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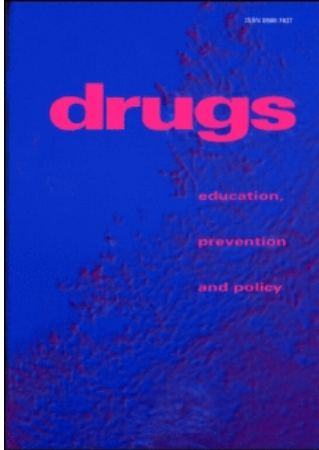
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The 5-Step family intervention in primary care: II. The views of primary healthcare professionals

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Abstract

Background: This is the second of two papers using qualitative methods from a study of an intervention for family members affected by close relatives' substance misuse problems.

Participants: 168 primary healthcare professionals (PHCPs: GPs, practice nurses and health visitors) working in general practices in two areas of England, and who took part in the study.

Data sources: Recruitment and post-session forms completed by PHCPs; telephone interviews with each PHCP 12 weeks after recruitment of a family member; interviews with PHCPs at the end of the study.

Results: At the end of the project PHCPs were overwhelmingly positive about the family member intervention and about primary care as the appropriate site. Difficulties were encountered, however, in identifying and engaging affected family members, who were often excluded on grounds of the complexity of their problems or the level of their distress. Shortage of PHCP time and other practice-related factors added to the difficulty. Active work by a PHCP was often necessary in order to make the link between presenting symptoms of physical or mental ill-health and the existence of a family substance misuse problem. When family members were identified and recruited, PHCPs were usually positive about what was achieved. Nearly all were in favour of an approach that combined giving a self-help manual with some follow-up contact with a family member as needed.

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Conclusions: Taken in conjunction with statistical outcome findings of significant reductions in symptoms and changes in ways of coping, plus qualitative analysis of the views of family members, the present results encourage the view that a flexible form of this intervention should be developed for use in primary healthcare, and that further work should build on existing strengths and attempt to overcome weaknesses identified.

Keywords: *Family intervention, substance misuse, primary care*

Introduction

This is the second of two papers reporting the results of analysing qualitative data from a trial comparing two levels of a primary care-based intervention for family members of close relatives with alcohol or drug problems. The prevalence of substance-related problems is high (Singleton, Bumpstead, O'Brien, Lee, & Meltzer, 2001) and such problems create severe, often long-lasting stressors for close family members (Dorn, Ribbens, & South, 1987; Orford et al., 2005; Strategy Unit, 2003), who, not surprisingly, have been found to be at heightened risk for ill-health of various kinds (Copello, Orford, Velleman, Templeton, & Krishnan, 2000a; Moos, Finney, & Cronkite, 1990; Orford et al., 1998). This group of family members is therefore likely to constitute a large group of primary healthcare patients whose symptoms may be attributable, at least in part, to the stressors associated with living with a relative experiencing a problem of substance misuse. Because of the varied nature of their symptoms, the link with a family alcohol or drug problem may not easily be recognized.

Despite that evidence, there has been a lack of health service commitment to families affected in this way (Copello & Orford, 2002). Specialist substance misuse services generally devote very little of their resources to them, and primary healthcare professionals are not confident in recognizing or dealing with alcohol and drug problem-related family problems (Copello et al., 2000a; Howells & Orford, 2006; Velleman & Orford, 1999). Indeed professional and academic ideas about the position of family members may have served to stigmatize them in the past (Orford et al., 2005).

But there are encouraging signs of that situation changing, including the development of treatments that either involve family members in their relatives' treatment (e.g. Barber & Crisp, 1995; O'Farrell & Fals-Stewart, 2006; Thomas & Ager, 1993) or which attempt to respond to the needs of family members in their own right (e.g. Halford, Price, Kelly, Bouma, & Young, 2001; Howells & Orford, 2006). The latter includes the 5-Step intervention, which is based upon a stress-strain-coping-support model (SSCS) of the experiences and health risks faced by family members affected by alcohol or drug problems (Orford, 1992; Orford et al., 2005). It is designed for use in the primary care setting where two studies have provided preliminary support in the form of significant pre-post changes in key outcome variables (Copello et al., 2000a; Copello, Templeton, Krishnan, Orford, & Velleman, 2000b; Copello et al. submitted).

These developments may be seen as part of a much wider move towards interventions that involve family members or in other ways attempt to enhance social support in cases of chronic illness or behavioural disorders (Hogan, Linden, & Najarian, 2002; Martire, Lustig, Miller, & Schulz, 2004).

In the companion paper to the present one (Orford, Templeton, Patel, Copello, & Velleman, 2007) results were reported of an analysis of qualitative data obtained from participating family members during the second study of the 5-Step intervention in primary care. That paper highlighted both strengths and weaknesses of the approach from the perspective of family members. A proportion of family members described positive transformations in their ways of coping with a relative's substance problem, and the large majority were favourable towards the intervention and its use in the primary care setting. A large minority, however, thought it had not been effective in their cases and were able to identify a number of weaknesses of the method. The present paper complements the first by reporting on the views of the primary health professionals who took part in the same study. It focuses on their views on identification and recruitment of family members, the ways in which family members presented in general practice, the nature of the interventions carried out and any problems encountered, preferences before and after the study for full or brief versions of the intervention, and other pertinent questions including the appropriateness of general practice as a site for this kind of work.

The present data were collected as part of a study that took the form of a cluster randomized controlled trial comparing full and brief forms of the 5-Step intervention. The former consisted of up to five sessions with a PHCP plus a self-help manual based on the SSCS model and specially designed for the study. The latter consisted of one PHCP session confined to the delivery to the patient of the self-help manual. Statistical results of the study showed before-to-after changes in symptoms and ways of coping, but showed no difference in outcomes between the two forms of the treatment (Copello et al., submitted). The study involved 197 primary healthcare professionals (PHCPs: GPs, practice nurses and health visitors) working in either the Birmingham or Avon and Wiltshire areas of England.

Method

The data were in open-ended, textual form. Interviews and conversations with PHCPs were recorded by researchers in the form of detailed field notes containing some verbatim quotations. The analysis was qualitative, using a method that drew on both a relatively structured approach (framework analysis; Ritchie & Spencer, 1994) and the less structured grounded theory approach (Strauss & Corbin, 1998). The authors met regularly as a team throughout the period of analysis and paper drafting in order to discuss, challenge and refine the results and conclusions, and all authors have commented on several drafts

of the present paper. For a more detailed description of the method see the companion paper (Orford et al., 2007). Sources of data were as follows:

Recruitment forms: completed every time a family member was recruited or a potential family member was not recruited. Covering how the family member was identified or, if not recruited, why the family member was not asked to take part; the nature of the family member's presenting problem or situation; how long the PHCP had known the family member and how long the PHCP had been seeing the family member in relation to the relative's substance problem.

Notes of conversations between researcher and PHCP during the recruitment phase. Covering progress, achievements and difficulties in recruiting family members.

Post-session/consultation forms, filled in by the PHCP after each session. Covering the content of the session/consultation.

Telephone interview with each PHCP 12 weeks after the recruitment of a family member (by which time the intervention should have concluded and generally had). Covering aims, whether those were felt to have been achieved, aspects of the intervention that were found to be easy or difficult, confidentiality issues that might have arisen, and preference for the full or brief form of the intervention.

Interviews with PHCPs at the end of the study (i.e. 12 months after the study start). Covering reasons for not approaching some family members, applicability to alcohol and/or other drugs, opinions about which PHCPs could deliver the interventions, difficulties in delivering the intervention/self-help manual, difficulties in participating in the study, ease of incorporating the intervention into normal practice, value of training and ongoing support from the research team, preference for full or brief form of intervention, opinions about possible future use of the intervention in practice, how the intervention might be used, whether primary care was thought to be the right setting for the intervention, etc.

Of the 197 volunteer PHCPs whose practices were included in the study (half randomized to deliver the full intervention, half the brief form), 29 dropped out before or immediately after training. Of the 168 who therefore became active in the trial (61 GPs, 69 health visitors [HVs] and 38 practice nurses [PNs]), 85 went on to successfully recruit at least one family member. In total they recruited 143 family members.

Volunteer PHCPs were already a highly self-selected group of all those approached in the two study areas. Even so, less than half went on to recruit a family member, and the large majority only recruited one or two within the study period. There must therefore be a doubt about the feasibility of carrying out this kind of intervention in the primary care setting. It is therefore of importance to obtain the views of those professionals who took part in order to complement the statistical results of the evaluation (Copello et al., submitted) and the views of participating family members (Orford et al., 2007). The present paper aims to present the views of participating professionals regarding the value of the intervention, the difficulties in carrying it out, and the prospects for its future use in primary care.

Results

Results are illustrated with examples taken from verbatim quotations from PHCPs included in researchers' reports of interviews with PHCPs or directly from forms completed by PHCPs. All such illustrations are shown in the text by placing them within inverted commas (all examples in the Tables are direct quotations from PHCPs' interviews or forms).

Identification and recruitment

Those family members who were recruited as participants had been known by the PHCPs who had recruited them for a median two years (a quarter for six years or more, but another quarter for one month or less). On the other hand the median span of time over which a family member had been seen by the PHCP with regard to the substance problem in the family was a mere four weeks: at one extreme a substantial number were discussing the substance problem with the PHCP for the first time, while at the other extreme 15% had been talking about the problem for more than two years.

When asked *how* family members had been identified, one of the largest categories, accounting for approximately a third of all replies, indicated that the PHCP knew about the substance problem in the family prior to the trial. Some such replies indicated that the substance misusing relative was known to the PHCP (e.g. 'I knew the boyfriend was taking drugs—the boyfriend was a patient of mine and I got to know his girlfriend'; 'Husband came to see me about his problem—I spoke to him about the study and suggested that he bring his wife in to see me'). Other replies indicated that the family member was already known to the PHCP (e.g. 'I've seen her before in regard to these problems—it has been a longstanding problem and my colleagues see her partner'; 'Single mother with multiple partners in the past—two sons are drug users [and] the practice is aware of the sons'). In other cases it was implied that the family, including the participating family member and the relative about whom the family member was concerned, was known to the PHCP (e.g. 'This family member is the mother of a client I see [who] had to involve her mother to look after her child—this is how I found out about the substance use problems and I've been helping the family member for some time'; 'I now know this family member and the drinker as they have had a child together'). Other PHCPs, mostly health visitors and practice nurses, were referred potential participants by practice colleagues, a category that accounted for approximately one in six of those successfully recruited. In all cases in this category the referrals had been made by GPs. One practice nurse reported that a family member had first been identified and put forward to a GP by a member of the practice reception team.

Another large category, accounting for about a third of all replies to the question about how family members were successfully recruited, indicated that the family member had disclosed the substance problem to the PHCP. This category included: 'For a needle-stick injury due to the son's heroin use';

'Her children were having behavioural problems and needed referral-on for help—at this point the mother disclosed that the problems were due to her husband using drugs'; 'She told me—she has marital problems and experiences domestic violence'; 'She has just found out about her son's cocaine use and is very upset'; 'The family member brought the substance user in to see me for help'.

In about one case in every six who were recruited, the PHCPs explained that they had found out about the family members' problems in the normal course of work or after suspecting a problem and enquiring further. Many of that group of PHCPs were health visitors. Examples are shown in Table I. In those instances it was made clear that the identification of a patient who was a family member affected by and concerned about the excessive drinking or drug use of a close relative was something that required active work on the part of the PHCP. Even in those cases where the PHCP indicated that the substance problem was already known about, or the family member brought the problem up during a consultation, it was still often the case that the PHCP had needed to be active by being aware of signs, following up leads, probing or persevering, as had been emphasized in the training. Only one health visitor mentioned a method suggesting routine screening: 'I do ask people directly, it's part of my assessment questions'.

Failure to recruit. At the end of the study, when asked to make any final comment, one of the most frequent types of statement was of disappointment, even apology, for having been unable to recruit any family members to participate in the trial, or disappointment at not recruiting more family members, e.g. 'I am sorry I never found anybody—it would have been useful to us and I'm sure some people would benefit from it'; 'I got a bit concerned about the lack of interest, i.e. patients not coming forward to seek help despite poster on display... maybe we aren't doing enough to identify... I wonder whether we are asking the right questions'. During the recruitment phase of the project and again at the end of the project PHCPs were also asked why potential family members were *not* recruited. In many cases PHCPs were able to talk about individual potential recruits whom, for various reasons, they did not invite to take part. Some of the reasons reflect project exclusion criteria, e.g. the family member's own substance

Table I. Examples of active work required to identify that a patient was a family member (FM) affected by and concerned about the excessive drinking or drug use of a close relative.

-
- I did a developmental check at 3 months. At this point, I could see that the FM was not well and the child was not doing well because of this. I probed her to get more details about problems and, after probing, she disclosed that her son had a substance use problem. (HV)
 - I went to the FM's home and there was a strong smell of cannabis. The FM's partner was there. That is how I knew. I have been back since though and I was nearly sick with the smell. (HV)
 - FM came in for blood pressure check. Very high. I asked if there were any reasons for this. FM then talked about her daughter drinking and taking drugs. (PN)
 - I see the drinking relative. I made links to the partner, who visits for minor ailments, etc. At one of these consultations, I raised the issue of drinking and the project. (GP)
-

misuse problem or lack of sufficient literary skills, or contact with the relative now irregular or intermittent. But by far the largest number of replies explained in various ways that the PHCP thought the family member's problems were too complex or that the family member was too distressed to take part. Examples are shown in Table II.

Only three PHCPs did not ask particular family members to take part because of sensitivity about the possible response of the relative, e.g. 'This FM [Family Member] was shown the manual and reported that she did not feel safe to take the manual home'; 'The relative does not believe she has a problem. She would think that both I and her husband were being disloyal if I approached him'.

In addition, it was often stated that *family members had declined to take part* despite having been identified as suitable participants. Two reasons for declining participation stood out. One was, again, the factor of the complexity of a family member's problems and the sheer amount that was going on in a family member's life. For example, one family member was recovering from a heart attack and did not want any extra stress. Another's marriage had just broken up and the extra work of taking part in a research project was not wanted. In another family, the problem drinking relative had recently been in hospital and social workers were also involved with the family. Others were said not to have been able to face taking part, including being daunted by the self-help manual. Others had complex, related issues including child protection.

The other substantial group of statements about reasons potential participants gave for declining consisted, by contrast, of statements that the relative's drinking or drug use, although identified by the PHCP as sufficient of a problem for potential inclusion in the project, was not currently sufficiently distressing for the family member to warrant participation.

Practice related factors. A large number of statements about the difficulties involved in recruiting family members related, not to the circumstances of family

Table II. Family members' distress and the complexity of their problems were main reasons for not recruiting family members into the project: Some examples.

-
- The patient was not up to it, too acutely distraught at the time. (GP)
 - Both husband and wife have quite serious illness not connected with the drug/alcohol problem and I thought it would not be suitable for me to invite them into the project for this reason. I am not sure that all of their problems are due to drug/alcohol problems. (PN)
 - The FM, whose wife was a drinker, was quite angry and aggressive towards his wife. I didn't feel I had the skills to cope with that. (PN)
 - Too many problems—split up from partner—sexually abused. I am not sure where this family member's problems lie. There are complex issues. (HV)
 - A lot of distress in the family. (GP)
 - The FM has a number of domestic violence issues and I think she has contacted the domestic violence unit before. I'm not sure how much this FM's domestic violence issues are wrapped up with the alcohol problem and I don't want to ask this person because I'm not trained in domestic violence issues. I don't feel as a professional that I could properly help this person with her problems. (HV)
-

members themselves, but rather to factors inherent in the work of the PHCPs themselves or the practices within which they worked. The most prominent issue here was lack of time. Sometimes it was simply stated that the PHCP was very busy, but often specific circumstances were referred to, such as recent changes of job, part-time secondment, demanding family responsibilities, illness, or Trust reorganization.

GPs, in particular, referred to lack of time to take part more fully, and they were often explicit about the low priority that they were able to give to the project. A number of GPs admitted that they had adopted a waiting or opportunistic approach to recruitment, and had not gone out of their way to recruit actively, due to lack of time. A small number of GPs found it difficult to comply with the research procedures.

Health visitors and practice nurses were more likely to speak about the difficulty of obtaining full collaboration, and patient referrals, from their GP colleagues. Sometimes this was attributed to staff shortages or time pressures within the practice generally. But more often there was reference to colleagues' ambivalence about taking part, resistance, or even outright antagonism and failure to refer patients. In addition reference was made to difficulties in the way of obtaining referrals for the project from colleagues in the practice, either because GPs were said to work individually in the practice and were unlikely to refer, because they might be concerned about confidentiality issues if patients were referred, or because referral was thought to be difficult if a family member was not a patient in the same practice. One PHCP drew a contrast between the lack of difficulties in obtaining GP referrals to her for the Stopsmoke campaign and the 'cloak and dagger' fashion in which drug and alcohol problems appeared to be treated.

Working with individual family members

Presenting problems. When asked about the problems initially presented by those family members who were recruited to the project, PHCPs' replies were roughly evenly divided between those referring to illness symptoms—some physical, others psychological—and those that referred directly to problems in coping with the excessive drinking or drug taking of a relative. An example of the latter type of presentation, described by a practice nurse, was that of a wife whose long-standing excessively drinking husband had recently been hospitalized after experiencing major fits. She was concerned that this might happen again and that she would not be able to cope. Another case, also described by a practice nurse, was that of a pregnant woman who had recently asked her heroin-using partner to leave for the second time.

Examples of family members presenting with symptoms of physical illness included, for example, a mother of a heroin-using son, who had recently moved back home while he underwent detoxification, who felt very isolated and distressed, and presented with increasing blood pressure and inability to lose weight (seen by a HV). Another example was that of a daughter who had been

trying to give her problem drinking father a lot of support since her mother had died, and who presented with low back pain (seen by a GP). An example of a presentation in the form of psychological symptoms was that of a mother whose partner was a heroin addict, and who had presented with depression, which started postnatally, and panic attacks (seen by a GP). The following two examples show mixed presentations, combining physical symptoms with psychological and social problems:

Presenting problems: Husband—palpitations, depression, stress. Wife is an alcoholic. She won't acknowledge the problem. She is often drunk at home and fails in aspects of childcare. So there are adverse effects on their relationship and on care of the family and family life. (GP)

Presenting problems: Wife—depression; Husband—ill health, shoulder problem; and now relationship difficulties. Their daughter, aged mid 20s, is addicted to heroin. She has been through the detox programme based in our surgery with drugs project worker supervision. The parents say their daughter deceived the worker and hadn't stopped at all. She is now back on heroin. (GP)

What did you do in today's consultation? From the forms that PHCPs were asked to complete after each consultation it was clear that most who were in practices giving the full intervention had attempted to stick to the staged, 5-Step intervention plan, and that, by and large, had been successful. Most positively referred to were alternative ways of coping with the relative's drinking or drug taking (session 3 according to the protocol). Discussions about increasing social support (session 4) were often mentioned although there were fewer indications that positive changes had been made in that area. Education/information about alcohol or drugs (session 2) received some favourable mentions.

One GP, for example, referred to discussing a family member's decision to withdraw from her heavy drinking brother-in-law to whom she had given a home. Another GP reported providing education to a wife about the effects of alcohol and had discussed its role in her relationship with her husband. They talked about her tendency to tolerate unacceptable behaviour on her husband's part, and at the next session her change from being a tolerant copier to being more assertive, while trying to find a strategy that would preserve her husband's self-esteem. A health visitor reported discussing ways that a mother could cope with her son's addiction and financial problems: in the past she had paid numerous fines for him relating to driving offences but had now removed the car from him and felt much stronger as a result. Much of the next session was spent discussing social support networks and exploring the possibilities of informing other family members about the problem. A practice nurse reported how a family member had made rules about the use of heroin by her partner in the house. Another aim was to help her explain the situation to her children.

Several PHCPs referred to discussions with family members about difficult decisions regarding the possibility of separation from relatives. For example a health visitor referred to a family member, who had presented with a facial injury caused by her partner, making a major decision to split from him and having tried to re-established links with her family. Another health visitor

reported that a family member had taken out an injunction against her partner and now felt more positive about the future and the way she was responding: social services had been involved at the time of initiating the intervention because of serious concerns regarding domestic violence. Another health visitor, in the final session with a mother, discussed traumatic events that had occurred over Christmas culminating in the family member telling her daughter to leave home. A further example came from a GP who reported the frustration felt by the family member about whether she wanted to stay with her partner or leave: she thought she had helped him get off alcohol through a home detoxification, but now thought that he was back on alcohol, and there had been some verbal and physical aggression on his part.

The PHCP's evaluation of an intervention. Asked what changes they thought had been made to the family member's situation, PHCPs often were able to refer to what they perceived to be positive changes, particular themes being the family member now focusing less on the relative and the family member feeling more positive about her/himself. Examples of positive evaluative statements are shown in Table III. Others were not so positive, often referring to the difficulty of achieving change given the family member's circumstances or the fact that the family member was already well-informed. For example: 'By the time we started the intervention she had already made key changes; going through stuff again was painful for her'; 'This family member had counselling and other support before. It was difficult for me to bring fresh ideas and fresh approaches'; 'We really came to the conclusion that she copes as well as anyone given the circumstances, so I felt I hadn't contributed much'. Sometimes the intervention was thought to have been helpful by giving support and reassurance about changes that had already been made.

Table III. Positive evaluative statements made by primary health care professionals at the end of interventions with family members.

-
- Some changes in behaviour when she gets angry or upset. Distancing herself more and not getting sucked into an argument. She's not so embarrassed by his behaviour when they go out—it's not her fault. (HV)
 - The fact that she was in a position of mental strength to tell her daughter to leave the house. (HV)
 - Feeling better in herself, she used to internalize things, which affected her health. She overcame her feelings of shame and guilt. (HV)
 - Her self-esteem and confidence have improved. She's less depressed, her mood has improved. (HV)
 - She feels decisive—wants to make a life for herself—she's much more confident and supported and has a greater self-belief. (GP)
 - The fact that I had something tangible, practical . . . to offer . . . to help her. To help her realize that she's not alone . . . To help her set boundaries that may help her resolve her guilt, especially now her son has moved out and she is torn between this being a good and a bad thing. (GP)
 - I feel like we're talking about the real issues, i.e. not her physical problems. I've discussed a lot more about her life and the impact of her relative's problem on her. (GP)
 - She's realized she can't stay in the relationship but we've got more work to do. (PN)
-

A number of health visitors in the full intervention group expressed difficulty in maintaining an exclusive focus on the topic of the intervention. They reported having needed to discuss such issues as housing, childcare arrangements, infertility, psychosexual counselling, diet, smoking, exercise and retirement. Asked after the intervention was complete which aspects had been found most difficult, the following health visitors said:

Restrictive, talking about one aspect. Difficult to approach the steps in order. Not sure that I did deal with the problem—I would try and make each step the focus, but the conversations tended to go off at tangents. (HV)

It was difficult keeping to the structure. So many other issues were involved too that were much more urgent, such as social, financial, and physical safety—domestic violence issues. I had longer sessions than I'd planned. (HV)

Confidentiality. PHCPs were specifically asked whether any issues had arisen regarding confidentiality. A number replied in the affirmative, and in some cases the issue had caused some awkwardness for the PHCP. In one case the relative about whom the family member was concerned was in the next room in the clinic and the HV was careful to shut the door and not to mention names. Another HV had a referral of a family member from a practice GP and therefore had details, such as the relative's name. The HV was uncertain whether this information should have been known, particularly since the family member said that she was not going to refer to her relative by name. A GP reported that a family member had not wanted the self-help manual to be found by the relative, and had wanted to fill in the forms in the surgery, and for those to be kept separate from the relative's records. The GP had complied with those wishes about keeping information separate but had not felt it appropriate to be involved in the manner in which the family member kept the manual secret from the relative. Another GP was seeing the relative as well as the family member, and the latter did not want the former to know of her involvement. The GP reported, 'It was her choice. We had discussions about it. She told him when she was ready'. Another GP reported difficulties in contacting the family member without the relative finding out: 'We had to get her a bag to put the manual in. I agreed not to contact her unless absolutely necessary and not to discuss anything with [the relative]'.

Views at the end of the project

The majority of PHCPs who had recruited family members reported that they had found it easy to incorporate the work into their normal practice. Those who answered otherwise nearly always cited time pressure as the reason for the difficulty, some referring specifically to 'all the paperwork' involved. A number stated that they had not in fact incorporated the intervention into normal practice, either spending longer on sessions than would normally be spent or seeing a family member on top of the existing caseload. Several practice nurses replied in that way, one referring to, 'separate appointments out of treatment room time';

another saying, 'I did it after my surgery—sometimes I was here until 7.00 p.m.'; another, 'I'm very busy—I did it in my own time'.

Thinking of the family members they had worked with during the project, most PHCPs said that they would normally have identified those family members as patients experiencing problems relating to alcohol or drug problems in the family, although many went on to comment that they would not normally have responded so well to those family members' needs. For example, in the absence of the project, a health visitor said, 'I would have supported her but not been so well informed', and another said she would have, 'Popped in every now and again, see if there was anything I could do, general chit chat'; one GP would have, 'Given a small amount of my time and antidepressant medication', and another would have, 'Just chat[ted] to him but nothing as in-depth'; one practice nurse said she would have, 'Just been a listening ear', and another would have 'Document[ed] it, and the doctor would take over'.

Preference for the full or brief intervention. PHCPs were asked whether, at the outset of the project, they had had a preference for being in either the full or brief intervention group, and whether their opinions had now changed. The overwhelming majority of those whose practices had been assigned to the full intervention stated a preference for being in that group, if not at the outset then certainly by the end of the project. Ninety percent of that group concluded that it was an appropriate intervention. Although most of the PHCPs' comments about the self-help manual were favourable, those who had experience of being in the brief intervention group were more mixed, less than half concluding that giving the manual alone was appropriate. For example:

Just leaving something felt like 'unfinished business'. (HV)

People are so low that they need more directed support, follow-up, motivation. (GP)

I tend to think additional input would be a good thing, even if it's just the odd phone call or follow-up visit, because you want to make sure they've made some effort to look at the self-help book and you want to see whether they're motivated to change things. (PN)

Replies varied by professional group. Most of the health visitors and many of the practice nurses expressed a preference for having been in the full intervention group, even if that had not been a clear preference at the outset. GPs in the brief intervention group, on the other hand, were quite likely to finish the project stating a preference for being in that group. That preference was nearly always attributed to the time factor. Some simply stated that time was an issue for them, but amongst additional comments were the following:

It's better to give more but not within resources. Seeing family members for sessions probably at the expense of other patients not getting extra support. (GP)

[Full intervention] in an ideal world. Opinion changed—in reality I haven't got the time, so I would prefer to just give out the manual. (GP)

Self-help group. Time commitment. Fear of getting over-involved, patient getting dependent and keeping on coming back. (GP)

Future role of the intervention in primary care. No fewer than 96% of all PHCPs who took part in the project, whether or not they successfully recruited at least one family member, replied in the affirmative to the question, If the intervention [full group]/the self-help manual [brief group] became widely available, would you use it?

PHCPs were asked what form of intervention they would recommend if their primary care teams decided to prioritize support for family members concerned about relatives' alcohol or drug problems. The full form of the intervention was favoured much more frequently than the brief (by over 50% compared to only 1–2%) but a large number of suggestions were for applying one or other on a flexible basis depending upon a family member's needs and circumstances, or applying some combination of, or compromise between, the two forms. Amongst the replies were those shown in Table IV.

A number of GPs, in particular, expressed concern about who would be responsible for carrying out such work. Reference was made, for example, to the hope that 'somebody in the team' would be willing to do the work, and to the possibility of it being carried out by a counsellor in the practice, a 'dedicated professional', or a community psychiatric nurse. When asked specifically whether it was felt that the work could be carried out by other primary care professionals, most were positive that GPs, health visitors or practice nurses could carry out the work, although some expressed doubt regarding their own or another of those professions (some were unsure whether GPs would have the time, and a number thought that nurses, including practice nurses and district/community nurses, might be too 'task oriented'). One additional group who were mentioned by several HVs and two GPs, as primary healthcare professionals who could deliver such an intervention, were midwives. School nurses and general hospital nurses and other hospital staff were mentioned by a number of practice nurses.

Finally, PHCPs were asked whether they thought that primary care was the right setting in which to do this kind of work. The overwhelming majority (all but 2–3%) said, 'Yes'. Comments made reference to the accessibility and lack of stigma associated with primary care, cost-effectiveness, the orientation of

Table IV. Primary healthcare professionals' suggestions for the ways in which full and brief forms of the family member intervention could be flexibly combined.

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- Give people manual first with an option for them to come back and ask for sessions if they want it. You could then give a manual much more readily without wasting time and only do extra sessions with people who are really committed. (HV)
 - I would like to see options available that give choice for professionals and for families. (HV)
 - A booklet available but some kind of support or follow-up too. Perhaps something like telephone counselling/support. (GP)
 - One or two structured sessions, with the manual. You can only give so much time and some time has to go to the [alcohol or drug] users. (GP)
 - A combination of both depending on circumstances. If I gave the self-help manual I would still want to follow-up. (PN)
 - Something in between—not regimented follow-up—self-help with access to other resources, e.g. specialist referral. (PN)
-

primary care towards working with whole families, easier identification of substance-related problems, a safe environment, and the likely reluctance of many family members to be referred to a specialist setting. A number made the point that primary care should not be the only site for this kind of work. There were mentions of Families Anonymous, links with specialist and voluntary services, walk-in centres and family centres, youth clubs, and community mental health teams.

Amongst the very few who were negative about the involvement of primary healthcare were the following two practice nurses:

No—other agencies have more expertise. Lot of strain on primary care at the moment. Taking out of primary care may also de-medicalize the problems. (PN)

‘No—because of time difficulties and because GPs don’t want to know because of time constraints and sometimes stereotypical prejudiced views about the user group. (PN)

Those who had experienced difficulty in recruiting family members often expressed disappointment at the end of the project, and uncertainty about how such difficulties could be overcome in primary care. For example:

On the whole I feel it’s a worthwhile project but I think primary care is too burdened with other problems, it just wouldn’t happen, particularly in inner cities where the problems are huge and the resources are small. (GP)

I think something could be done with it. Practice nurses are so pushed for time that they can’t give enough attention to patients. My workload has grown 10% in the last four years . . . administrative work eats into patient time. (PN)

Discussion

The project described in this and the companion paper (Orford et al., 2007), along with our earlier study that preceded it (Copello et al., 2000a, 2000b), has been the first, to our knowledge, that has attempted to respond directly to the needs of family members presenting in primary healthcare settings and identified as being affected by the alcohol or drug misuse of a close relative. Other projects have involved family members closely in their relatives’ treatment (e.g. Copello, Orford, Hodgson, Tober, & Barrett, 2002), or have involved couples therapy (e.g. Fals-Stewart, Birchler, & O’Farrell, 1999), or have focused on the needs of family members in specialist treatment settings (e.g. Howells & Orford, 2006; Miller, Meyers, & Tonigan, 1999; Templeton, Zohhadi, & Velleman, 2007). The present paper has reported on the views of primary healthcare professionals (GPs, practice nurses and health visitors) who took part. At the end of the project, primary care professionals’ views were overwhelmingly positive about primary care as an appropriate site for this kind of work and about the value of the approach promoted by the project, as well as the ability of a range of primary care workers including GPs, health visitors, practice nurses, counsellors and community psychiatric nurses to do this work. The results presented here, taken with the qualitative analysis of the views of participating family members (Orford et al., 2007) and pre–post outcome results of this study and the earlier

feasibility study (Copello et al., 2000b, submitted), encourage the view that this might be a form of intervention that could be disseminated in primary healthcare more widely.

Significant difficulties remain, however. Besides the problem of capturing the interest of busy primary care professionals and teams in engaging in an intervention for family members affected by relatives' alcohol or drug problem (Copello et al., 2000a, submitted), the present study reveals the difficulty that professionals often find in identifying and engaging affected family members. Professionals very often had to go out of their way to be active in order to identify such a problem, openly discuss it with the family members, and engage the latter in the intervention. The problem of identification had already been noted in the preceding feasibility study (Copello et al., 2000a, 2000b) and detailed attention was given to that issue during the initial training and subsequent support phases of the present study. Nevertheless, doctors, nurses and health visitors described large numbers of family members who might have taken part who were either not approached to take part, or who when approached declined to take part. One of the commonest reasons for not suggesting that a family member should take part was the view of the professional that the family member's problems were too complex, or that the family member was too distressed to take part. This was sometimes on account of mental health problems, sometimes the complication of child protection issues, but also because of a range of other distressing or complicating factors, sometimes leaving the professional questioning whether the alcohol or drug problem should be such a focus.

It is likely that some of the reluctance of PHCPs to recruit family members on account of problem complexity or family member distress, could be attributed to the research element of the project. But that is unlikely to be more than a part of the explanation. It seems clear that many presenting family problems, relating in some way to a relative's excessive drinking or drug taking, are complex problems, and any intervention of this kind that is seen by PHCPs as only applicable to uncomplicated substance problems will be bound to be limited in its applicability. If the approach is to be more widely used in general practice, thought needs to be given to these issues regarding complexity. Our own view is that there is no evidence that the intervention is contraindicated for complex circumstances and that, on the contrary, they might stand to benefit most.

Although doctors, health visitors and nurses who gave the full version of the intervention sometimes expressed frustration that only a certain amount was achieved, or that a family member's situation remained unchanged, many were positive about changes that they could attribute to the intervention. Many of the changes described were in line with the aims of the intervention, i.e. to help family members find ways of coping that they found more useful, and to reduce family members' symptom levels (Copello et al., 2000b, submitted). Family members were often described as happier, more confident, more assertive, less anxious or depressed, eating better or smoking less. Although not all family members benefited, the changes described for some patients were consistent with those described by family members themselves (Orford et al., 2007). Both family

members and their primary healthcare professional helpers emphasized a shift of focus, on the part of the family member, away from a predominant and emotionally draining concern with the problem drinking or drug-taking relative, and the strengthening of personal confidence. Improvements in social support might take longer to achieve.

Again like most family members who took part in the project (Orford et al., 2007), most of the professionals were of the view that a brief intervention that involved little more than giving the patient a self-help manual was insufficient, although the statistical results of the trial suggested that the briefer form of the intervention was equally as effective as the full version (Copello et al., submitted). Asked to think about the future implementation of such work in their practices, many were of the view that a flexible combination would be appropriate, involving the manual plus some face-to-face follow-up according to need. If such an intervention were to be more widely used in primary care, our recommendation would also be for a flexible approach that helps primary care professionals identify family members who may be affected by a close relative's alcohol or drug problem and assists them to respond positively to family members. That might include offering the kind of self-help manual used in the present project, with sufficient time given to introduce and explain the use of the manual and to monitor family members' responses to it, consistent with the amount of time that is available in the primary care setting.

Conclusions

It may be too early to reach an overall conclusion about the feasibility of the 5-step intervention in primary care. On the one hand, our experience has been that only a minority of practitioners volunteer to take part, that there are problems in identifying suitable patients to receive the intervention, and that many family members who might benefit are not given the intervention because they or their doctors, nurses or health visitors think their problems are too complex. When the intervention is applied it is sometimes thought to have been ineffective, often because it came too late or because it was insufficient to make a difference. On the other hand, the intervention was associated with measurable pre-post changes in coping and symptoms, and there were many examples of family members and professionals describing changes in the ways family members were viewing their circumstances, changes in the ways they were responding to their relatives, and relief of physical and emotional symptoms with which they were presenting in the surgery. The nature of these changes is consistent with what we know about the experiences of family members with close relatives with substance problems (Dorn et al., 1987; Orford et al., 2005; Wiseman, 1991) and with the kinds of changes described when a similar intervention for family members is used in specialist treatment settings (Howells & Orford, 2006; Templeton et al., 2006a).

An optimistic view would be that the problems encountered are no more than might be expected when first attempting to use a novel psychosocial intervention for a relatively hidden group in the primary care setting. The problems can be overcome. Some would be removed when the intervention could be used more flexibly, with a less stringent research protocol. General practitioners and their colleagues understandably need convincing of the value of taking on what may appear to be additional work, and demonstrations of the feasibility and positive outcomes will help to overcome such doubts. Some will feel that they are already undertaking this kind of family work, although comments of the professionals who took part in the present project suggested that participation enabled them to work in a much more focused way. There was considerable evidence of caution in applying the intervention in complex cases, but there were examples of practitioners successfully working with family members where there were issues of domestic violence and where social services were also involved. More experience is needed of applying the method in such complicated circumstances. Organizational constraints operated in a number of practices, making it difficult for a practitioner involved in the project to gain the interest and referrals of colleagues. But, equally, there were examples of referrals to the project being successfully made within a practice, and evidence of engagement of the whole practice including reception staff. In all these ways, the evident difficulties of carrying out such work in primary care might, with perseverance, be overcome. An important finding of this project, and of the earlier feasibility study, was that those primary care professionals who actively engaged in working with family members showed significantly greater positive changes in attitudes towards working with this patient group (Copello et al., 2000b; Templeton, Orford, Velleman, & Copello, in preparation).

In common with the companion paper on the views of family members (Orford et al., 2007), the present paper has a number of limitations, notably the lack of a check on 'testimonial validity' (Stiles, 1993). We believe a strength, however, was the collection and analysis of opinions from both those who delivered the 5-Step intervention (the present paper) and those who received it (the companion paper). The fact that the two sets of participants had similar perspectives on a number of topics—for example the value of some face-to-face contact, the nature of the positive changes that were sometimes brought about, the need to think about how the intervention is used when circumstances are complex, the likely greater value of the intervention when delivered at a comparatively early stage, and the appropriateness of the primary care setting for the intervention—lends confidence to the findings. We believe that the two sets of qualitative analyses have given us insights into the strengths and limitations of the intervention that would not otherwise have been available to us. One final proof of the value of these analyses will be the extent to which the results are used to change the intervention method and/or the theory behind it—what Stiles (1993) referred to as 'reflexive validity'.

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