

## **Early experience with a web-based intervention with family members of alcohol or drug misusing relatives.**

By

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### **Abstract.**

*A wide range of interventions are currently available on the internet for mental health and behavioural conditions. They included treatment for anxiety, depression, weight loss, obsessive-compulsive behaviours, specific phobias, panic disorders and various other conditions. Despite the variability, the general consensus is that they do lead to positive outcomes and often that it provides a means of reaching a far greater number of people than previously possible. Web-based intervention that target alcohol or drug users are few and even fewer is those that seek to support family members of users. This paper reports our early experience in the development and evaluation of this evidence based programme support programme. The programme is based on the the 5-Step Intervention which was found effective when delivered in other formats (namely face-to-face and self-help). This intervention offers support to those who are affected by someone else's alcohol or drug misuse taking them through 5 stages specified in the intervention programme. This intervention emerged based on the theoretical perspective of the Stress-Strain-Coping Support Model. This paper presents the preliminary results of the pilot phase with 18 participants / entrants into the programme with follow up at 3 months post registration. And usage statistics of the first few months in which it has been opened up for public access. Results show great potential for this format reaching many that would otherwise find accessing*

### **Introduction**

#### **Alcohol and Drug Problems**

The pleasures and the benefits that are mentioned by many alcohol and other drug users are accompanied by a number of adverse consequences, these adverse consequences however extend beyond the user. Substance use has been captioned severally as a private crime with the public being the victim, or as a hidden assault on the society. This is a reflection of the fact that it is a problem manifestly experienced by a few, but having far reaching ramifications that affect all of us. The negative impact of the alcohol or drug use transcends the individual using or misusing the substance. Alcohol and other drugs are casually implicated in many problems ranging from casualties to many health and social problems. It could have adverse effects for family life, work function and the performance of other social roles. Relatives of people with drug and alcohol problems have shown high levels of stress and trauma that places them at risk of both mental and physical ill health (Svenson et al. 1995)

The actual number of the affected family or network members that are affected in this manner is however unknown. There are ways to arrive at some estimate of this number however. If we assume that for every 1 misuser there will be at least 2 family members so affect we could look at national statistics on dependency to give us some estimate. Considering Singleton et. al (2001) results of the 2000 National household survey, which found that 7.4% of adults in UK had some degree of dependency, 6 months prior to interview, if each user affects two family members are negatively affected this will put those affected at approximately 14.8% of the 8 million people. Some have argued that this is an overestimation as people that have problems may be on their own and hence no family member is adversely affected. On the other hand, this may be a gross underestimation as the level of substance abuse set as harmful, is quite high. Besides there are communities particularly those in African countries like Nigeria where a large family structure and social network is the norm, and in these settings more people would be affected by the relative's drinking. Irrespective of the exact figures, it would be accurate to state that the affected family or network members far outnumber those actually misusing alcohol or drugs. These figure is large enough to warrant attention.

These family or network members consistently report the experience of living with or being in close contact with someone that has an alcohol or drug problem as being very unpleasant and stressful (Dorn et al 1987; Orford et al 2005). The stress is often very intense and long-lasting placing family members at a great risk of ill-health, which may account for the greater frequency with which family and network members present at GPs and health clinics. (Orford et al 1998; Copello et al 2000). There is evidence to suggest that working with the family members in treatment can lead to significant reduction in the severity of the negative impact they experience (Barber & Crisp, 1995; O'Farrel, 1996; Miller et al. 1999; Copello et al 2000; Halford et al. 2002). Additionally, working with family members and the wider social network of the alcohol or drug misusing individuals leads to a number of positive outcomes for the user, namely: the entry into treatment

and engagement of the substance misuser (Barber & Crisp, 1995 Copello et al 2005), as well as the greater retention in treatment (Dobkin et. al, 2002; Miller & Wilbourne, 2002).

Despite the accumulating evidence, the delivery in alcohol or drug services have been slow in adopting therapeutic approaches that include the family and network members. Most of the services currently available focus almost solely on issues of screening, identifying, and intervening briefly or otherwise, for the individual alcohol misusers. Only very few approaches involve the family members, where they do, it is to encourage or provide support to the user for entry into and retention in treatment (Velleman & Templeton, 2002, Copello and Orford, 2002). This gap in service provision for family members becomes wider when considering brief interventions for alcohol or drug problems; here the needs of the family member are left largely unaddressed.

This non-inclusion of family and other network members in service provision may in part be due to a number of existing theoretical perspectives on alcohol drugs and the family. Many of these theoretical formulations (pathology model, dysfunctional family, family systems, co-dependency) viewed the family member more in pathological terms. Postulations of these perspectives implicate family members in the creation and maintenance of the problem. The emergence of a more detailed understanding of the experience of family members living with someone misusing alcohol and other drugs, has led to the formulation of a Stress-Strain-Coping-Support Model.

### **The Stress- Strain–Coping-Support Model**

With the emergence of a more detailed understanding of the experience of family members living with someone misusing alcohol and other drugs, the Stress-Strain-Coping-Support Model was developed (Orford et. al, 1998a, b, c, 2001, 2005).

The SSCS model suggests that

- 1) Stress - Living with a relative that is misusing alcohol or other drugs is stressful;
- 2) Strain - That concerned family members will experience strain, this is often evident in the high levels of physical and psychological symptoms
- 3) Coping - Family members in this situation will try to adopt various ways cope with it.
- 4) Support - The quality and level of social support that the he/she receives can help in coping with the situation

The SSCS model differs from previous conceptualizations of the alcohol and family in several ways;

- Family is seen differently, not so much as co-dependent or in a maladaptive /dysfunctional situation but as people who experience stress as a result of another persons drinking
- Places the family member, and not the substance user at the center of interest
- Focus on present circumstances and actions in regards to the relative's drinking
- Focuses on family members needs and whether further specialist attention would be needed
- Provides a model of intervention

### **The 5-Step Intervention**

This is an approach to intervention that was developed based on the SSCS model (Copello et. al. 2000a, b, 2002). As an intervention it was designed to be delivered in the primary care setting. It took into consideration the fact that a vast majority of people are registered with GPs and do visit their GP's once a year, and thus the primary care setting would provide a valuable avenue for the delivery of health promotion advice & a variety of brief interventions. Additionally, it is known that family members whose relatives have a drinking problem visit there GPs more frequently than do others (Anderson, 1996; Svenson et. al. 1995), this increases their accessibility to interventions delivered in the primary care setting.

For acceptability and willingness of the professionals to deliver this intervention in the primary care setting it was made brief. It consist of 5-Steps, the input that is required in each of these steps vary according to the individual circumstances of each family member. These steps are listed sequentially below:

- Step 1:* Listening to understand full dimensions of family member and the problem
- Step 2:* Providing relevant information and advice.
- Step 3:* Exploring how family member copes/responds
- Step 4:* Exploring and enhancing social support
- Step 5:* Referring on for further Specialist Help (where this becomes necessary).

A training manual had been written for inclusion in the intervention package along with summary cards and self-help pamphlets. Two primary health care projects-primary care project (PCP) 1 & 2 have been conducted in which health care workers were trained in responding to the needs of family members, even in

situations where they came in without the drinker (Copello et al , 2000). The first project was a pilot using 21 primary health care professionals from the Birmingham and Bath area. These included general practitioners, practice nurses, and health visitors. This first project was designed to evaluate the effects of the 5-Step intervention. For the second phase, the package was revised and used in the training a total of 91 health care professionals. Additionally a self-help manual has been written and used (Templeton et al.2000). As an intervention is has been evaluated in different settings (Arcidiacono et al 2007; Copello et al. 2007a, Orford et al. 2007a, b; and Templeton et al. 2007; Velleman et al 2007). The family members of alcohol and drug users recorded a significant reduction in symptoms of stress, as well as adopting healthier forms of coping with the drinking problem of their relative. In addition, physicians reported that as a result of their participation in the trials they had greater level of confidence, support, knowledge, legitimacy, self – esteem and overall attitude in working with family members (Templeton, 1999).

There are different challenges that is posed in dissemination of this evidence based 5-Step Intervention on a much wider scale. At one level it would be the investigation of the applicability of this approach to intervention in other settings, such as social care settings, social services and statutory and non- statutory alcohol and drug services. A related goal would be identifying groups that may not currently be reached, or taken into consideration, in the current formulation of this intervention, and look for ways to adjust to the needs of this group. This would involve running more control trials evaluating the 5-Step Intervention and disseminating this information across primary care practices, and other services. At another level is making self-help manual available to a wider population, placing it within the reach of more family members. One of the feasible means through which this may be possible is by placing it on the internet.

### **Internet-Based Interventions**

The therapeutic potential of the internet has been widely reported but less rigorously investigated. What these studies have consistently shown, is that there is a sizable demand for internet-based interventions. There is a continually increasing number of people that are using the internet for health related information (Murero et al. 2001; Tatsumi et al,2001; Powell & Clarke, 2002). The internet may thus play a potentially revolutionary role in how health care is delivered in the future, and there is thus a need to position alcohol and drug treatment services in such a way that it can make full use of this medium.

There are a wide range of interventions available on the internet for mental health and behavioural conditions. Despite the variability, there is a consensus in that positive outcomes have generally been reported in the treatment of these conditions. They included treatment for anxiety (Newman et al, 1997, 1999), depression (Christensen, Griffiths, Korten., 2002; Clarke et. al., 2002), obsessive-compulsive behaviours (Robinson & Serfaty 2003), and specific phobias as well as panic disorders (Devineni & Blanchard, 2005; Kenwright et al 2004; Marks, Shaw & Parkin 1998; Marks, 2003). Studies of this nature lend credence to the high probability of reaching a large number of people through this medium as well as to the efficacy of computer-delivered treatment paradigms. The use of the internet for treatment of certain conditions is however plagued with high attrition rate, an issue that would need addressing for all treatments that are currently using the internet option.

### **Study Rationale**

Though the internet has shown great potential for use in the treatment of the above mentioned conditions, its use in treatment and intervention with substance abuse, trail far behind. The few online substance abuse intervention programs vary tremendously in quality and complexity. Only a few of the available sites provide theory-driven and evidence-based approaches to treatment. To date, no studies have been found in literature that focuses of the family member as a person in need of help in his or her own right.

The research work will develop and implement a trial of an internet-based intervention for family members of alcohol and drug users based on the 5-Step Self-Help Manual. Having this service available for family members on the internet has certain advantages:

- It would provide an approach to intervention that is currently not readily available.
- It would be accessible to much wider number of family members, than could possibly be provided in/by walk in centres.
- It could be accessed by anyone anywhere in the world irrespective of physical, geographic or lifestyle limitations.
- Accord a level of privacy for family members and their relations,
- Would empower individuals, as they would achieve some sense of power and control over self and their environment which is an important underlying goal of self-help approaches.
- The timing is flexible enough to fit each individual's program. This is particularly important to individuals who are either working and therefore find it difficult to get time for treatment for a problem

which they cannot adequately justify to employers, or they are living too far from the treatment facility to be able to make full use of it.

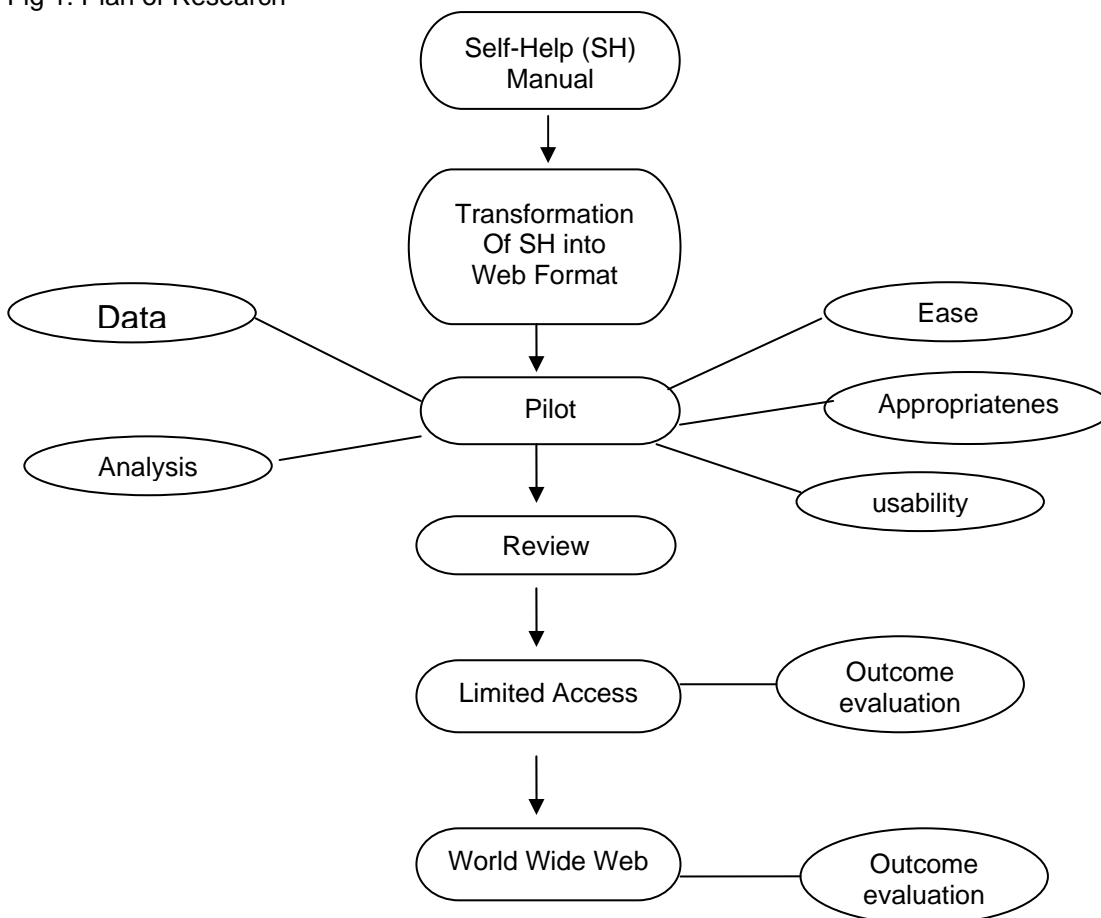
Through this study it will be clear if the availability of the self –help manual on the internet is a viable alternative, for interventions that targets the forgotten population of family members of those who have alcohol or drug problem.

## Method

### Plan of Research

The process of getting the self –help format transformed and to a point where it becomes available for use on the internet by family members of relatives with a drug problem will take several stages. These stages are outlined below:

Fig 1: Plan of Research



### Transformation of Self-Help Manual into web-format

The objective at this stage was transforming the self-help manual into the web format and evaluating the usability of the application. A method user-fit method suggested by Poulson et al.(1996) was used where the first 6 FNMs will be encouraged to use this package working one-to –one with a researcher. While doing this they were asked a set of predetermined questions about the content, ease, and the usability of the application. These questions explored their feelings how they felt about the instructions, how they felt it could be improved. Questions were also asked in regards to navigation through the program to see if it was comprehensible and easy or whether there are aspects that need to be changed to make it better. The users will be prompted to talk through what they are doing and express any difficulties verbally as well as their feelings about the process.

The aim of this stage was to identify potential problems with the prototype; problems such as, difficulty in using the controls, reading the words on screen, or interpreting the language used. Crucial at this stage was to obtain on-going feedback from the users in regards to the design process. This help evaluate the performance of the software that is in actual use. Thus, the first prototype of the model will be evaluated.

## Limited Access

During this phase the program was revised taking into consideration some of the comments that were obtained from the testing of the prototype to make it more user-friendly. Here individuals referred or that have agreed to participate in the study were given a password with which they can do so. Access to the site at this stage was limited to those that have been tested and meet the criteria for inclusion.

During the restricted access recruitment was carried out via participating institutions. These included two GP practices and two Specialist Drug and Alcohol Teams. Family members were recruited through their contacts with these associations either in the process of driving loved ones for their appointments they were invited into the sessions and given the option of assessing this support online or they were recruited through their loved ones who either took back pamphlets on the website to give to them or informed of this support facility.

*Recruitment of Participants:* Family members were recruited through two main routes. The first route was conducted through a variety of sources (eg contact with project team, services etc), the second was through a one-time event organized to provide computer access and technical support to family members that were interested in taking part in the trials.

The criteria for inclusion of FNM in analysis included:

- ✓ The individual considered themselves sufficiently affected and/or concern about the alcohol or drug use of a relative.
- ✓ The FNM must have been in contact with individual in the last six months
- ✓ The problematic drinking or drug taking incident(s) had occurred within the last 6 months.
- ✓ FNM were at least 16 years and above.

*Route One:* This first recruitment route was ongoing involving a variety of sources to recruit family members to the project. Some FNMs were identified by key workers in the NHS trust/GP surgeries and Specialist Drug Services. The key workers in their course of work would identify potential family members and invite them to participate in the evaluation of the web-based programme. These family members were identified in the surgery when they present with symptoms due to relative's drug and alcohol problematic use. The other channel through which family members were identified in this project was through their contact with members of research team. Posters and leaflets were printed and distributed, informing and inviting family members to be a part of the on-going trial of this web-based support for family members who were concerned about a relative's alcohol or drug use

Through this on-going recruitment route 20 family members had indicated their interest in taking part. Of these 15 successfully logged in and registered on the programme. The 5 that did not register were followed-up four weeks later to see what they were experiencing and if they were able to login. Results of this showed that one did not login because of not being able to have access to a computer to do so while the remaining 4 had not logged in to use the programme as they could not find the time to do so. They still maintained their interest and desire to be a part of the programme.

Out of the 15 people recruited through this route only 9 were included in the final analysis, the 6 that were dropped did not meet the criteria for inclusion in the study, Three of these were dropped as they were professional health care providers seeking an experience of the web-programme in order to enable them referred it for the use of family members. Two of the FM were dropped as baseline information provided showed that their relative's problem had not been active in the past 6 months. The last case dropped was as a result of giving more than three "don't know" responses in one of the baseline measures.

*Route Two:* The second recruitment route was through the organization of a one-time event for family members of alcohol and drug misusing relatives. Thus a workshop was scheduled in which family members were invited to a workshop where they were given access to a computer terminal from which they could login to the web-based programme and if required receive technical support while doing so. In preparing for this workshop, the investigator arranged for invitation e-mails to be sent through various institutional channels to staff of three universities within the locality as well as students of one of these universities. In the other universities students were on vacation and those approached to distribute this to the student body felt that could not be reached in the time available. The email sent out, invited participants who were concerned about someone else's drinking to a "two-hour workshop for family members" within the university where they would have access to a computer terminal and support in login to the web-based programme. Posters and Pamphlet were also printed and strategically placed in the University and leaflets sent to the staff of 4 primary schools and 3 secondary schools.

Information about the two-hour workshop was also online on the alcohol policy podcast. Furthermore, various Specialist Drug Agencies were contacted to pass the invitation across to family members that they

were in contact with informing them of the upcoming workshop. Reimbursement of travel expenses and refreshment was promised at the workshop.

In response to the invitation to the workshop 17 FNMs indicated their interest in participating in this workshop. Some were not however able to make it for the workshop on the scheduled date. Of those who had earlier indicated interest but could not make it for the workshop they were later contacted and informed that they could still participate in the programme if they still desired to do so. Information and instructions for logging in was sent out to them. Investigator also made enquiries as to why they were not able to participate in the workshop. Different reasons were given: two lived in towns that were far away and could not get permission from work to attend. Another gave illness as reasons for not being able to make it, one had fallen ill after returning from a trip and the other having to care for a family member that had fallen ill. Two others cancelled at the last moment because of situations that arose. There is no information on why the remaining three who could not attend. Out of the total of 17 that indicated a desire to be a part of the workshop, a total of 8 FNMs attended this workshop. Two of these were later dropped from analysis as the relatives drug use had not been active in the last 6 months.

From these two recruitment routes - ongoing recruitment drive & one-time event a total 15 FNMs (on-going 9 & one-time 6) that registered on the programme met the criteria and were included in the analysis. The data presented here are from all the participants that registered since the release of the site on December 2006 and the download of data in 25<sup>th</sup> September, 2007. They were FNMs who obtained a registration code, logged in, gave permission for their data to be used in research and were allocated individual database records. These participants were required to register before they were allowed to access any of the modules of the 5-Step Intervention. The registration involved providing demographic information as well as responding online to the baseline measures.

### Open Access

During the period where the restrictions were removed, the individual no longer needed to have a registration code which in the previous stage was obtained by the recruiting agency. Links from other related programs had been established allowing people to access the site through various search engines. Data gathered at this stage will allow for continued monitoring and evaluation of the Programme, monitoring data was systematically collected with step exposure to different recruitment activities

During the first two months in which nothing was done to advertise this site making people aware there were an average of 30 people in the first 2 months. After these three months email messages with attachments: poster and published evidence of its efficacy was sent to Specialist Drug and Alcohol Teams. It was thought that they would in the course of their work be in direct contact with family members or indirectly through their contact with the users.

Fig 2: Site traffic March to April

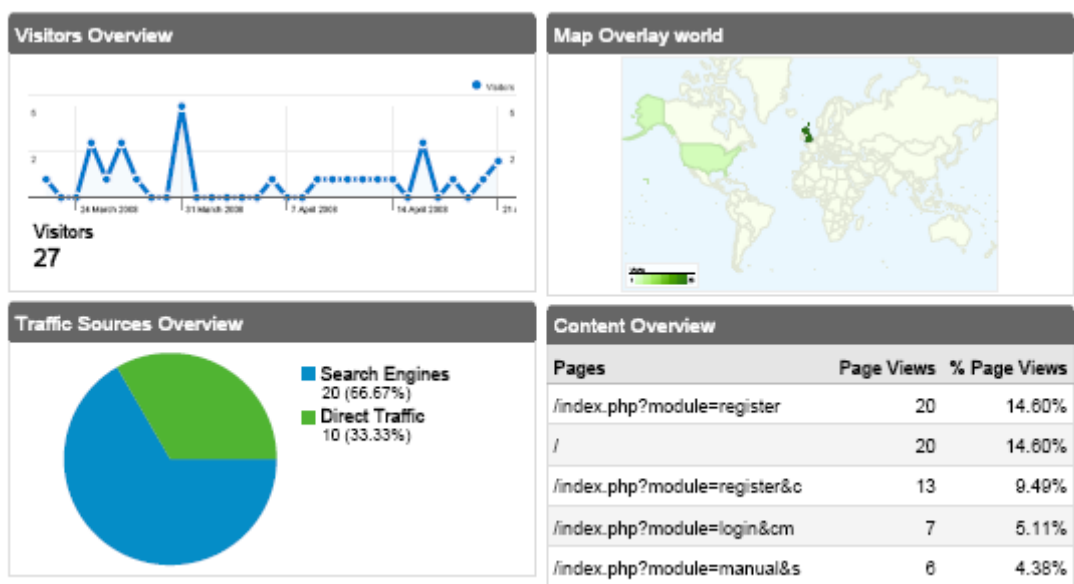


Fig 2: Site traffic April – May

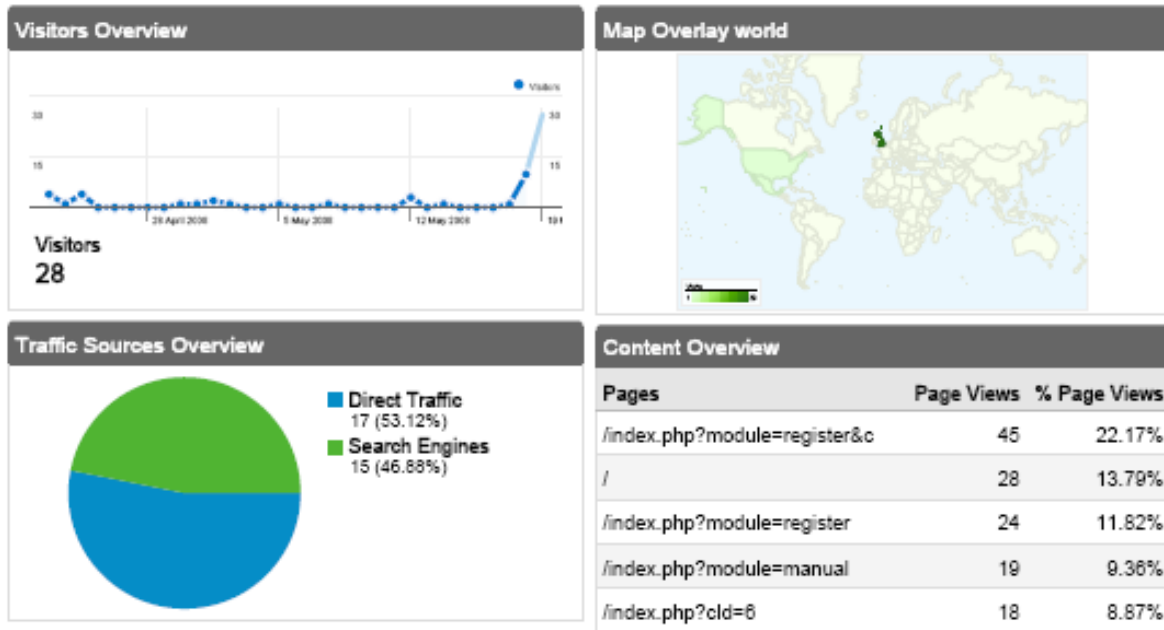
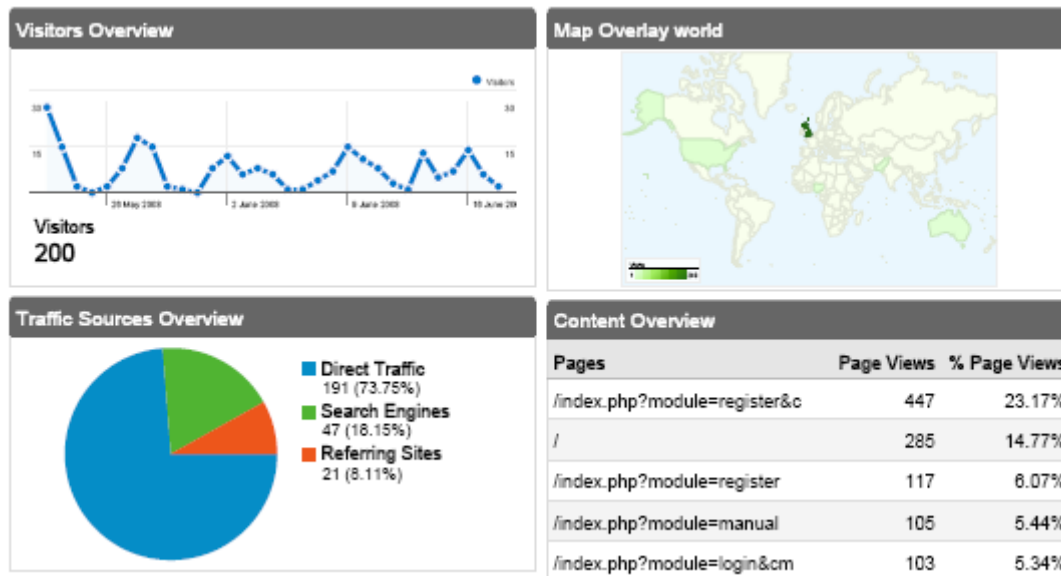


Fig 3 te traffic May – June



## The Layout of Website

### Site Design

The site is designed in such a way that on arrival to the homepage the family/network members are presented with general introductory information about what the “Involving Family Members project” and the Alcohol, Drugs and the Family (ADF) group.

There are links from on the home page to available publications, quotes from family members that have experienced this approach and professionals that have been able to work with family members using the approach; the nature of work so far accomplished in involving family members in the treatment of relatives and love ones that have an alcohol or substance misuse problem. Links to collaborating organizations as well as other sources of help for which a family member in that situation may find useful. The privacy policy, log in page will be available.

The program will begin with a screening to see the suitability of the individual to use this application, next the individual's consent will be sought online in two stages. The first will be to participate in the research; this will include potential risks, benefits, and right to withdraw from treatment. The second stage will contact procedures, which will allow for participant to be contacted or reminded by email or any preferred means when the time for filling in the second/or possible third assessment format is due. Where the participant does not consent he will not be allowed access into further stages of the self-help.

When logging in for the first time individuals will be required to complete a number of self-report questionnaires. When they log in on subsequently they will be allowed to proceed straight to the module of the self-help that they desire to visit or work through.

The initial assessment will tap demographic information about the participant in addition to getting information on the symptom rating, the participants' coping responses in the past three months, and the impact of the alcohol or substance use on the family.

**Follow up assessment**

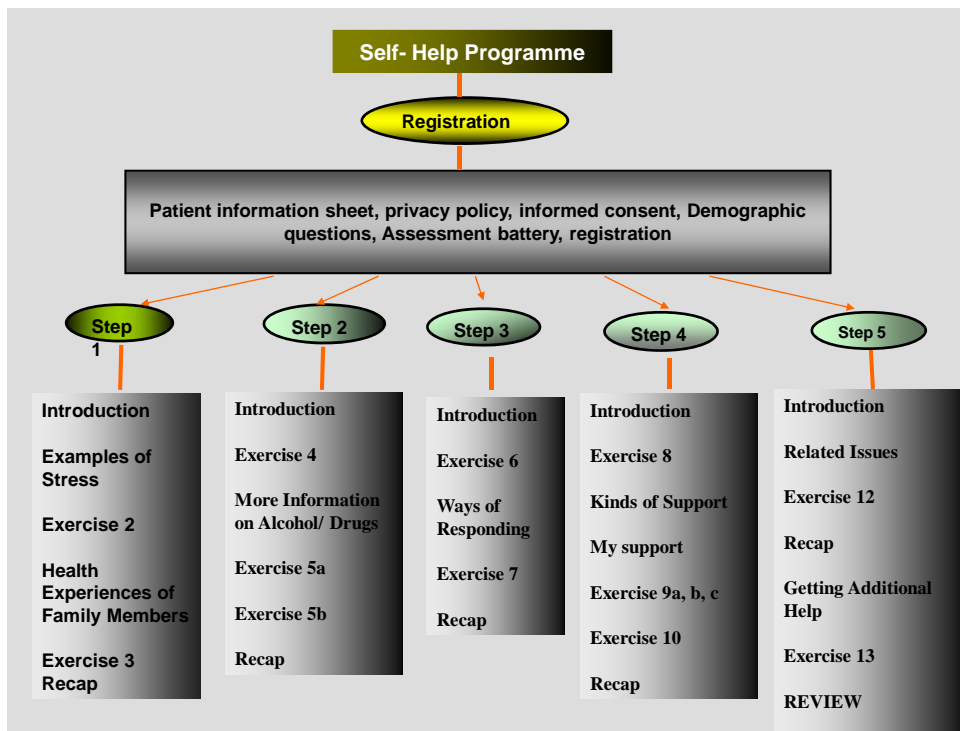
Participants in the computer assisted self-help were contacted via and auto –e-mail at different intervals. A small number responded within time but for others repeated mails had to be sent. In the first instance they were asked to return to the site to fill in the follow –up questionnaire. As the responses obtained through this was poor we decided to change and request to interview them about their experience in using the site and then after the interview asked for them to fill the follow-up questionnaire. Many requested for a raw copy of the questionnaire to be sent in a prepaid return envelope for them to fill and return.

**Internet Sessions**

The sessions are designed in such a way that they could be taken in any order that the person desires. He is advised to proceed through each of the stages/modules sequentially; he is however not forced to do so as the program will allow for entry at any level. The program itself is arranged in five different modules to reflect that of the self – help manual.

Sessions track the progress of the participant through the modules. The cookie files do not store personal information.

Fig 4: Self-help programme



Each module generates homework for each participant to complete between the computer sessions.

Users/visitors to the website will be required to provide anonymized information with regards to their situation. Visitors to the site will also be required to answer a few of the questions from the standard measures that have been used in previous stages (SRT,CQ,and the FMI). Other measures that will be taken

in the course of this study will relate to the internet behaviour of the visitors to the site. Thus information will be sought in regards to:

- Site hits by day, month, gender, geographic area, time of day.
- Pages visited
- Time spent on each page/module
- Questions about their use and evaluation of the site
- Search engines used by visitors to access the site

### **Measurements**

All measures taken will be administered and submitted online as self-report questionnaires. Three scales will be used to gather information on for evaluation of the progress of the family member in the program. This as mentioned will be the Family Member Impact scale (FMI), the Symptoms Rating Scale (SRT) and the Coping Questionnaire (CQ). The respondents will be required to fill in the questionnaires at each of the measurement intervals.

**The Family Member Impact (FMI) scale** This is a 16 item scale that measures the perceived impact that alcohol and other drug use by a relative is having on the family member or the family as a whole. It was derived largely from three sources:

1. The hardship scale developed by Orford et. al. (1976)
2. Experiences that were most often recalled by adult offsprings whose parents had with a drinking problems (Velleman and Orford (1999); and
3. In-depth interviews with family members of relatives with a drinking or substance misuse problem in England and Mexico (Orford et. al., 1998b)

FMI questions included questions such as; "Does your relative have very changeable moods?", "Have family finances been affected?" "Are you worried that your relative has neglected his/her appearance or self-care?" The individual is to choose one of the four possible fixed response options, either: "Not at all", "once or twice", "sometimes", or "often" and this are scored 0,1,2, and 3, respectively.

**Coping Questionnaire (CQ)** The coping questionnaire is designed to assess ways in which family members have over the previous 3 months been coping with the problem drinking or drug taking relative. It consisted of 68 questions some of which in its original format was limited to measuring only the effect to husband's alcohol problem on the wives. This version has been used in various studies both with in and outside of the UK (Hayashi, 1978, Mcgrady and Hay, 1987; Holimila, 1997). This scale has been adapted a number of times making it now relevant for husbands and other family members, this adaptation additionally has extended it beyond the relative's alcohol problems drinking to also for his/her drug use. This adapted version is also much shorter with only 30 questions. This version has been shown to be reflective of the three moods of coping that is found in this population: engaged, tolerant-inactive, and the withdrawn (Orford et al 1998b). by Holmila (1997) reported a similar three factor structure when using a modified version of the CQ. The coping questionnaire has questions such as: "Have you felt too frightened to do anything?" "Have you encouraged your relative to take an oath not to drink or to use drugs?" "Have you felt too hopeless to do anything?" response categories for these and other questions here are "No", "Once or twice", "Sometimes", and "Often" and are scored 0,1,2,3 respectively.

The internal validity for this scale is .85 (the engaged coping has been found to be .82, Tolerant-inactive is .78 and withdrawal coping is at .67 (Orford et al. 2005)

**Symptom Rating Test (SRT)** developed in by Kellner and Sheffield (1973). This questionnaire consist of .....It is used to assess the extent of physical and psychological ill-health in the general population. It is brief, consisting of 30 listed symptoms of which the respondent is to indicate the frequency which he has experienced each of them within the past 3 months. These symptoms, for example include; "Feeling dizzy or faint", "Feeling tired or lack of energy", and "Feeling nervous". There are 3 possible responses, of which the family member chooses from; these are "Never", "Sometimes" or "Often" and are scored 1, 2, and 3 respectively.

Authors initially suggested that four sub-factors (anxiety, depression, inadequacy, somatic) could be derived from this scale. Other studies (Welch, McColl and Peace, 1989; Matson, 1995) point to the underlying structure being better defined by the two factors: physical and psychological symptoms, rather than the four suggested by the authors. More recent work (Orford et al (2001) using principal component analysis support the existence of a two structure. This has made it possible to derive three possible scores from this scale:

the total score, as well as the psychological and symptom subscale scores. As expected high correlations have been found to exist between the two subscales.

Internal reliability coefficient for this scale is .93. For psychological symptoms it was .91 and for physical symptoms it was .81. Orford et al (2005) point out that the validity of this scale when used with family members of drug using relatives, is demonstrated in that the scores obtained among this group (mean 26.3) is far higher than those of a control group in the UK reported by Cochrane and Stopes-Roe (1980) (mean of 8.0) but comparable to that of psychiatric outpatients and day patients (mean of 24.6) (Orford et al, 2001; Copello et al, 2000b)

## Results

### Characteristics of Family / Network Members

*Gender & Age of Affected Others:* In the pilot phase there were a total of 15 FNMs that met the criteria for inclusion in the study and were thus included in the analysis. This was made up of 12 (86.67%) female and 3 (13.33%) males. The mean age of FNM was 44.33 years (SD=13.66), ranging from 28 – 73 years. A similar number was obtained from those that registered during the open access phase.

Table 1: Gender of family members

Gender	Pilot (n=15)	Open Access (n=15)
Male	3(13.3)	4(26.7)
Female	12(86.7)	11(73.3)

*Gender & Age of Relatives:* Each FNM included in analysis mentioned being concerned about the drinking or drug use of one of their relative. The number and percentages of those that registered in each phase is shown below.

Table 2: Gender of Relatives

	Pilot (n=15)	Open Access (n=15)
Male	12(80)	13(86.7)
Female	3(20)	2(13.3)

*Occupation of registrants:* The largest percentage of registrants in both was that of restricted and open access were in full time employment this was 40% and 50 % respectively.

Table 3: Occupation of FNMs in the programme:

Occupation (n=18)	Pilot (n=15)	Open Access (n=15)
Full time employment	6(40.0)	8(53.3)
Part time employment	2(13.3)	2(13.3)
Retired	1(6.7)	1(6.7)
Student	1(6.7)	1(6.7)
Looking after Home	4(26.7)	1(6.7)
Permanently sick or disabled		2(13.3)

*Relationship of FM with Relative:* Family /network members were also required to indicate how they are related to the alcohol or drug misusing relative. The possible responses in this category included: Father/Mother, Husband/Wife/Partner, Brother/Sister, Son/Daughter, or Other. Table 4 below shows responses obtained by FNMs to this question.

Table 4: Relationship of FM with Relative

Relative (n=18)	Pilot (n=15)	Open Access (n=15)
Father/Mother	2(13.3)	-
Spouse	5(33.3)	6(40)
Sibling	2(13.3)	1(6.7)
Child	5(33.3)	7(46.7)
Other	1(6.7)	1(6.7)

**Nature of presenting problem:**

*Problem presented by relative:* Family members were asked to tick the main problem which their relative has. Response category included drinking problem and drug problem, or Both drinking and drug problem. Results from the data (see table 5) shows that an equal number of family members were concerned for alcohol or drug problem (40% each) while the presenting problem was both alcohol and drugs in 20% of the cases. This was not so different with those that registered during the open access phase.

Table 5: Nature of presenting problem

Nature of problem	Pilot (n=15)	Open Access (n=15)
Drinking	6(40)	5(33.3)
Drugs	6(40)	6(40)
Both	3(20)	4(26.7)

*Duration of problem:* Whether it was a drinking or drug problem we were also interested in the duration of the problem. Family members were asked "How long do you feel that your relative has had problems with drugs and/or alcohol?". Responses included "1-6 months", "7-11 months", "1-2 years", "3-5 years", "6-9 years", "> 10 years". Table 6 below shows responses of family members to this question.

Table 6: Duration of the presenting problem

Duration	Pilot (n=15)	Open Access (n=15)
1- 2 years		1(6.7)
3-5 years	4(26.7)	3(20.0)
6-9 years	1(6.7)	2(13.3)
> 10 years	10(66.7)	9(60.0)

**Site Usage Statistics:**

Measures were also taken of the usage of the site by the FNMs. We were here interested in seeing the frequency and pattern of usage of the site along with the time that the individual spent on each of the pages / step of the programme

Of the 15 FNMs that had successfully logged in, filled registration baseline information, and were allocated a user identification record on the data base, 12 of them had subsequently returned to the website to make use of the support programme. Table 6 below shows the time spent by each of these 12 FNMs on each of the five steps, and the number of days that they individual has used in accessing these steps.

Table 6: Duration of Relative's Problem and Time (minutes) spent by FNM on each step of web programme

No	ID	Duration of problem	Step 1	Step 2	Step 3	Step 4	Step 5	No. of Days & Pattern
1	28	3-5 yrs	18.52	-	-	-	-	1- visited Step 1 spending the time there and logging off without getting back on the system.
2	43	6-9 yrs	35.33	5.82	-	-	-	2- went through Step 1 and then did a bit of 2 before stopping, repeated this also when visiting site the second time (which was approx one month later)
3	57 smart	>10yrs	6.22	-	-	-	1.82	1- Started with step 5 spending a short while before returning to step one
4	42 Carol	>10yrs	17.4	3.65	5.12	7.85	9.97	1- went through each step of the programme sequentially
5	84	>10yrs	11.46	1.35	-	-	-	1 - Spent time in step one then briefly went to step 2
6	99	3-5 yrs	11.85	1.47	3.5	3.32	2.97	1 – Went through the whole programme sequentially in one day and then repeated the process again for all the stages
7	102	3-5 yrs	36.91	0.47	-	-	-	3 - Logged on in 3 separate days separated by a couple of days. Spent this time moving from step 1 & 2
8	104	>10yrs	13.43	0.16	0.07	9.03	3.55	1 – Moved sequentially through each step of the programme
9	105	>10yrs	11.35	-	-	-	-	1 - All of the time was spent on Step 1
10	106	>10yrs	0.61	-	-	-	-	1 -
11	107	>10yrs	11.85	-				1 - Spent time in step 1
12	116	>10yrs	19.76	6.15	4.12	1.1		1 - Went Through to step 5 sequentially spending less time with each progressive step
<b>Mean</b>			<b>13.91</b>	<b>2.73</b>	<b>12.81</b>	<b>5.33</b>	<b>4.58</b>	

Data from the table shows that all 14 FNMs that did register and return to the web-programme spent an average of ----- minutes on Step One of the programme. Four however stopped at this stage and did not go further with the programme. A further 3 dropped off after visiting Step Two. The remaining 5 FNMs went up to Step Five thus completing the programme.

The pattern of usage of the programme was also examined. Family/Network members were encouraged at the beginning to progress sequentially through the programme starting at step one and working up. They were however not forced to do so and could in reality access the steps in any order that they desired. All participants seem to have progressed sequentially through the programme as arranged on the site. Most of the FNM did this in one day and afterwards never returned to it. For one of the participants that went to Step Two, evidence shows doing the first two steps in day one and then repeating this process when logging in 5 days later. A second participant seemed to constantly be returning to the different exercises in step one and two of the programme. Four out of 5 of the participants that completed the programme did so in one day and did not return to it. Two however completed the programme in one day but returned again after within the week to go over the programme again proceeding sequentially but being a slightly more selective with the pages viewed and spending less time in each of the viewed pages. The greatest frequency of

returning to the programme was 3 days by a FNM that stopped at step two. FNM used 3 days to cover aspects of Step One and Step Two, appearing to go over these steps at each login. The login was separated by an initial period of 4 days then followed by 1 week.

**Baseline scores on assessment measures:**

Table 7 below shows mean and standard deviation of the responses of all registrants whose relative's drug or alcohol problem was active within the last 6 months.

Table 7: Baseline scores on the outcome measures

Scale	Pilot Baseline Mean (SD)	Open access Mean(SD)
<b>Family Member Impact</b>		
■ Total Impact	31.33 (10.45)	32.47(8.14)
■ Worrying Behaviour	20.73 (8.35)	21.20(6.57)
■ Active Disturbance	10.6 (3.29)	11.27(2.92)
<b>Coping Questionnaire</b>		
■ Total coping score	49.4 (16.47)	44.40(17.67)
■ Engaged Coping	25.4 (10.7)	21.13(10.54)
■ Tolerant Coping	12.6667	10.33(5.73)
■ Withdrawal Coping	12.0000	13.47(5.18)
<b>Symptom Rating Test</b>		
■ Total Symptom	28.3333	27.33(8.74)
■ Psychological Symptoms	9.0000	9.40(3.
■ Physical Symptoms	19.3333	3117.93(6.26)

**Concluding remarks**

This early experience of providing help for family members does point to the fact that it is feasible to use this platform in reaching out to family members of alcohol and drug misusing relatives. The programme is however limited to those that have both access and time in which they may be able to login undisturbed in this programme. Of particular interest has been the recruitment of participants, making family members aware of this programme has been particularly challenging as we saw that in the pilot, using GP practices and Some specialist drug and alcohol agencies does not lead the upsurge in usage that is expected when it is advertised in these venues. However when we did use these professionals working in these organizations in pass the brochures to family members it did increase traffic to the site (from an average of 30 to 250)

Usage of the site itself reflects surfing behavior on the internet, where people visit the site browse around for a little while and then exit the site without spending much time visiting all the pages. It would appear that they seem to just visit the site browse through to see if it is “sticky” and then exit the site. A few that took more than one day in going through the programme spent far less time on their subsequent visits.

This programme would however be limited in its being used by computer literate individuals. Though some family members have praised it for its clarity and simplicity or ease of understanding others have found navigation and computer literacy a must in deriving the full benefits of the programme and were not able to access the site without the support of some other person.

Follow-up is a problem that needs to be fully addressed as most people preferred to do it offline when they were given the option to do so. In a fully automated web-based programme monitoring and doing follow-up would need to be properly looked at

Despite its potential as a resource for family members in the western more industrialized societies there will still be a question as to its applicability and use within the Nigeria or other African countries. There will be challenges that one would have to overcome and research evidence needed to be gathered that would help in gaining a better understanding of the factors that may be at play. We would at one instance need to know the degree to which the culture of self-help is utilized by individuals seeking solutions to health and related issues. Where self-help is not a choice used by individuals in these societies it would be one of the factors or challenges to find a way around.

Additionally there is the issue of low level of computer literacy and accessibility of internet facilities for family members. This accessibility is both in terms of the cost implications for family members where searching the internet is quite expensive and geographical access to these internet cafes that work could pose a challenge as some services at the many of the existing internet café can be intermittent. A way forward will be to have organizations such as CRISA run trial sites where standalone computers are dedicated to family members along with the existence of support in login to the programmes. This is currently being discussed. It would be that programmes of this nature will lead to further dissemination of this resource for family and other network members.

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