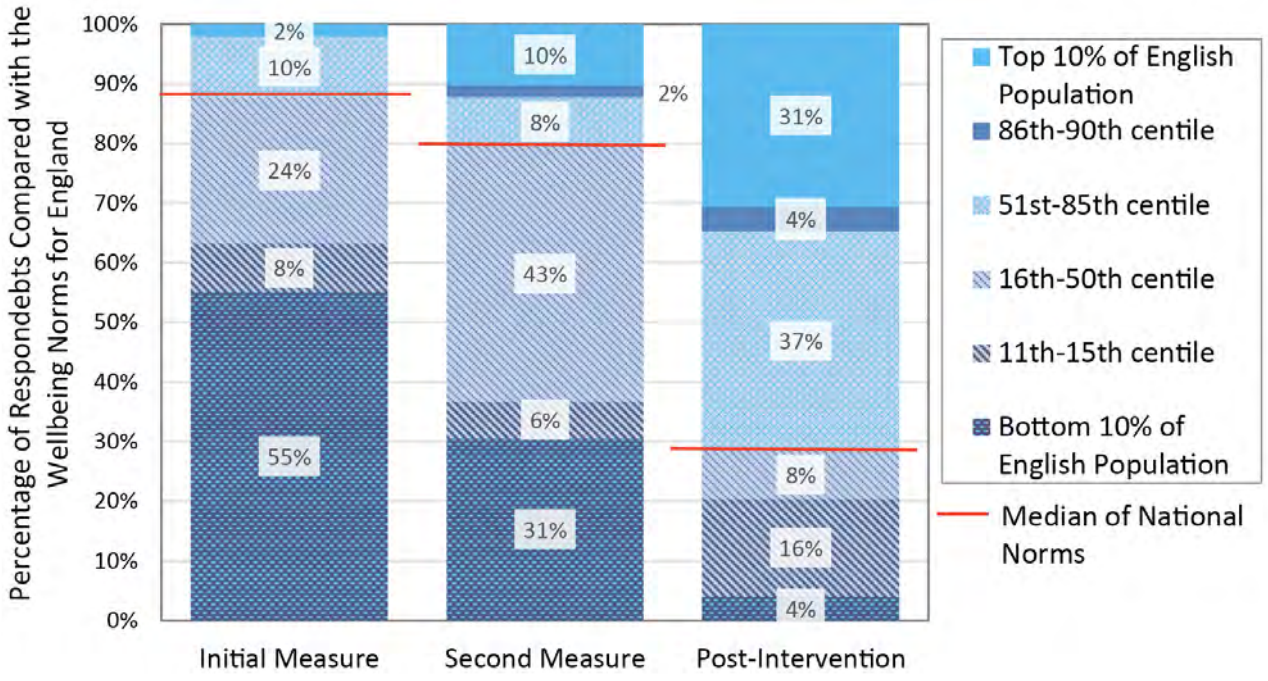
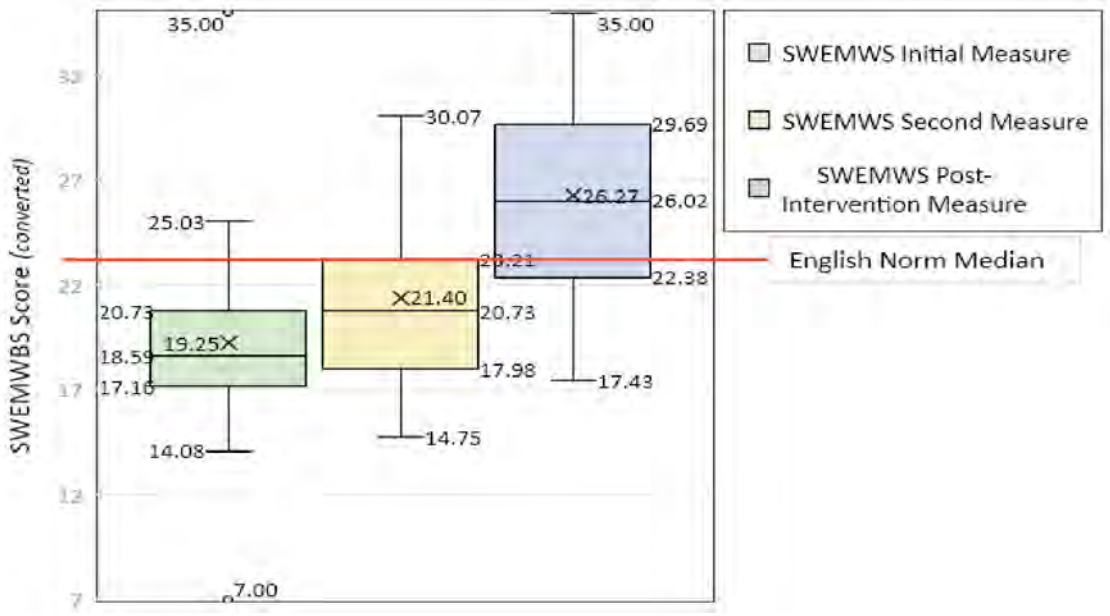


Figure 15: Box and Whisker Chart, Comparison of Wellbeing Scores for the Post-Intervention Cohort, Initial, Second and Post-intervention Measurements, Showing Mean, Median and Quartile Scores

Comparison of Wellbeing; Initial, Second and Post-Interventional Measurements, showing Mean, Median and Interquartile Scores. (n=49)



At the second measure the wellbeing scores for the post-intervention cohort, although very significantly improved compared with the initial mean scores, were still comparatively low with 65% of respondents below the national median norm. The post-intervention scores improve again and were very ***(p≤0.000)*** significantly better than the second measure score, with 71% above the median English national norms.

5.2.7 Correlations of Mental Wellbeing Post-Intervention Respondents with Stress, Strain, Coping and Social Support for Post-Intervention Respondents

Table 61: Correlation of Wellbeing (for the Post-intervention Cohort) with Stress and Strain. Initial, Second Measures and Post-Intervention Measures. (Spearman's Rank Order Correlation, r_s)

	Stress		Strain	
	Worrying	Active	Psychological	Physical
Initial Measure *(Post-Intervention Respondents)*	-0.258	-0.445	-0.550	-0.665
Significance	n.s.	*p≤0.001*	*p≤0.000*	*p≤0.000*
Second Measure *(Post-Intervention Respondents)*	-0.394	-0.362	-0.463	-0.549
Significance	*p≤0.01*	*p≤0.01*	*p≤0.000*	*p≤0.000*
Post-Intervention	-0.648	-0.576	-0.660	-0.705
Significance	*p≤0.000*	*p≤0.000*	*p≤0.000*	*p≤0.000*

Worrying stress does not correlate initially with wellbeing for this post-intervention cohort (n.s.). All other stress scores at each measure, and all strain scores were highly significantly inversely related to wellbeing ***(p≤0.01)***.

Table 62: Correlation of Wellbeing with Coping Strategies for the Post-intervention Cohort; Initial, Second Measure and Post-Intervention (Spearman's Rank Order Correlation, r_s)

	Reactive	Proactive	Tolerant	Withdrawn
Initial Measure *(Post-Intervention Respondents)*	-0.417	-0.320	-0.403	0 .480
Significance	*p≤0.001*	*p≤0.05*	*p≤0.01*	*p≤0.000*
Second Measure *(Post-Intervention Respondents)*	-0.283	-0.154	-0.388	0.348
Significance	*p≤0.05*	n.s.	*p≤0.01*	*p≤0.01*
Post-Intervention	-0.637	0.002	-0.706	0 .622
Significance	*p≤0.000*	*n.s.*	*p≤0.000*	*p≤0.000*

All reactive, and tolerant strategies were inversely significantly related to wellbeing. Post-Intervention the relationships for mental wellbeing with proactive, tolerant and withdrawn coping were very highly significant ***(p≤0.000)***.Proactive coping was significant (*p≤0.05* inversely) only at the first measure and non-significant at either the second or post-intervention measures

Table 63: Correlation of Wellbeing with Support for the Post-intervention Cohort; Initial, Second Measure and Post-Intervention (Spearman's Rank Order Correlation, rs)

	Reactive	Proactive	Tolerant	Withdrawn
Initial Measure *(Post-Intervention Respondents)*	-0.417	-0.320	-0.403	0 .480
Significance	*p≤0.001*	*p≤0.05*	*p≤0.01*	*p≤0.000*
Second Measure *(Post-Intervention Respondents)*	-0.283	-0.154	-0.388	0.348
Significance	*p≤0.05*	n.s.	*p≤0.01*	*p≤0.01*
Post-Intervention	-0.637	0.002	-0.706	0 .622
Significance	*p≤0.000*	*n.s.*	*p≤0.000*	*p≤0.000*

Helpful informal support correlates significantly with wellbeing initially ***(p≤0.05***), but highly significantly both at the second measure and post-intervention measures. Unhelpful informal support was significantly inversely related to wellbeing at the second measure (i.e., high unhelpful=low wellbeing), but not otherwise. Formal helpful support correlated very significant initially and at post-intervention, but not at the second measure.

5.2.8 Correlations of Improvement in Mental Wellbeing Post-Intervention Improvements in with Stress, Strain, Coping and Social Support for Post-Intervention Respondents

Table 64: Correlation of Improvement in Mental Wellbeing and Stress Strain, Coping and Support Between the Second and Post-Intervention Measures. (Spearman's Rank Order Correlation, r_s)

Improvement In:		Improvement in Mental Wellbeing	
		Correlation	Significance
Stress	Worrying	0.6169	*p≤0.000*
	Active	0.5763	*p≤0.000*
Strain	Psychological	0.6375	*p≤0.000*
	Physical	0.6936	*p≤0.000*
Coping	Reactive	0.5486	*p≤0.000*
	Proactive	0.2290	n.s.
	Tolerant	0.5211	*p≤0.000*
	Withdrawn	0.5591	*p≤0.000*
Support	Informal Helpful	0.5166	*p≤0.000*
	Formal Helpful	0.2572	n.s.
	Informal Unhelpful	0.1521	n.s

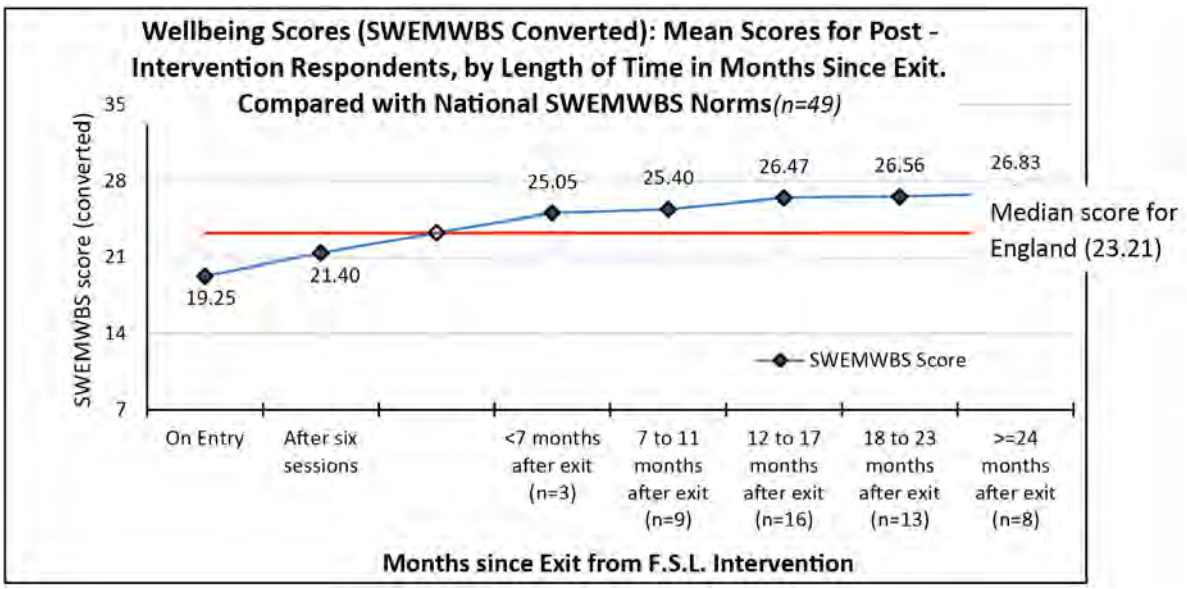
Between the second measure and post-intervention wellbeing improved very highly significantly with nearly all stress, strain, coping and support. The improvement in proactive coping was not correlated significantly with proactive coping, formal helpful or informal unhelpful support.

The post-intervention cohort differed significantly from the main evaluation group in that initially their social support was very significantly lower, although not at the second measure. The results for the post-intervention group cannot, therefore, be regarded as representative of the whole evaluation cohort.

Mental Wellbeing Post-Intervention Compared with Time in Months Since Exit

The wellbeing scores appear to improve with time since respondents had exited the F.S.L. intervention.

Figure 16: Mental Wellbeing: SWEMWBS (converted); Mean Scores, by length of time in months since exit. (n=49)



6. Groups

6.1 Background

Support groups are informal gatherings open to anyone who feels attendance would be helpful, whether or not they access F.S.L. one-to-one services. Groups serve as peer support, an exit mechanism from F.S.L. one-to-one sessions providing continuing support, an introduction to, and/or as a context to, other F.S.L. services.

There is an F.S.L. 'host' who ensures that everyone has a chance to speak, and who can provide relevant information and correct misapprehensions. The content is directed by the group themselves. There is a format, people introduce themselves and quickly say what has been happening to them during the previous week. Usually the talk evolves from there. On occasions, if the group feels it would be helpful or interesting, there may be speakers from other services. Multiple relationships develop simultaneously, members have relationships with other members, with the group, and with the group host.

The individuals attending a group were united in their condemnation of drug or alcohol misuse. Although everyone was listened to sympathetically, members who did not conform were sometimes treated more critically. The Afro-Caribbean lady whose son was abusing cannabis was listened to sympathetically, until she declared that a lot of people in her community used hash, and when asked, agreed that she did too. There was a frosty silence.

One group in a relatively small town had been running several years. The host was a volunteer who had previously been a client of F.S.L. There were about eight regular members, nearly all female, who had been attending for some time. They knew each other well, meeting for coffee outside the group sessions. They knew each other's problems and could discuss details. Newcomers were welcomed, but they were such a tight group that some new members found it difficult and dropped out. It has recently been restarted in a different location, and with a different 'host'. The other group was much larger, about fifteen regular attendees, and with more diverse membership. Although the majority were female there were at least two men who regularly attended, and others who dropped in and out.

The smaller group had no problems with the meetings being recorded, but the larger group felt that it would inhibit people. Quotes were extracted from notes taken at group meetings. These were analysed using Yalom's therapeutic factors (Gonzales de Chavez et al. 2000). Social aspects and effect on family were also included in the analysis as they were pertinent to F.S.L.'s work. (See Appendix 3)

6.2 Cohesiveness

"I regard everyone here as my friend."

"I've rung A (another group member) several times this week, just for a bit of moral support."
Wife of husband who is abusing alcohol.

"Getting together for coffee is great"

"The group has been my lifeline."

"It was the first time I really laughed today."

"It's great coming to the group, I don't think we've had a group we haven't laughed.
I don't laugh outside."

"Talking to others in a similar situation is very beneficial because you often feel alone and lost."

6.3 Information exchange

"Learning factual information from other members in the group. For example, about their treatment, or about access to services." (Yalom & Leszcz, 2005, p. 12)

"Today's session on what drugs look like and their effects was so useful"
Mother of drug using daughter.

"At least now I have some idea of why he's sometimes so high rushing round, and other times really depressed and just wants to sleep. I didn't know he drank alcohol to calm down after the coke"
Mother of son using cocaine and alcohol.

"Actually, seeing those tabs made it seem more real." *Father of drug-abusing daughter after session where F.S.L. caseworker had taken in replica samples of drugs to show the group.*

"XXX, who works in S2S (the Drug and Alcohol treatment service) came in and it was really helpful to hear what he had to say about their side. It also showed it could happen."
Mother of multiple drugs abusing daughter.

"It was helpful to hear what people had to say about cocaine and alcohol, it explains a lot."
Mother of daughter misusing cocaine.

"I thought cannabis was just that stuff we used to take back in the sixties. I really didn't realise it could be so addictive and do so much harm." *Father of son who was misusing cannabis.*

6.4 Interpersonal Learning and Self Understanding

"Listening to you all's shown me how I could deal with things better."
Grandmother of cocaine using granddaughter.

"I have become more able to look at how I can change me rather than him."
Mother of son using cocaine.

"It's great to hear when 'B' talks about setting boundaries and how that has helped her daughter. It makes me feel I can do it." *Mother of cocaine-using daughter.*

"I find it really hard, setting boundaries, but you all just keep going, and I'm getting there, I don't really get his morphine for him anymore. It' s difficult because I'm still worried, he'll be attacked by louts who can see he's not up to fighting back. They wait for him at the crossing. I go with him, but that's dangerous too." Mother of son abusing opiates. "You're putting yourself at risk… " Comment from another group member.

"He said he wanted money to pay his rent. I knew full well he had had the money yesterday, but he was in such a state. I just kept saying to myself, 'It could be the £50 that kills him…" Mother of alcohol-abusing son.

"It's been really helpful hearing people's way of dealing with things." Mother of cannabis-abusing son.

"If you say you can't manage life without the children and that Social Services will remove them if you see T (partner, who had a restraining order preventing her from seeing him), you are going to have to make a choice, them or your partner" Comment from group member to man whose partner was drinking to excess and who had talked about needing his children above anything and then dropped that he had dinner out with his partner the previous weekend.

"I really thought it was useful to hear C (mother with drug-using daughter) talk about how she managed to keep going with boundaries, and not letting her in when she turned up on the doorstep high."
Mother of drug-abusing son

"I think you're so brave to say to the police that you wouldn't take your daughter in when they brought her back. I really admire the way you stuck to your guns." To mother of daughter who was using MDMA

"If you give him £20 for food, you know full well is probably going to be spent on drugs or alcohol" (Mother of drug/alcohol abusing son).… "Perhaps you could give him the food instead of money?"
Another group member.

"I listen to you all, you're so much stronger than me, but I think I am getting better at trying to keep the boundaries." *Mother of Son drinking to excess.*

6.5 Universality

"We're all in a club we don't want to be in."

"I thought I was on my own, I hadn't realised that there were people who had the same problems as me."

"… everyone here looked no different from me, I thought I had walked into a PTA meeting the first night, you all looked like someone I would meet at a school or church function".

"What's important to me is hearing stories similar to my own. Knowing that I am not alone and that this happens to anyone".

"Listening to you all and what you've been going through makes me realise I'm not alone, and that there are people worse off than me."

6.6 Installation of Hope

"I think of 'D's daughter who was so ill, now she's in recovery, 9 months and going strong - that has given me hope" *Grandmother of cocaine-using granddaughter.*

"The speaker today, who was addicted to heroin, now he's working for S2S (treatment/recovery service), that gives me hope for my son." *Father of alcohol-abusing son.*

"People here have just been able to make life more bearable, that's so hopeful."
Father of alcohol- and drug-abusing son

"Now I have a sense of control over an uncontrollable situation, even though it's a bit tenuous"
Mother of heroin-abusing son.

"Sharing what I've gone through does helps me with worries about my daughter"
Mother of daughter with multiple substance use.

"I used to come here each week and dread that I was going to be told 'E"s daughter or 'F"s son had died, they were both so close, and now both are in recovery."

6.7 Catharsis

"I used to stand at the door of his room and look at him sleeping and think, 'It would have been better if you had died before you had all the pain.'" *Mother of (adult) son*. – there were murmurs of agreement.

"U went for me, raging and threatening to hit me. Stupidly I got out. When we went back you can imagine the state of the house. He was passed out again. I had to clear up the sick and mess and rang VOICE. They assessed we were at high risk for domestic abuse. X is unstable we need someone to help him, then we'd be OK." Mother of alcohol abusing son. "You had to look after yourself first, that's the most important." (another group member).

"I've even thought that I wish she'd died. it would have been so much easier, for both of us. Mother of heroin-using adult daughter.

"…They wanted £120,000. they kept coming back. I said I didn't have the money, but they threatened to put him in hospital. Then they shot him in the leg, they said it would be worse next time. I've got nothing left. I used all my saving, I have no pension, no future…" "How much did you end up giving?" "Just £70,000, they let me off 'cause I was a woman on my own." *Mother of heroin-using son, in tears.*

"The bloody payday loan companies, they should be banned!" *Father of cannabis-using son who constantly borrows money he cannot pay back.*

"I know I shouldn't, but if I go and get it (the substance) at least I know he's not going to be attacked on the way. I couldn't bear to see him in so much pain" Mother of cocaine-using son.

"I go and get it (cocaine), I hate it, but if I let him go, he'd probably be beaten up."
Mother of cocaine-using son.

"He seems to have a target painted on his forehead. There's a local group who just liked to kick the s*** out of him. He had to move from his accommodation because they kept coming, banging on the door, and wanting things like his phone. He lost everything, the new tv, even clothes." *Father of alcohol-abusing son.*

"Came home from work to find the front room trashed, sick, split beer. Dog having her own party in it all. The good news was that he had crashed out. Peace!" *Mother of alcohol-abusing son.*

"I finally get him into the car, get him to S2S (treatment), see him to the door, and he walks right out the back!" *Father of man misusing alcohol.*

"We had 3 hours purgatory with him in A&E. there was some physical damage. Tablets prescribed. I thought, 'Here we go again.'" *Mother of alcohol-abusing son.*

"I had to take him to hospital again, it's only a couple of weeks since they detoxed him. Next time, I'm just going to call an ambulance." *Wife of husband who drinks to excess.*

"It's just not knowing that's the worst, not knowing whether she'll turn up, be drunk or high, not knowing if she has gone to her appointment." *Mother of alcohol/drug-using daughter.*

"… he took the money for the mortgage from behind the clock. He wasn't supposed to be in the house, but G (husband who has dementia) let him in, I wasn't there. He's done it before. I called the police" *Mother of multiple drug-abusing son*.

"I got the lecture, (from husband), 'He's in no fit state. You have to get him alcohol. So, I went shopping for beer. It's my whole life at the minute, buy it… give it… then get the abuse from it." *Mother of alcohol-abusing son.*

"He went out driving again, he passed out at the wheel. I wanted to call the police because he could kill someone, but I just wasn't able to." *Wife of man who had been regularly driving his car while very drunk.* She hid the keys. At a later group meeting… "He had an accident ran off the road, luckily no-one hurt, but the police were called, and they're saying driving without due care and attention, he'll lose his licence." "At least no-one was hurt." "And you didn't have to split on him!" *Another group member*.

"Being able to get everything out in the open to others so that I can handle my feelings, that's what this group does for me. I always feel better afterwards." *Wife of man misusing alcohol.*

6.8 Altruism

"Being able to help someone else, it makes the hell you have been through seem worth more."

"If I can help anyone else who's got problems like ours…"

"Although 'V' (daughter recovering from Alcohol misuse) is so much better, 10 months and counting, I'm still coming because I think it helped me, so I'd like to pass it on."

"If things get too much, you're welcome to ring me." To wife of man abusing alcohol, who frequently had fits and collapsed.

6.9 Social Support

"Of course, you were right to call the police, it must have been hard." To sister of alcohol abusing brother who was banging at the door and swearing."

"Yes, I did that too, when he asked for money to buy food, I gave him some sausages from the freezer!" to a group member who had been giving money to SU and had, on this occasion, refused money and given food.

"It must be hard to take on a child of that age, where did he sleep?" (A)… "That age is difficult anyway, when he's just had to leave his mother it must be really difficult." (B) … "Did you get money from social service to help?" (C) "No, it was all so sudden, I didn't think to ask." *Mother of alcohol abusing daughter who took in her 12-year-old grandson when she was told he would otherwise go into social care.*

"If he does that again just ring me, you can come over to ours." To wife of alcohol abusing man who locked her out.

"I've given up on W (alcohol abusing husband), I realised that I'd lost all my friends. The people who used to call for us now walk straight past our gate. They got tired of him falling over and passing out so now I go out on my own. Listening to you helped give me confidence." *Wife of husband who drinks to excess.*

Feedback suggests that more than 50% of attendees meet socially outside the groups.

6.10 Effect of Attending Group on the Family.

"I'm talking to my husband again; we've been so angry with each other because he just gives in and gives him money. There are other ways of dealing with it. At least we can talk about it now."
Mother of son drinking to excess.

"My son is beginning to realize he has to behave. You've helped so much, just listening to you."
Mother of son drinking to excess.

"Just getting out from it all makes me feel better, and I think it's helped all of us (family) to cope better."
Mother of cocaine-using son.

"I don't think I'd still be with my husband if it wasn't for you all, at least I can get it off my chest."
Mother of son drinking to excess.

"Now that I'm being stricter with 'X' (daughter using cocaine) my other two (teenage) children are behaving better too."

"My younger son couldn't understand why I gave in to him (user) all the time, he was so angry. We've been getting on better now." *Mother of cocaine-using son.*

"My older son is speaking to me again. I'm calmer and he can see I'm trying."
Mother of son drinking to excess.

"I think this has been a lifeline for our family. I was in such a state, flying off the handle all the time."
Mother of cocaine-using son.

"Being able to laugh has lifted some of the strain, when I go home I can talk sensibly to X"
Mother of son with alcohol problems.

"I really think 'Z' is going to go back into treatment. Now we're not shouting at each other all the time, and I called the police when he threatened me, he realises I'm serious about not putting up with it. He's thinking about it. I wouldn't have had the strength to keep going if it hadn't been for F.S.L. and you."
Wife of a husband with alcohol problems.

7. Social Issues

Whereas some AFM are reporting “We’re a nice middle class, family, these sorts of things don’t happen to us.” It is clear from the data collected by F.S.L. that many of these families have multiple problems.

Families of AFM attending F.S.L. often:

- Have low self-esteem, confidence, and feelings of self-efficacy
- Have low expectations, and low optimism
- Are below the English national norm for Wellbeing and Health
- Suffer both physical and mental abuse
- Experience high incidents of domestic violence
- Experience criminality
- Have debt and arrears, and/or may not be able to pay for essentials
- Have housing issues
- Suffer stigmatisation, isolation, and discrimination
- Experience family breakdown
- Have safeguarding issues

All data were taken from monitoring forms completed on entry to F.S.L.. Data reported here were collected by F.S.L., from clients who gave consent. Percentages were calculated using 184 the number of AFM who gave permission for data to be used, but there were a high number of AFM who declined to answer individual questions.

The percentages are likely to be considerably under-reported.

7.1 Diagnosed Health Conditions

(see Appendix 4.1: Health, Tables 81 to 83)

While 85% of AFM on entry reported no physical health condition, 13% had physical or sensory impairment, and three (2%) progressive/life limiting conditions.

Of the AFMs who answered the question about diagnosed mental health, two thirds (68%) reported no mental health issues. Of the remainder only thirty-six, (18%) of AFM reported depression.

Caseworkers, however, considered this to be an under representation; depression in AFM was likely to be undiagnosed as many AFM did not feel able to go to a doctor with problems. Caseworkers, as appropriate, may suggest to AFMs that they should see their GP. Four of those that volunteered information reported post-traumatic stress disorder. Several reported multiple mental health issues. Although 44% of SUs were reported as having no diagnosed mental health condition, 76 (41%) had been diagnosed with depression, and twenty-seven of these (15% of those responding) had at least one other mental health problem.

7.2: Housing

(See Appendix 4.2: Housing, Tables 84-86)

Most families were owner occupiers (120, 60%), another 30 (15%) lived in social housing, and 17 (9%) in privately rented accommodation, (11) 6% of AFM were living with the family, but only one family was in temporary accommodation.

Although 89% AFM reported no problems with housing, twenty families were having housing difficulties due to the SU. Eleven of these families (6% of respondents) were in arrears over rent or mortgage and 4 (5% of respondents of this question) stated that their housing was at risk due to the SU, or had problems for other reasons.

Over a third (35%) of SUs were reported as living with their family, just over a quarter (26%) were owner occupiers, and another 25% lived in rented accommodation. Four percent (8) had no fixed abode, and 2% lived in temporary accommodation, one was in custody.

7.3: Finances

(See Appendix 4.3: Finances, Tables 87 to 93)

Nearly two thirds of AFM attending F.S.L. were reported as employed full time, part time, or were self-employed. Eleven (6%) were unemployed and 20% retired. Six percent described themselves as homemakers. There were also 4% who were long term sick or disabled. There was no category for carers.

Under half (83, 45%) of SU's were reported as employed, with about a third (26) of these described as self-employed. Thirty-nine percent (71) were unemployed, and 4% (8) retired. There were six long term sick or disabled (3%), six students over eighteen, and 2 homemakers.

Forty-five percent of SUs were reported as living on their own wages or own means, and 6 (3%) were students, another 8 (4%) were retired, and there were six long term sick or disabled. While 31% of SU were living on their own wages alone, a third (33.5%) were claiming benefits, of these 37 (21%) had no other source of finance. Some 47% of SU were dependent at least partly on their families and, of these 17% were wholly dependent on family (or other).

Two-thirds of the AFM (n=117, 64%) had given money to the SU and of these 61 (52%) had given from their savings. While 88 (75%) of AFM reported that giving money had had no impact, just over a quarter (38, 32%) of the 117 respondents who had reported giving money said it had impacted social life.
Ten, 9% responded that they were living on savings, while (21 18%) said their saving were now gone.
Over a quarter (33, 28%) reported that they were unable to pay for essentials, and 15 (13%) that they themselves were in debt.

AFM were not asked if they considered their SU to be in debt. It is considered likely, however, that this was the case for many.

7.4: Criminal Activity and Criminal Justice System.

(see Appendix 4.4: Criminal Activity and Criminal Justice System, Tables 87 to 88, also Child and Vulnerable Adult Protection Issues Tables 94 to 96)

Again there were many AFM who declined to answer individual questions, there were 123 (67%) who did not respond.

These figures are not mutually exclusive. Thirty-one families (17%) reported a present risk of domestic violence perpetrated by the SU, and twenty-three (13%) domestic abuse by the SU in the past twelve months. Nine (5%) reported domestic violence against a child or adult in the previous year. There were fifteen AFM (8%) who indicated there had been a crime against the family in the previous twelve months. Twenty families (11%) responded that police had called concerning domestic incidents more than once in the previous year. and 7% that police were frequent callers. Fourteen percent of AFM reported that the SU had an ASBO. Many families reported multiple varieties of criminal activity.

Twenty-one percent (39) of SU were involved in the criminal justice system at the time of the AFM's the data were taken, and another forty (22%) had been in the past. At that time six SU were in custody, and another twenty-two had been previously.

7.5: Children and Child/ Vulnerable Adult Protection.

(See Appendix 4.5 Child and Vulnerable Adult Protection Issues Tables 97-100)

It is particularly stressful to have children who might be at risk. Many families were fearful of social services involvement, worried the children might be removed into care; it was one reason such families self-isolate.

There were 40 (20%) of families where children were reported as living in a house with a substance user, and twenty-eight where children were living elsewhere (some families had both).

Child protection

Seventy-seven AFM did not respond to this section (n/a were not recorded)
There were ten families where social services were concerned for a vulnerable adult. Four families were reported as having both a vulnerable adult and a child/children at risk, Thirty-two AFM reported that social services were involved with their families on behalf of a child/children. Eight families had a child protection plan, and there were six families with a child in need, fourteen with an EHA, one family had a child/children in foster-care, and there were three with a looked after child. There were four families where children were living with kinship carers, (usually to stop the children going into care).
Data were not mutually exclusive.

Of the families where there was both a child/children and SU in the household, there were 6 where AFM volunteered that there was a past or present risk of abuse or violence, five of these already had social services involved with the children.

From other data F.S.L. know that there were more families with children who may be at risk.

8. Discussion

Living, or caring, for a SU creates tensions and conflict, not just between the AFM and the SU, but within the family, who may disagree about how to cope. One family member may, for instance, react by getting angry, while another tries to avoid confrontation by clearing up after the SU, taking the blame for SU's actions, or even buying drugs so the SU doesn't initiate an aggressive row. A third may be angry that the SU is allowed to dominate and manipulate the family. Siblings often feel the SU is the focus of attention to the detriment of their own place within the family. Money is often a major problem, either replacing items that have been broken or sold; or by directly financing the substance use, or rescuing the SU from debt, or moneylenders. There is always the threat of blackmail, sometimes psychological, "I'll be 'ill' if you don't let me have money for…", sometimes physically aggressive or abusive.

Living with a SU is itself chaotic, influenced by the state and/or actions of the user, it would be unrealistic to expect all families to benefit equally from the F.S.L. intervention. the evidence showed, however, that the majority of families receiving support from F.S.L. improved their overall wellbeing and reduced their levels of toxic stress. When family members leave the service, they feel better able to cope, to look after themselves and their families. Accessing F.S.L.'s service improves family's ability to effectively resolve conflicts, allowing families to function more effectively, and enabling AFM to become resilient and contributing members of their communities.

8.1 Social Issues

(see Section 7)

Over a third of SUs were reported as living with their family (not as owner occupiers or responsible for renting). As over half SU were offspring of AFM clients, and there were less than ten percent of SU under 25 (although this was a small sample), the implication was that a large proportion of SUs were adult offspring living with their parents.

There was a high incidence of depression reported by AFM, although the level of undiagnosed depression was likely to have been underreported because AFM had not visited their doctor. AFM reported 44% of their SUs as having (diagnosed) depression, and some 14% were suffering from depression and at least one other diagnosed mental health problem.

Thirty-nine percent of SUs were reported as unemployed. Just under a third were claiming benefits, but 17% were wholly dependent on family support. Sixty-four percent of AFM reported that they had supported SUs by giving money, 34% from their savings. There were thirty-three families where the AFM reported that, due to the SU, they were no longer able to pay for essentials, (18% of F.S.L. respondents), and 12 (7%) of these AFM were also in debt.

Thirty-one AFM reported that their families were at past or present risk of domestic abuse. There were forty families where children were living in the same house as the substance user, six of these in families where there was a past or present risk of abuse.

8.2 Stress-strain-coping-support and wellbeing

Main evaluation (n=147)

(see Section 5.1)

Stress and Strain

In the main evaluation the mean values for stress and strain were significantly improved. That active stress was slightly less improved than worrying may be related to the fact that worrying stress was higher initially. It is suggested that an AFM was in better control of worrying stress (finances, social life), while active stress was related more to the SU (SU threats, quarrels, upsetting family occasions). While active stress can be managed to some extent (e.g., setting boundaries, refusing money, calling the police when threatened) this may take longer to have effect and may be difficult to maintain.
Over a third of the main evaluation cohort (35%) initially scored the maximum (worst) on all three questions for psychological strain; although case workers report that strain described by AFM during their first one-to-one session (i.e., before the initial measurement) was often higher for some AFM than their FMQ scores would indicate. It was conjectured that the initial one-to-one session may already have ameliorated strain symptoms, so the initial recorded response, taken on the second session, may not have revealed the full extent before starting with F.S.L.

F.S.L. work with other agencies and refer AFM to appropriate support (for instance among others, mental health, housing, finance, and/or legal). Some improvement in stress and strain may be due to these referrals.

The mean value for family burden (stress, strain, reactive and tolerant coping) was highly significantly improved between the initial and second measure.

Coping

Most families use a mixture of coping strategies as seem appropriate, the majority were aware that some coping methods are dysfunctional, but patterns of interactions and behaviours within the family become habitual. The evidence showed that AFM were more likely to use appropriate strategies after the five sessions covered by the main evaluation. Dysfunctional coping strategies (reactive and tolerant) were highly significantly improved. Although proactive coping was not significantly improved, as the mean for proactive coping was initially relatively high, and formed the largest element of the coping strategy (see figure 5) the low level of change was not necessarily meaningful.

Proactive, reactive and tolerant coping were highly significantly correlated ($p \leq 0.000$). It is suggested that the use of a proactive strategy, (sitting down with the SU to talk about his/her substance use, making it clear that reasons for substance use are unacceptable, and clarifying the expectations of what he/she should contribute to the family) could easily degenerate into reactive emotional exchanges and argument. Boundaries are not always easy for an AFM to set and to maintain, just as they may be difficult for a SU to accept. Equally one member of a family employing tolerant coping strategies might be the trigger for a disagreement between family members, and include the SU.

The correlations indicate that the less the AFM employed tolerant coping strategies, the less they were likely to use reactive or proactive strategies. The use of proactive and reactive approaches imply that the AFM is interacting with the SU, and indicates that the SU is still part of the family. As there is no significant correlation with withdrawn coping strategies it might be inferred that these respondents still consider him/her to be a focus of attention for the family.

Support

The mean for formal support improved very significantly between initial and second measurements, As F.S.L. routinely refer clients this may also have included work with other treatment agencies. The mean for helpful informal support was relatively high initially, indicating that for the majority of AFM there was support from family and friends, and although the mean was lower at the second measure, the difference was not significant. The mean for unhelpful informal support was very low (initial mean=2.8, and second=2.58, out of 9), suggesting that AFM were not routinely subjected to unpleasant comments from family or friends.

Stress, Strain, Coping and Support Correlations

There was no correlation between the improvement in withdrawn coping and improvements in either stress or strain. Improvement in dysfunctional coping strategies were very highly correlated with all improvements in stress and strain ($p \leq 0.000$).

Proactive coping improvement correlated highly significantly with improvements in worrying stress and psychological strain ($p \leq 0.001$) and very significantly with active stress ($p \leq 0.01$). but less significantly with physical strain ($p \leq 0.05$).

Improvement in helpful formal support was not significantly related to improvement in stress or strain. Although improvement in helpful informal support is only significantly related to improvement in psychological strain ($p \leq 0.001$), unhelpful informal support improvement was significantly related to improvement in all stress and strain scores, particularly active stress ($p \leq 0.005$). Unhelpful comments clearly strongly affect stress and the attendant symptoms of strain.

Improvement in reactive and proactive coping was not significantly related to improvement in support; it appears that reactive and proactive coping are not affected by social influences. Improvement in tolerant coping was very significantly correlated with improvement in unhelpful support ($p \leq 0.000$) but had no other significant correlation. It would appear that as family and friends observe that the AFM is less subservient to the SU (for instance, clearing up after him/her, giving money or buying drink or drugs) there are fewer unpleasant comments.

Improvement in withdrawn coping was significantly ($p \leq 0.05$) related to improvements for helpful informal and formal support.

Wellbeing

Initially mental wellbeing was low, but the scale of the distress was unknown. More than 87% of respondents on the first measure scored under the median norm for England, and 54% in the lowest decile. At the second measure the proportions compared with the national norm had improved very significantly, but there were still 80% below the median and 35% in the lowest decile.
Nearly a third (31%) of the 147 respondents had significantly materially improved their mental wellbeing between initial and post-intervention measurements, although 14% responded that it was materially worse.

Wellbeing Correlations

Wellbeing improvement was highly significantly correlated with improvement in stress, strain, reactive and tolerant coping strategies. It was also very significantly correlated with most coping strategies. ($p \leq 0.000$). Improvement in formal support improvement was significant, but informal, neither helpful not unhelpful support was not.

Proactive coping improvement was not significantly correlated with improvement in wellbeing.

8.3 Stress-strain-coping-support and wellbeing post-intervention

(see Section 5.2)

Initially the mean for unhelpful support is very high post-intervention, with 29% scoring that they ‘often’, and only 4% that they were ‘never’, subjected to unpleasant remarks. (In the main evaluation 2% responded ‘often’ and 28% ‘never’.) The findings for the post-intervention study cannot be assumed to apply to the main evaluation cohort as social support was initially significantly worse for the post-intervention respondents. By the second measure, however, they were no longer significantly different in this respect.

With very few exceptions post-intervention respondents continue to improve for all constructs. Stress, strain, reactive, tolerant and withdrawn coping strategies, and helpful formal support were all at least significantly ($p \leq 0.05$) improved between the initial and second measurement.

The mean for proactive coping was significantly lower ($p \leq 0.05$) post-intervention, as was helpful informal support. Unhelpful support was not significantly changed.

Correlation of Improvements in Stress, Strain, Coping and Support Post-Intervention.

All improvements in stress and strain were very highly significantly ($p \leq 0.000$) correlated with improvements in dysfunctional coping strategies. Improvements in withdrawn coping were significantly correlated with all stress and strain, although physical symptoms were significant only at the $p \leq 0.05$ level. This differs from the main study where improvements withdrawn coping were not significantly related to stress or strain. Improvement in proactive coping has no significant relationship with improvement in worrying stress, although significantly related to improvements in other stress and strain scales. This differs from the main intervention where improvements in proactive coping were very significantly corelated with worrying stress, but only with physical symptoms at the ($p \leq 0.05$) level.

The improvement in informal support was significantly ($p \leq 0.05$) related to improvement in worrying stress, and physical strain. There was no other significant relationship with stress, strain or support. Unhelpful informal support improvement, unlike the main evaluation study, was not significantly related to improvements in stress or strain.

The mean for unhelpful support between the initial and second measures for the post-intervention respondents was very highly significantly ($p \leq 0.000$) worse than for the main evaluation study. There was no significant change in the mean scores between the second and post-intervention measures. Improvement in withdrawn strategies are significantly correlated ($p \leq 0.05$) with improvement in unhelpful support.

Improvement in proactive strategies were not significantly correlated with any improvement in any social support, although most dysfunctional coping strategies had no significant relationship with social support. Tolerant coping improvement , however, was significant at the $p \leq 0.05$ level for both informal helpful and unhelpful improvements in social support.

Wellbeing Post-Intervention

Post-intervention wellbeing was again very highly significantly improved for most measures. Formal support was not correlate, but formal support from F.S.L. had finished. For post-intervention respondents proactive coping was not significantly correlated with wellbeing at either the second, or post-intervention measures, and only significantly initially ($p \leq 0.05$).

When compared to the Norms for England, the initial and second measure mean values showed a similar patten to that of the main evaluation cohort; but between the second measure and post-intervention they had, again, improved very significantly, at this measurement there were only 24% respondents below the median and 45% in the top 15%. A very substantial number of the post-intervention clients showed positive and meaningful change between initial and post-intervention (67%), although 16 % showed meaningful deterioration.

Post-Intervention Correlations of Improvement in Wellbeing and Stress, Strain, Coping and Support. Improvement in proactive coping and in helpful formal support, or unhelpful support are not significantly correlated with mental wellbeing improvement post-intervention.

Wellbeing mean scores appear to improve with the time since respondents had exited the F.S.L. intervention. There were too few respondents, however, to calculate significance.

8.4 FMQ and Wellbeing Summation

Mental wellbeing remains a cause for concern. Despite the very significant mean improvement ($p \leq 0.01$) between the initial and second measurement in the main study, over a third of AFM scored in the bottom decile. The improvement continued after completion of the F.S.L. intervention, and was very highly significantly increased ($p \leq 0.000$). Post-intervention there were only 4% in the bottom decile while there were 71% above the median national norm value and some 67% had meaningful improvement in mental wellbeing.

The very high correlation between improvement in wellbeing and virtually all domains indicated the relationship was substantial, however correlation does not imply causation; the relationship was likely to be circular; as coping methods improve, the AFM's feeling of self-efficacy improves, so stress and strain improve, mental wellbeing improves; and thus, the AFM is better able to employ more appropriate coping strategies.

Proactive coping seems to be problematic for some AFM. Improvement in proactive coping is not significantly correlated with increased mental wellbeing in either the main evaluation study or post-intervention. While it forms the largest proportion of coping strategies, both for main evaluation and post-intervention respondents, there is no significant improvement between the mean of first and second measurements in either, and there was a significant fall in mean values between the second and post-intervention ($p \leq 0.05$).

Improvements in proactive coping, and stress/strain are significantly correlated for the main evaluation, but not worrying stress in post-intervention. Improvements are not correlated with improved support either in the main study or post-intervention (although the slight, non-significant, relationship is inversely related).

The Family Member Questionnaire does not specifically address setting boundaries which is an important element of proactive coping. It is clear, however, from discussions in support groups that setting boundaries was seen as a major step in coping with their SU. In group discussion success in setting and keeping boundaries was applauded. It has been suggested that becoming better able to define and keep boundaries was one of the most important things AFM took away from the intervention.

Post-intervention clients were self-selecting, and their post-intervention results were likely to be different from the main evaluation cohort. The improvements were so striking, however, that it seems plausible that other clients also improved after completing the F.S.L. intervention, if not to the same degree. Whether post-implementation improvement in all areas continues further is an area that would benefit from further research.

This study cannot be directly compared with other studies that use the Family Member Questionnaire, because the 'initial' measure was not taken until the second visit. Initial measurements for this study were likely to be worse on the first visit than were initially recorded. The impact on stress strain and modified coping strategies, however, were similar to other studies, most of these constructs being very significantly improved.

8.5 Support Groups

Qualitative data show that participants found the opportunity to share experiences and coping strategies with peers very helpful. Social connectedness of participants was identified as helping them 'feel better'. Group members also reported positive impacts on other family members (not attending the support group), including better communication and clarity about boundaries and responsibilities.

Support groups form an important transition for AFM who no longer need one-to-one counselling, but would still like, or need, support. While one-to one consultations allow AFM to explore their own problems, working with a group allows a different perspective, one of shared lived experience.

8.6 Evaluation Summary

The intention of F.S.L. is to help improve a family member's ability to manage adverse experience, to become more resilient. While the Family Member's Questionnaire (FMQ) gives insight into the mechanism of the process, the mental wellbeing scale (SWEMWBS), interrelated to resilience as it is, helps evaluates an overall outcome.

> The work of Family Support Link was very clearly successful. The stress-strain-coping-support model provides a theoretical framework, and the 5-Step a methodology for their work. The fact that it was delivered by caseworkers who are themselves experienced and empathetic allows AFM to speak freely about their problems.

Where do Family Support Link go from here?

The 8 areas that have been identified include:

1. Working towards improving the wellbeing of families with a drug or alcohol using member, particularly encouraging social networking, both with peers, and other members of their communities. This would include identifying unmet peer needs and helping develop support services.

2. Developing a parenting support programme.

3. Developing a collaborative early intervention service to identify and support emerging problems of drug use by family members.

4. Developing a whole family approach, with opportunities for family members, including the user, to be supported in joint sessions in conjunction with other appropriate agencies.

5. Widening the visibility of F.S.L amongst front-line workers and families by increasing Family Support Link's community presence, so it becomes better known and thus more available, reducing barriers for people wanting or needing to access the Family Support Link service.

6. Ensuring that knowledge and understanding of the impact of substance use on families reflects the diversity of the local population; being aware of cultural imperatives as well as physical or mental barriers that might hinder AFM seeking help.

7. Amplifying and increasing the profile and coverage of family's stories within the community and media would highlight the experience and voice of those individuals to make others aware of the problems they encounter, particularly for those who belong to groups that may be less likely to access the service.

8. Supporting family members to have a more active role in the development of the organisation, developing collaboration and co-production opportunities with clients.

Appendix 1. F.S.L. Active Clients, Referrals and Discharges.

Data were from referral forms and data collect by F.S.L.

Borough: Active F.S.L. Clients and Referrals

Table 65: Referrals by Borough

Borough Referrals-Urban	Active Urban Clients *(n=246)*	Percentage Urban Active	% All Active	New Urban Referrals *(n=190)*	Percentage All Urban	% All New referrals
Northampton	80	33%	16%	81	50%	38%
Kettering	76	31%	15%	37	23%	17%
Wellingborough	59	24%	11%	25	15%	12%
Corby	31	13%	6%	20	12%	9%
Urban districts	246		48%	163		76%

Rural Borough Referrals Rural	Active Rural Clients *(n=94)*	Percentage Active Rural	% All Active Clients	New Rural *(n=72)*	Percentage New Rural	% All New referrals
East Northamptonshire	52	55%	10%	39	10%	10%
Daventry	27	29%	5%	18	5%	5%
S. Northamptonshire	15	16%	3%	15	4%	4%
Rural Districts	94		18%	72		19%

No Borough Stated	Active Clients	% All Active	New referrals	% All new
	177	34%	133	34%

Table 66: Referral Agency/Source (AFM active and referred 1st April 2017 to 31st March 2019)

Referral source	Active Clients	Percentage Active Clients	New Referrals	Percentage New Referrals
Self	350	68%	267	68%
Drug service statutory	52	10%	46	12%
Other	29	6%	19	5%
Concerned Others	19	4%	14	4%
Drug service non-statutory	19	4%	6	2%
SPOC	19	4%	19	5%
Social Services	11	2%	9	2%
Education Service	8	2%	7	2%
Children and Family Services	2	0%	2	1%
Children's Social Services	2	0%	2	1%
Adult Treatment Provider	1	0%	1	0%
Hospital	1	0%	1	0%
Criminal Justice Other	1	0%	1	0%
Employment Service	1	0%	1	0%
GP	1	0%	0	0%
Probation	1	0%	0	0%
Total	*517*		*395*	

Discharges

Table 67: Number of Discharges 1st April 2017 to 31st March 2019

Discharges in Period	Count
Adult discharges:	408

Table 68: Discharge Reason

Discharge Reason *(n=408)*	Count	Percentage
Successful Exit - Goals Achieved	206	50%
Family member deceased	6	1%
Family member in recovery	4	1%
Moved out of county	1	0%
Family member enters prison	0	0%
Non-engagement	91	22%
Inappropriate referral	57	14%
Withdraws from the programme	20	5%
Persistent DNA	9	2%
Referral withdrawn	7	2%
Unable to make contact	7	2%

Table 69: Discharges by Borough (n=207)

Urban Borough	Count Urban Clients *(n=305)*	Percentage Urban Clients Discharged	Percentage All Clients Discharged *(n=408)*
Northampton	127	31%	31%
Wellingborough	68	17%	17%
Kettering	66	16%	16%
Corby	44	11%	11%
	305		75%

Rural Boroughs	Count Rural Clients discharged *(n=88)*	% Rural Clients Discharged	% All clients Discharged
Daventry	34	50%	16%
East Northamptonshire	24	31%	12%
South Northamptonshire	12	19%	6%
Rural	70		22%

Table 70: Length of time attending F.S.L.

Length in Service	F.S.L. Discharges *(n=408)*	Percentage
0-3 months	156	38%
3-6 months	82	20%
6-12 months	96	24%
1 year or more	74	18%

Average stay was 3 months or less.

Appendix 2. Family Member Questionnaire April 2017 To April 2019

Stress Questions: Means and Standard deviation

Table 71: Stress, Questions, Means and Std.Dev. Initial and at the Second Measure

To your knowledge, have any of the following happened in the last 3 months, as a result of your relative's drinking/ drug use? 0=never,1=once or twice, 2=sometimes, 3=often		Initial Measure N=147		Second Measure N=147		Improvement 1st to 2nd	
		Mean	std. dev	Mean	std. dev	Mean	Sig.
Worrying	1. Have the family's finances been affected?	1.68	1.18	1.39	1.24	0.29	*p≤0.01*
	2. Does your relative's drinking/drug use get in the way of your social life?	1.88	1.07	1.48	1.06	0.39	*p≤0.01*
	3. Are you worried that your relative has neglected his/her appearance or self-care?	2.03	1.08	1.68	1.17	0.35	*p≤0.01*
Active	4. Has your relative picked quarrels with you?	1.74	1.14	1.47	1.19	0.27	*p≤0.01*
	5. Has your relative sometimes threatened you?	0.63	1.06	0.48	0.88	0.15	n.s.
	6. Has your relative upset family occasions?	1.48	1.10	1.05	1.12	0.42	*p≤0.01*

Scored out of 18: 0 =no stress, 18 =very stressful

Strain Questions: Means and Standard Deviation

Table 72: Strain/Symptoms: - Questions, Means and Std.Dev. Initial and at the Second Measure

To your knowledge, have any of the following happened in the last 3 months, as a result of your relative's drinking/ drug use? Scored 0=never,1=sometimes,2=often		Initial Measure		Second Measure		Improvement	
		Mean	std. dev	Mean	Std dev	Mean	Sig.
Psychological	7. Worrying	1.78	0.48	1.54	0.62	0.23	*p≤0.05*
	7. Being irritable	1.39	0.61	1.25	0.70	0.14	n.s.
	9. Had thoughts that you cannot push out of your mind	1.47	0.65	1.23	0.70	0.24	*p≤0.05*
Physical	10. Had parts of the body feel weak	0.80	0.82	0.69	0.78	0.11	n.s.
	11. Cannot concentrate	1.26	0.69	1.03	0.76	0.23	*p≤0.05*
	12. Awakening early and not being able to fall asleep again	1.35	0.73	1.12	0.78	0.24	*p≤0.05*

Scored out of 12: 0 =no stress, 12 =very stressful

Coping Questions: Means and Standard Deviation

Table 73: Questions, Means and Std.Dev. Initial Measure and at the Second Measure (n=147)

To your knowledge, have any of the following happened in the last 3 months, as a result of your relative's drinking/ drug use? 0=never,1=once or twice, 2=sometimes, 3=often		Initial Measure		Second Measure		Improvement in mean score	
		Mean	std. dev	Mean	std. dev		Sig.
Reactive, Engaged Emotional	13. Started an argument with him/her about his/her drinking/drug use?	1.46	1.10	1.24	1.06	0.22	$p \leq 0.05$
	14. Got moody or emotional with him/her?	1.76	0.99	1.50	1.05	0.25	$p \leq 0.05$
	15. Watched his/her every move or checked up on him/her or kept a close eye on him/her?	2.01	1.01	1.69	1.14	0.33	$p \leq 0.05$
Proactive Engaged Assertive	16. Sat down together with him/her and talked frankly about what could be done about his/her drinking/drug use?	1.82	1.06	1.71	1.08	0.11	n.s.
	17. Made it clear that you won't accept his/her reasons for drinking/taking drugs, or cover up for him/her?	1.86	1.18	1.82	1.09	0.04	n.s.
	17. Made clear to him/her your expectations of what he/she should do to contribute to the family?	1.74	1.16	1.74	1.10	0.00	n.s.
Tolerant	19. Put yourself out for him/her, for example by getting him/her to bed or by clearing up mess after him/her after he/she had been drinking/taking drugs?	1.33	1.25	0.97	1.14	0.35	$p \leq 0.01$
	20. Given him/her money even when you thought it would be spent on drink/drugs?	0.94	1.17	0.80	1.11	0.14	n.s.
	21. When things have happened as a result of his/her drinking/taking drugs, made excuses for him/her, covered up for him/her, or taken the blame yourself?	0.88	1.09	0.60	0.89	0.28	$p \leq 0.01$
Withdrawn/ Independent	22. Pursued your own interests or looked for new interests or occupation for yourself, or got more involved in a political, church, sports or other organisation?	1.33	1.13	1.50	1.13	0.17	n.s.
	23. Got on with your own things or acted as if he/she wasn't there?	1.70	1.01	1.78	1.06	0.08	n.s.
	24. Sometimes put yourself first by looking after yourself or giving yourself treats?	1.42	0.93	1.56	0.95	0.14	n.s.

Each scored out of 9

Withdrawn/Independent coping was scored so as coping increases scores improve, i.e., not at all independent =0, Making a life outside the SU=9

Social Support: Questions, Means and Standard Deviation

Table 74: Social Support Questions, Means and Std.Dev. and at the Second Measure (n=147)

In the last 3 months, have these things happened when you have been concerned about your relative's alcohol or drug use: (Never =0, Once or Twice=1, Sometimes=2, Often=3)		Initial Measure		Second Measure		Improvement	
		Mean	std. dev	Mean	Std dev	Mean	Sig.
Informal Helpful	25. Friends/relations have listened to me when I have talked about my feelings	2.02	0.99	1.92	0.97	-0.10	n.s.
	26. Friends/relations have been there for me	2.18	1.01	2.13	0.95	-0.05	n.s.
	27. Friends/relations have talked to me about my relative and listened to what I have to say	1.91	1.04	2.02	0.96	0.11	n.s.
Formal Helpful	27. F.S.L. or other care workers have given me helpful information about problem drinking or drug taking	1.75	1.15	2.51	0.78	0.76	*p≤0.01*
	29. F.S.L. or other care workers have made themselves available for me	1.95	1.17	2.67	0.73	0.72	*p≤0.01*
	30. I have confided in my F.S.L. or other care workers about my situation	1.90	1.16	2.75	0.67	0.85	*p≤0.01*
Informal Unhelpful	31. Friends/relations have said things about my relative that I do NOT agree with	1.05	1.01	0.99	0.97	0.07	n.s.
	32. Friends/relations have said that my relative does NOT deserve help	0.81	1.09	0.77	1.07	0.04	n.s.
	33. Friends/relations have said nasty things about my relative	0.94	1.05	0.82	1.02	0.12	n.s.

Helpful informal and helpful formal support were both scored inversely so the better the support the higher the score

Data for Post-Intervention were provided as subscales, individual item scores were not available.

The Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS)[1]

Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 weeks						
		None of the time	Rarely	Some of the time	Often	All of the time
34	I've been feeling optimistic about the future	1	2	3	4	5
35	I've been feeling useful	1	2	3	4	5
36	I've been feeling relaxed	1	2	3	4	5
37	I've been dealing with problems well	1	2	3	4	5
38	I've been thinking clearly	1	2	3	4	5
39	I've been feeling close to other people	1	2	3	4	5
40	I've been able to make up my own mind about things	1	2	3	4	5

Individual question means are not applicable for the Shorter Warwick/Edinburg Mental Wellbeing Scale because the total score was converted, rather than simply being the sum of the question answers.

[1]The Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS)© NHS Health Scotland, University of Warwick and University of Edinburgh, 2008

Appendix 3. Group Feedback

All adult clients accessing F.S.L. Groups over the three years were sent an anonymised satisfaction survey. There were 95 sent out and 51 returned completed, some 54%, high for a postal survey, indicating the results were likely to be representative. Some recipients may only have attended a couple of group meetings, whereas some may have been attending regularly.

Reasons for Attending the F.S.L. Group

Table 75: Reason for Attending the F.S.L. group (n=51

What are your main reasons for attending the group?	Count	Percentage
Support for Me	48	94%
To Increase Knowledge	19	37%
Support for Someone Else Attending	11	22%
No Other Local Support	7	14%
Social Aspect	4	8%

Source of Information About the Group.

Table 76: Source of information about the group. (n=51)

How did you hear about the group?	Count	Percentage
Drug/alcohol agency	15	29%
Local Press	14	27%
G.P.	9	18%
Social Media	6	12%
Through Family Support Worker	5	10%
Poster/Leaflet	5	10%
Friend	3	6%
Other	2	4%

Positive Effects of Attending the Group

Table 77: Positive effects of attending the Group (n=51)

Has attending the group has a positive effect on any of the below?	Count	Percentage
Understanding drug misuse	46	90%
Coping with day-to-day challenges	42	82%
Feelings of isolation	40	78%
Stress levels	34	67%
Wellbeing	34	67%
Confidence	31	61%
Self-Esteem	20	39%
Other	0	0%

Most Personally Useful Aspects of the Group

Table 78: Most Personally Useful Aspects of the Group (n=51)

What would you say were the most useful aspects of the group to you personally?	Count	Percentage
To meet others in a similar situation	46	90%
To increase my knowledge	36	71%
To get practical advice	33	65%
To help educate other/share stories	30	59%
To feel connected	28	55%
Support network for me	28	55%
Local to where I live	23	45%
The group host	21	41%
Listen to Guest Speakers	17	33%
Free to attend	10	20%
Other	0	0%

Social Networking, Meeting Outside the Group

Table 79: Social Networking, Meeting Outside the Group (n=51)

Have you met or intend to meet up outside the group on a social basis?	Count	Percentage
yes	30	59%
no	21	41%

Experience of group

The questions were not asked on every occasion, so percentages are given rather than numbers. The number of responses for each question was noted.

Table 80: Group experience (n=51)

	Very Positive	Slightly Positive	Neutral	Slightly Negative	Very Negative
Overall experience of the group (n=23)	43%	39%	9%	9%	0%
Content of the group discussion (n=11)	55%	36%	9%	0%	0%
Venue/Location and accessibility (n=15)	40%	40%	7%	13%	0%
Group host (n=12)	92%	8%	0%	0%	0%
Length of the group (n=11)	82%	9%	9%	0%	0%
Frequency of group meetings? (n=11)	82%	9%	9%	0%	0%

What's good and what could be improved?

- Group has been my lifeline.
- It's taught me how to deal with things better.
- Travel is a problem for me, the meeting is too far away. A Group in Daventry would be fantastic, and I would be willing to help.
- Humorous as well as serious.
- We are lucky to have this facility.
- It would be good to spread to other places.
- Have stands at places like Weston Favell to raise awareness.
- We need daytime meetings.
- Sometimes we stray away from why we attend.
- A bit more discussion, personal situations can be repeated often and in too much detail.

Appendix 4: Social Issues

Appendix 4.1: Health
Appendix 4.1.1 AFM's Physical Health

Of the 187 AFM who answered the majority (85%) reported they had no physical disability, 11% reported a physical impairment, and 3% sensory; of those 1% had both physical and sensory impairment. Most of the 180 AFM who reported their substance using family member's physical disability recorded no impairment (86%), with 25 (14%) reported as having a physical impairment. The detail of physical health for the SU were not recorded.

Table 81: Client's Physical Health

Client's Physical Health (n=184)	Count	Percentage
None	159	85%
Physical Impairment	20	11%
Sensory Impairment	5	3%
Both	2	1%
Progressive/Life Limiting Condition	3	2%

Table 82: AFM's Mental Health Issues

AFM, Diagnosed Mental Health Problem *(n=184)*	Count	Percentage
No Diagnosed Mental Health Condition	132	68%
Depression (Diagnosed)	36	18%
Learning Disability	4	2%
PTSD	4	2%
Bipolar	3	2%
Personality Disorder	3	2%
Schizophrenia	2	1%
Cognitive Impairment	1	1%
Psychosis	1	1%
Schizo-affective disorder	1	1%
Other- Unspecified	17	9%

Appendix 4.1.2: Substance Users' Diagnosed Mental Health Issues

Table 83: Substance User, Multiple Mental Health Issues, Percentage of Issues reported.

Substance User Mental Health Issues	Count	Of 184 Respondents to the questionnaire	Of those Reporting Issue (n=94)
Depression	78	42%	83%
Personality Disorder	14	8%	15%
Psychosis,	13	7%	14%
Bipolar	11	6%	12%
Cognitive Impairment	7	4%	7%
Learning Disability	7	4%	7%
PTSD	6	3%	6%
Schizophrenia,	6	3%	6%
Schizo Affective,	4	2%	4%
Other	34	18%	36%
None	81	44%	

Appendix 4.2: Housing
Appendix 4.2.1: AFM's Housing Status

The majority of F.S.L.'s clients were owner occupiers (60%), 6% live with the (extended) family, but.

Table 84: Housing Status of F.S.L. Clients

AFM 's Housing Status	N	%
Owner occupier	119	65%
Rented - social tenant	30	16%
Rented - private	17	9%
Living with family	11	6%
Temporary accommodation	1	1%

Appendix 4.2.2: Families' Housing Problems (Due to SU)

Table 85: Client's Housing Problems

Families' Problems with Housing due to SU (	Count	Percentage
No Problems	162	88%
Mortgage Arrears	2	1%
Rent Arrears	9	5%
Housing at Risk Due to SU	4	2%
Housing Problems	5	3%

Appendix 4.2.3: Substance Users' Accommodation

Table 86: Housing Status of Substance Users

User's Housing Status (n=182)	Number	Percentage
Living with family	64	35%
Owner occupier	48	26%
Rented - private	25	14%
Rented - social tenant	20	11%
Other	12	7%
No fixed abode	8	4%
Temporary accommodation	3	2%
In custody	2	1%

Appendix 4.3: Finances
Appendix 4.3.1: Client Employment Status

Table 87: Client Employment Status

Client's Employment *(n=184)*	Count	Percentage
Full Time	63	34%
Part Time	37	20%
Self Employed	11	6%
Unemployed	11	6%
Student (over 18)	8	4%
Retired	38	20%
Homemaker	11	6%
Long Term Sick/Disabled	7	4%

Appendix 4.3.2: Substance User's Employment Status

Table 88: Substance User's Employment Status

Substance user's Employment Status *(n=184)*	**Count**	**Percentage**
Full Time	45	24%
Part Time	12	7%
Self Employed	26	14%
Unemployed	71	39%
Student (over 18)	6	3%
Retired	8	4%
Homemaker	3	2%
Long Term Sick/Disabled	6	3%
other	7	4%

Appendix 4.3.3: Substance User's Source of Income

Table 89: Substance User's Source of Income

Substance user finances *(n=184)*	**Count**	**Percentage**
Living on wages/own means only	56	30%
Claiming benefits only	37	20%
Dependent on family/other only	31	17%
Claiming benefits + Dependent on family	17	9%
Claiming benefits + Living on wages/own means	5	3%
Dependent on family/other + Living on wages/own means	33	18%
Dependent on family/other + Claiming benefit, & Living on wages/own means	1	1%
n/a	4	2%

Appendix 4.3.4: AFM Had Given Money to Support Substance User

Table 90: Given money to Substance User.

Given money to Substance User *(n=184)*	**Count**	**Percentage**
Yes	117	64%
No or n/a	67	36%

Appendix 4.3.5: AFM Had Used Savings to Support the Substance User.

Table 91: Used Savings to Support Substance User

Used Savings to Support SU *(n=117)*	**Count**	**Percentage**
Yes	61	52%

Appendix 4.3.6: Impact on AFM of giving Money to the Substance User

Table 92: The Impact for the AFM of Giving Money to Substance User

The impact *(n=117)*	**Count**	**Percentage**
No Ability to Pay for Essentials	33	28%
Debt	18	15%
Savings gone	21	18%
Now Living on Savings	10	9%
Social Life	38	32%

Appendix 4.3.7: Impact on AFM of Giving Savings to the Substance User

Table 93: Impact on the Client of Giving Savings to Substance User

Impact on Client of Giving Savings *(n=97)*	**Count**	**Percentage**
No impact/problem	56	58%
Impacted	42	42%

Appendix 4.4 Criminal Activity and Criminal Justice System.

AFM volunteered that over 44% of SUs were or had been involved with the criminal Justice system. Some 39 (22%) of were currently involved (e.g., Courts, Probation, Tag, Drug Treatment Order), and another 40 (22%) had been at some time in the past.

Of those who identified an impact of giving savings *(n=42)*	**Count**	**Percentage**
Impacted on day-to-day social life/activities	24	59%
Savings now gone	21	51%
Unable to fulfil plans	23	56%

Appendix 4.4.1: Criminal Activity Directed Against the Family by Substance User

Table 94: Criminal Activity Directed against the Family by Substance User

Criminal Activity by Substance User *(n=184)*	**Count**	**Percentage**
Present risk of domestic violence perpetrated by substance user	31	17%
Domestic abuse perpetrated by substance user in the last 12 months	23	13%
Child or adult suffering of domestic violence in the past year	9	5%
Criminal offence against family	15	8%
Police called concerning a domestic incident more than once in the past year	20	11%
Police frequent callers	12	7%
Substance user has ASBO	25	14%
n/a	123	67%

Appendix 4.4.2: Substance User Involvement in The Criminal Justice System (Police, Courts, Probation, Tag, Drug Treatment Order)

Table 95: Substance User's Involvement in Criminal Justice System

SU's involvement in Criminal Justice System *(n=184)*	**Count**	**Percentage**
Currently (at time measure was taken)	39	21%
In the Past	40	22%
Never	100	32%

Appendix 4.4.3: Has the Substance User Been Involved in the Prison System?

Table 96: Substance User's Involvement in the Prison System

User's Involvement in Prison System *(n=28)*	**Count**
Currently (at time measure was taken)	6
Past	22

Appendix 4.5: Children and Child/ Vulnerable Adult Protection.
Appendix 4.5.1: Families' Social Service Involvement

Table 97: Social Service Involvement with Family (n=188). Forty-two respondents identified Social Service Involvement

Type of Social Service Involvement	Count	Percentage (n=42)	Percentage (n=189)
Child Protection	8	19%	4%
EHA	14	33%	7%
Looked after child	3	7%	2%
Child in Need	6	14%	3%
Kinship Care	4	10%	2%
Foster Care	1	2%	1%
Adult Social Care	10	24%	5%

Appendix 4.5.2: Families with Children Living in the Substance User's House

Table 98: Families with children living in the substance user's house (n=188)

Children living in Substance User's House	Count	Percentage
Children living in substance user's house	40	20%
Parent with children living elsewhere	28	14%
n/a	11	6%
No	109	

Appendix 4.5.3: Children Living in the Substance User's House-Abuse issues

Table 99: Families where there are children living in the substance user's house-abuse issues

Children living in the Substance User's House – Abuse Issues *(n=40)*	Count
Past or Present risk of child/adult abuse	6
Adult/child abuse (within the last year)	3
Domestic Violence by Substance User	3
Police called out to a domestic incidence in the past year	16

Appendix 4.5.4: Children Living in the Substance User's House-Criminal Justice Issues

Table 100: Families where there are Children Living in the same house as the Substance User-Criminal Justice Issues

Children Living in the Substance User's House- Criminal Justice Issues *(n=39)*	Count	Percentage
Criminal offence against the family	6	15%
Police called more than once in the past year for a domestic incident	6	15%
Police frequent callers	4	10%
Substance User has ASBO	7	18%

Of the families where there were children living with a substance user there were 15% of families of children living with the SU where there had been a criminal offence against the family (other than abuse), and 18% where the SU had an ASBO.

Appendix 5. Client Feedback

Satisfaction Surveys

Satisfaction surveys were sent out quarterly, but permission to use the data were not sought in every case, so those have not been reported here. Responses were very similar to those in Dec 2019 when a survey was sent out to 74 clients in with 30 (40%) responding.

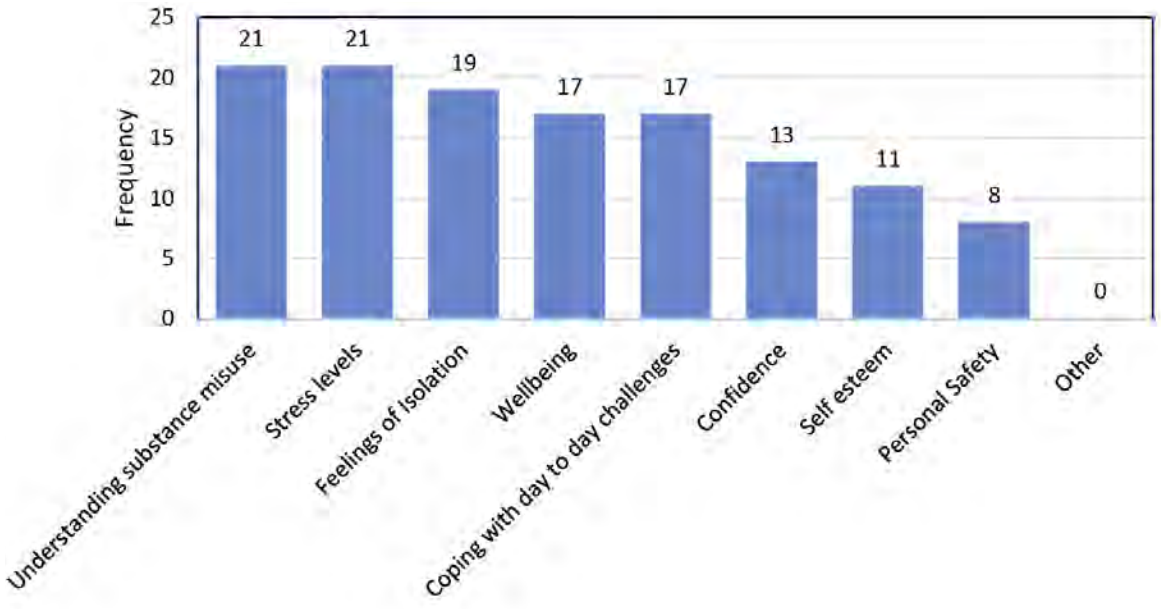
Has attending your 1-1s had a positive effect?

Table 101: Has attending your 1-1s had a positive effect? (n=30)

	Count	Percentage
Understanding of substance misuse	21	70%
Stress levels	21	70%
Feelings of Isolation	19	63%
Wellbeing	17	57%
Coping with day-to-day challenges	17	57%
Confidence	13	43%
Self esteem	11	37%
Personal Safety	8	27%

Figure 17: Has attending your one-to-one sessions had a positive effect? (n=30)

Has attending your 1-1 sessions had a positive effect on any of the below (n=30)



What would you say were the most important aspects of 1-1 support to you personally?

Table 102: The most important aspects of one-to-one sessions

	Count	Percentage
To get practical advice	23	77%
Support for me	21	70%
Knowing that I have F.S.L. there for me	19	63 %
It's confidential	16	53 %
To increase my knowledge	16	53%
Free of Charge	15	50 %
My support worker	14	47%
Local to where I live	13	43%

Do you feel involved in your care plan and support?

Table 103: Do you feel involved in your care plan and support?

	Count	Percentage
Very Positive	24	80%
Neutral	2	7%
Slightly Negative	1	3%
Very Negative	0	0%
Slightly Positive	0	0%

If your support worker made a referral to another service for you, were you kept informed throughout the process?

Table 104: If your support worker made a referral to another service for you, were you kept informed throughout the process? (n=13, n/a=17)

	Count	Percentage
Very Positive	9	69%
Slightly Positive	0	
Neutral	4	31%
Slightly Negative	0	
Very Negative	0	

Do you feel involved in your care plan and support?

Table 105: Do you feel involved in your care plan and support? (n=30)

	Count	Percentage
Very Positive	24	80%
Slightly Positive	0	
Neutral	2	7%
Slightly Negative	1	3%
Very Negative	0	

Would you recommend this service to others?

Table 106: Would you recommend this service to others?

	Count	Percentage
Yes	30	100%
No	0	-

Comments from Feedback day 2019

F.S.L. Service and the Practitioners

Family support link is having someone to listen. Someone to understand, an outlet to talk being in support groups. Don't tell family about me. Not giving in to giving money. Stress on the family at times.

I have a daughter who is in recovery from alcohol and previously heroin. I was getting to point of seeking help from a doctor when I was directed to F.S.L - my husband and I were desperate. I'm sure I would have ended up on medication- but Family Support Link listened - and UNDERSTOOD. Helped me to understand what was happening and how we could get through this terrible time. Family Support Link were there to listen and advise, at times of extreme distress.

Friendly professional service there for you all the time.

The knowledge, patience and understanding of the 1-to-1 workers. The ease of access to talk with someone. Family support really help to give family members the ability to get through these traumatic times that families go through. The support and understanding of the workers and other service users is very important.

Being able to discuss your feelings, i.e., anger, and try to understand mental health.

Finances was bad (sic), then I was supported by F.S.L.

Having people who understand helps… Very helpful to talk to others who have been through same experiences.

Being reassured that some of my worries are normal in my situation. Also made comfortable so that could talk about weaknesses in myself.

Son who is 34 with ADHD and drug addiction facing homelessness. F.S.L. have helped understand that I can't change him, and I can only try to deal with it differently.

I had help communicating with people. More self-reliant. I knew how to reach people I need.

F.S.L. is helping me to learn that it's not my fault, for a long time I thought it was. And helping me to say no. They (family) don't allow me to live.

F.S.L. stopped me from feeling isolated.

Since being with F.S.L., I think more rationally and feel in control.

Setting boundaries helped me feel in control, and putting my foot down helped him too, he realised he couldn't push me around.

To have voluntary help is a big plus.

I felt isolated because members of the family had gone off in their own box. Looking at mirrors not a door in the hall of mirrors, F.S.L. opened the door. I don't expect support from family anymore. F.S.L. gives direction.

One-to-one support for both my husband and myself. Not having to travel too far from South Northants to access support. Information given from support worker. More understanding of addiction. Learning how to set boundaries. That it is a free service and accessible to all.

One-to-one sessions with a qualified worker. Support group. User group involvement.

One-to-one support being accessible if needed. Helping with the support of young people.

It understands the problems and difficulties of those (trying) to support those who have addiction in the family.

Professional advice and understanding. Feeling you're not alone and you can discuss everything without feeling judged.

Someone to talk to/ non-judgemental. Advice on other services/knowing the support is there whenever it's needed, you are not alone.

When I walk through the office everybody is friendly and says hello.

We were at loggerheads and needed experienced assistance to cope with the problem, as it was a first for us both.

Being able to have the help and support needed when you are feeling at your lowest. Always just a phone call away.

Service has made a huge difference to my life and helped me cope better thank you all.

Appreciated: it's a brilliant service.

More confidence. Would have avoided people not now, I want to get out. Organised me telling me to look after myself.

I have become more able to look at how I can change me rather than him.

F.S.L. is trying to help me unpick the mess my life has become. I've always been strong and capable. The fixer, who sorts everybody out.

Service is invaluable to me. Knowledge I have learnt has enabled me to be more prepared with situation at home.

Feel betrayed by addict but didn't (sic) feel that so much now I understand it's not our son, it's the addiction.

Hoping I will be able to learn more about the addiction and be able to help more.

At this early stage, we are quite happy how things are progressing.

Hugely beneficial.

All very positive.

Helped a lot.

Support valued.

Fantastic support.

All the workers are understanding, realistic, listen and respond with practical advice and suggestions. They have lots of knowledge and if they don't know something, find out! Because of their support, you can build confidence to be able to deal with situations the family is facing.

Brilliant help from X and Y (F.S.L. workers) helping getting moved into council property. Without their (sic) valued support, I would have been left with no help at all.

Having my support worker to talk to and knowing they're there has helped tremendously.

Support worker has helped beyond me beyond measure. I cannot thank them enough.

Knowing the worker is there has helped a lot.

Worker supportive helped me put into effect decisions I was struggling with.

Professional support worker.

Being reliant on a support worker is not healthy.

Support worker accommodating.

Confident in support worker.

Have had 2 support workers both excellent.

Important to be with someone who knows.

Very supportive.

Confident in support worker.

It's just lovely to have someone to talk to. I hadn't occurred to me I could set my phone on silent. Spotting things that I didn't know was connected.

Personal support…non-judgemental everyone understands.

Groups

Support groups is the most effective programme, and most families must benefit from their invaluable help.

Being able to talk to people that are suffering the same problems as yourself is such a great help.

Phone a friend. Never office hours when need help.

Weekly group sessions great for support but then between times can be a long time so 'mentoring' may be helpful!

Talking to others in a similar situation is very beneficial because you often feel alone and lost.

Family

We as a family all understand, how to "manage" our user. We are not undermining each other anymore. Consistent behaviour- guided by F.S.L.- from all members of our family has changed the user's behaviour.

F.S.L. allows you to stop putting pressure on others. Communication in the family was like smacking yourself in the side of the head.

User's relationship with family improved because F.S.L. taught us about boundary setting.

Family member's relationships have got closer than ever before- we all communicate openly, all the time.

Brother (sibling of SU) doing well and building relationship.

Keep things to yourself… Lucky to have a supportive partner who did it all together…though funnily now "through the other side" we may experience 'normal' daily life!

Sibling support of addict.

We argue less.

I kept having chest pains. I keep getting lost, so confused. I couldn't remember how to get to XXX, I was paralysed with fear, I started to cry. I rang my husband, he was horrified.

Husband doesn't let on, poker face. He supports me more than he used to, he was never very supportive.

Living with a user

Mental issues (user). On eggshells. Put the user first, anything for peace but not always works. Having someone to talk to offload. User doing what they want, not thinking of you.

Blame ourselves. You're (sic) blind to things happening. When do you stop caring (probably never)? started at 15-16; she's now 39 along with her sister (twin) who was worse but now clean but suffers from depression. We look after one grandchild 10, the other is with her.

Family relationships affected. Daughter feels neglected at times. XXX's problems completely take over my thoughts and causes me constant anxiety. Developing time with friends and family does help.

Affected all relationships DURING WORST OF ADDICTION. Friends and family back off because they don't get it and can't help. F.S.L. unable to fix it but it was helpful to have someone who did understand.

Stress. We bicker and disagree. Other boys are neglected. My mental health has been affected to the point I was admitted to hospital (psychiatric) for 3 weeks.

Christmas day our son (addict) went missing. Police called. 2 other boys and us; Christmas ruined. At least I could talk to the worker about it.

It's like a chain and you have to break a link otherwise you just go around and round. Nothing will change.

The son that died encouraged me to go to F.S.L. Brother didn't want me to until he was in recovery.

We now understand it more.

More able to talk about it with family and friends.

Less angry. More understanding.

More open-minded to addiction.

Can now talk openly and honesty with user and recognise signs that lead to relapse.

Able to recognise that what im (sic) feeling is normal and what my partner is doing is not unusual.

It's the last thing you think about before you go to bed and it's the first thing you think about in the morning. And I think, is he in the garden? He's crashed in the garden before. Sometimes, you go out in the middle of the night go to have a look, you think he might be unconscious. There's this fear you might find a body. And, partly, you wish he would die and that would be an end to it; then you think, did I really think that?

How F.S.L. can Improve

F.S.L. is a secret. Took our family far too long to find out the service exists.

Chairs in pods (interview rooms) need to be the same level, feels uncomfortable.

I found F.S.L. on google.

S2S (alcohol/drug treatment service) look at you like dirt as you are the enablers. F.S.L. support was there but unable to access straight away (many attempts trying to access support via drugs service).

More leaflets/ more STAR leaflets/ more magnets needed.

I would like more information and communication on the Facebook page.

More informal get togethers, a chance to meet other parents and families outside of my support group.

To recruit more people to our support group.

To get F.S.L. brand out there! Easier to find.

An F.S.L. Christmas party.

F.S.L. to link with First for Wellbeing. I was on this programme and was told to ring S2S who then referred me on to F.S.L.

To share my journey and experiences with other parents.

Trips for parents e.g., day out, a retreat.

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Tables

Figures

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