Abstract

The impact of substance use disorders on families is well documented in the literature, with families experiencing physical, emotional and psychological stress. Also documented is the perceived stigma experienced by those living alongside family members with substance use disorders. This paper focuses on the help seeking behaviour of those affected by substance use within their families, exploring the ways in which informal, semi-formal and formal supports are drawn on. The prohibitive factors and barriers influencing decision making by families in need is also discussed. Through a qualitative research approach this study collates the perspectives of a cohort of family members in Ireland, with a view to informing and enhancing the design and delivery of support services. While participants positively endorsed most forms of formal support, services were sought and accessed in an ad-hoc fashion, with a range of psychological, geographical and emotional barriers presenting. The availability of services and the stigma associated with having family members affected by substance use disorders are also highlighted. The paper provides opportunities and recommendations for potential ways of overcoming such barriers in order to access Family Support at an earlier stage.

Keywords
Substance use disorder, Family Members, Support,

'Bury don't discuss': the help-seeking behaviour of family members affected by substance use disorders

Introduction

The high numbers of people misusing drugs and/or alcohol represent a significant problem for families and society as a whole (WHO, 2014). Substance use disorders[1] can impact on physical and mental health and relationships, and contribute to a range of difficulties in terms of accidents, violence, unemployment, physical and mental illness, marital discord and family breakdown. There is also considerable evidence that substance use disorders can have a serious impact on users' family members and close friends (Copello et al., 2010a). Research highlights the numerous ways families can be affected by substance use disorders. Families endure a range of challenges, including threatening and aggressive behaviour, including verbal and sometimes physical abuse. Family members reported being manipulated, lied to, coerced and blamed for issues associated with substance use disorder. Families can also experience safety issues in the home, including unwanted visitors (Orford et al., 2010b). Learning to cope with and manage their lives under the stress of a family member's misuse of alcohol/drugs can be a prolonged, difficult and enduring process for families (Duggan, 2007; Copello et al., 2010a).

The coping and help-seeking behaviours of families impacted by substance use disorders vary and form part of a journey that can last many years (Duggan, 2007). Families are known to seek help solely for the substance user, at the expense of their own wellbeing (Salter and Clark, 2004; Barnard, 2007). They may experience a range of stages in coming to terms with and coping with substance use disorders, ranging from unknowing, coping alone and experiencing heightened negative emotions to seeking support, reclaiming the family and achieving positive outcomes (Duggan, 2007; Salter and Clark, 2004). Families may adopt a range of coping strategies. Al-anon and Nar-anon research suggests that family members concerned about a loved one's substance use disorder may try to control the loved one's substance use and behaviour in order to cope. Thus,

[1] The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), refers to substance use disorders. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. This term is used throughout this paper.

the concerned family member often becomes co-dependent on the substance user and relates in such a way that reinforces a pathological need for each other (Timko et al., 2012). Orford et al. (2010a) have identified the three main coping strategies as engaged, tolerant-inactive and withdrawal coping. The family member is said to engage when he or she is actively trying to change the relative‘s behaviour either through being supportive, assertive, controlling, or emotional. Occasionally, family members adopt tolerant-inactive coping strategies which involve more accepting and sacrificing responses and putting up with the behaviour. Withdrawal coping involves the family member to withdraw from the issues involved with substance use and place their own needs first. Orford et al. (2010a) claim less involvement in the engaged and tolerant-inactive coping, with an associated increase in withdrawal coping can lead to better outcomes for families. Broadly, the research indicates that families who seek support and learn new ways of coping move from a place of powerlessness to empowerment over a period of time.

Despite the prevalence of substance use disorders, it is regarded as a highly stigmatised behaviour and is viewed as both a controllable behaviour and a character weakness. Research suggests that alcohol disorders are among the most stigmatised of the psychiatric disorders (Keyes et al., 2010). Drug use is also considered to be one of the most stigmatised behaviours that not only affects substance users but their families also (Corrigan et al., 2006; Room, 2005). Users are often perceived as weak, selfish, dangerous, self-indulgent and lacking in self-control. Hence they are viewed as blameworthy and less deserving of support (Semple et al., 2005; Tindal et al., 2010; Keyes et al., 2010; Room, 2005). External perceptions of the stigma surrounding substance use disorders and mental health issues often become internalised by family members who then self-stigmatise and a cycle of fear, avoidance behaviours and concealment ensues (Adfam, 2012). This tightening circle of concealment may lead to social exclusions which often results in deterioration of physical and mental health among family members (Room, 2005). Stigma is viewed as a major obstacle to support-seeking and behaviour change (Keyes et al., 2010). Despite this, there is a paucity of research on stigma and consequently little is known about the impact stigma has on the families of substance users (Room, 2005). Family members may experience considerable long term stress. Stressors including confusion, contradictory emotions and negative feelings produce various negative physical and psychological outcomes (Salter and Clark, 2004). Orford et al. (2010a) describe how the person affected by substance use disorders becomes unable to play a full

part in their social group. This diversion of commitment is identified as posing a threat to the happiness, productivity and even existence of this group, the most important of which is often the family. The impact of substance use disorder is especially difficult for families to deal with. By undermining their confidence, it puts family members' own health at risk. Despite this, families are known to seek help solely for the substance user (Salter and Clark, 2004; Barnard, 2007). Families may even neglect their own health and wellbeing, becoming primarily concerned with the safety, health and the financial affairs of the user (Orford et al., 2013).

The help-seeking behaviours of families impacted by substance use disorder vary and form part of a journey that can last many years (Duggan, 2007). Families may experience a range of stages in coming to terms with and coping with substance use disorder, ranging from unknowing, coping alone, and desperately seeking support to reclaiming the family and achieving positive outcomes (Duggan, 2007; Salter and Clark, 2004). While research tends to focus on the ways in which families seek support for the user, there is some evidence on the supports accessed by families. Duggan (2007) identifies categories of sources of support for families. Firstly, families may benefit from informal social support provided by personal networks. Good quality social support is recognised as contributing to positive outcomes for families affected by substance misuse (Copello et al., 2010). The essential role of social support for families affected by substance use disorder is recognised as a fundamental coping strategy and underpins support both informally and formally. Duggan (2007) identifies that families may also benefit from professional support not specifically focused on drug issues, including support from professionals in other sectors such as personnel in a medical context or those in the criminal justice system. Finally, Duggan (2007) identifies that families may also access specialist supports, aimed exclusively at providing supports to the person affected by substance misuse and/or their family. Specialised supports may include family support work and family-based programmes, with both preventative and family-strengthening characteristics (Kumpfer et al., 2003).

While supports are provided by the community and voluntary sector, statutory sector and privately (Duggan, 2007), the level of service provision varies across Ireland. Families are not often aware of available supports. They may avoid help-seeking because of perceived stigma or a focus on the family member impacted by substance misuse. In addition, their support needs are complex and

diverse, requiring a family focus that provides multimodal strategies to both individuals and families (Nic Gabhainn and Walsh, 2000). Notwithstanding the benefits that social support brings, the challenge remains in the ability to identify and deliver appropriate supports to families affected by substance misuse (Orford et al., 2010b; Watters and Byrne, 2004). This study explores the factors and barriers influencing how families in the study cohort sought support to cope with substance use disorder within their families and whether they found this support beneficial.

Methods and Results

This paper draws on a study exploring the experiences of family members in Ireland who accessed drug and alcohol family support services. Among the objectives of the study, the following will be discussed in this paper:

- Coping mechanisms and existing supports utilised by families;
- family members' experiences of accessing formal support;
- perceptions of the types, sources and qualities of support; and
- contributing factors and barriers to accessing support.

A qualitative approach was deemed most appropriate for this study, as it aims to provide an in-depth and interpreted understanding of the social world, by learning about people's experiences, perspectives and histories (Ormston et al., 2014). Semi-structured interviews were conducted to access and record the experiences, opinions and recommendations of family members. Although qualitative research often focuses on small samples, the value lies in the depth of the data collected and analysed as the research is focused in a real world context based on rich, descriptive and meaningful experiences (Bryman, 2008).

Eligibility to participate in the research was based on participants having at least one family member with a history of substance use disorder for a minimum of five years and participants who had sought support from at least one drug/alcohol formal service/programme. A purposive sampling method was used. Participants were recruited through the Drug and Alcohol Task Force and the statutory Drug Services. These bodies provide the main route to formal support services in the geographical area covered by this research. In total, 14 family members were invited to

participate in the research, with 11 family members agreeing to be interviewed. One participant withdrew from the research post-interview. At the time of interview 5 participants had a family member with active substance use disorder, 3 had a family member in recovery and 2 participants' family member had died as a result of substance use disorder.

The cohort comprised of nine female participants and one male participant. Relationships to the person with substance use issues varied; seven participants were parents, one was a partner, one was a sibling and one was an adult child. In cases of the parents, six of the seven had more than one child experiencing substance misuse issues. The types of substance use the participants were exposed to are as follows: 4 – alcohol, 1 – cannabis and 5 – polydrug use. The participants were recruited from both rural and urban settings.

The data was analysed using manual thematic analysis. All interviews were audio-recorded and transcribed. Manual thematic analysis was performed through the process of coding to create established, meaningful patterns which included familiarisation with the data.

Findings and Discussion

Accessing Support: Informal, Semi-Formal and Formal

Regardless of the nature of substance use disorder or the familial relationship to the substance user, substance use disorder causes considerable distress and destruction to families. Families in this study experienced multiple negatives consequences on the part of their family member with substance use disorder. These included overdose, attempted suicide, bereavement, imprisonment and drug-related intimidation and violence. The experiences contributed to considerable strain for families, with participants describing feelings of stress, guilt, stigma, worry, shame, fear, embarrassment and feeling a sense of failure. Participants in this study sought support in a variety of ways. Many indicated that they were unaware of the types of support services available to them. In some cases, family members had not considered that they might need or deserve support in their own right.

Participants experienced different pathways to support services. Despite some knowledge of supports available to the misuser, there was a general lack of awareness of the need for and the range of support services available to family members themselves. Participants found their way to support services in a variety of ways. Five participants in this study sought support that was recommended by either family members or work colleagues. Two participants accessed support through information/education sessions that were run in local schools. Another participant specified that she was referred by social services to an addiction counsellor. In two cases, family members recommended Al-anon and through this support seeking behavior, these participants came in contact with other support services and substance use disorder counselling.

Despite evidence that access to informal supports can significantly help individuals cope with stressful situations (Gardner, 2006) participants in this study did not avail themselves of consistent informal support. In her research on parents' support needs Gardner (2006) highlighted that the greater the informal support network, the lower the degree of difficulty perceived by parents regarding their vulnerability, stress and ill-health. Conversely, the weaker their informal network, the greater their degree of difficulty. Reiterating this point, Sheppard's study on social support and parental coping showed a significant relationship between the adequacy of forms of support and positive outcomes. Those who consider their informal support network to be inadequate are liable to be particularly vulnerable and their capacity to resolve their problems consequentially diminished (2009, p.1443). Many participants in this study felt that such support was not available to them, or that it could not be accessed. The consensus from participants indicates that issues associated with substance use disorder remain a taboo topic, with fear of judgement, shame, stigma and embarrassment presenting as significant barriers to help-seeking behaviours. All participants stated that they were reluctant to seek support from other family members because they felt there was a lack of acknowledgment and understanding of the difficulties involved in coping with the user's addiction. Where informal support networks did exist, these were often created through contact with formal supports in the absence of family, friends and neighbours. Semi-formal supports were more common, with participants describing seeking help from a variety of professionals with whom they had contact. These included General Medical Practitioners (GPs), Gardaí[2], teachers and work colleagues. Participants provided mixed responses to the quality of

[2] Irish police force

these support. Participants felt that semi-formal supports lacked an understanding of the complexities of their situations and were sometimes non-empathetic.

Formal support in the context of this research involves substance use disorder services and substance use disorder related supports that the participants availed of. Eventually, all participants came into contact with either a drug education programme, family support group, a residential treatment centre or an addiction counsellor. In all cases, families had previously sought informal or semi-formal support. The evidence in this research purports that families endured substance use disorder for a number of years - up to 15 years in one case - before they became aware that support was available for themselves. The delay in accessing support was further compounded by a lack of awareness of the formal supports available and a lack of clarity around which support best suited their requirements. Initial contact with formal services was often a result of seeking support for the substance user and not for themselves or other family members. Consequently, many participants reported that it was through seeking a solution to the substance use disorder that they inadvertently received more support than they believed was available.

The table below summarises the different supports accessed. It must be noted however, that not all services were available or accessible to each participant. Other supports were only available on an ad-hoc basis. The one service that was consistently available (but not necessarily accessed) was substance use disorder counselling. This may, in part, be due to its accessibility in the geographical region or may reflect how the sample for this study was identified.

PLEASE INSERT TABLE 1 HERE

The majority of participants attended more than one support. The research findings indicate that the experience of formal support services was largely positive. The type of support most commonly accessed was addiction counselling. Others accessed various supports such as mindfulness, the church, yoga and non-specified courses. While all of the participants found formal support helpful, several participants attended more than one support for a variety of reasons and circumstances. Some reasons outlined were: seeking support for substance user, logistics, preferring one-to-one

support and others preferred group support. In some cases, family members attended more than one service for additional support. Examples include Al-anon and addiction counselling. It is also worth noting that some supports were time-limited while others operate on an ongoing basis.

Participants described how counselling and family support built their self-esteem and confidence. Many recalled receiving practical advice such as boundary setting in their homes. Emotional support was readily available within group sessions and through their newly formed networks of peers. Further to that, the majority of participants reported having better coping skills and a sense of wellbeing. Interestingly these coping mechanisms extended to other areas of their lives such as coping with loss and bereavement. Through engagement with formal services such as counselling, family support groups, education and information sessions, and family days at treatment centres, family members decreased levels of social isolation and became more informed regarding the impacts of living with substance use disorder for the whole family. The overall findings revealed that formal support services provided a "*comprehensive and rounded service*" (P8) and participants found them "*surprisingly effective*" (P3).

Barriers to Seeking Support

While participants were largely positive about their experiences of accessing formal supports, a number of prohibitive factors and barriers were presented. These ranged from: a sense of stigma and shame in accessing services; a lack of knowledge and awareness of the availability of services; a lack of clarity around which service best suited their needs; and logistical challenges in accessing the appropriate supports.

All participants found it difficult to identify when they sought help and the duration of that support. In most cases, help was sought for the substance user first. Participants were unaware that they needed or deserved support for themselves. Only when a crisis emerged or when their situations became chaotic and unmanageable did they seek help or were recommended help for themselves.

P1 recalled that while his son experienced problematic drinking from the age of twenty-four (now thirty-eight), it was only in the most recent three years that he and his wife (P2) had sought support after "*a few crisis situations*". Similarly, P10 whose son had engaged in over a decade of substance

use disorder from his early teenage years had sought support "*after trying everything possible and turning myself inside out and upside down and I suppose accepting I cannot do this myself*". Several participants, upon seeking support for the user inadvertently found support for themselves:

> "*I thought I would get help with him, for him. But it turned out it was for me and that was the start. That was like the door opening a little bit*" (P8).

Throughout the findings participants highlighted the lack of accurate information, appropriate referrals, insight into substance use disorder and lack of interagency cooperation as significant barriers to gaining support. Many found this particularly difficult when dealing with professionals such as GPs (General Medical Practitioner), psychiatrists, guards, teachers and psychologists. Four participants emphasised the lack of knowledge by medical and mental health professionals around prescribing medication, given their family members substance misuse history. One participant believed that too many services were involved and yet felt her needs were not met. The lack of tangible supports was also highlighted: for example, childcare and transport. In other cases, the poor visibility of available services was highlighted. Many outlined that doctors clinics, community centres, health centres and "local" notice boards should list support services available.

> *"I've yet to see any place that says "Family Support"…maybe I didn't see them but they're certainly not apparent!"* (P1)

While there is a dearth of research on the issue of service availability and accessibility (Stenton et al., 2014), many of the participants in this study reported little choice around which supports they accessed. Certain supports were not available locally. In some cases, participants described travelling long distances in order to access their preferred type of support. Other supports were only offered, for example, education supports, on an annual basis. P2 explained that she had to travel to her nearest large city for support and could only attend Al-anon every second week. When asked if Al-anon was available locally, she responded "*I don't know, I don't think so, actually I know I wouldn't go*".

> "*they don't want to go locally, you know, they want to go outside of where they* [live] *and then, of course, then there's problems getting there*" (P8).

In addition, childcare issues while attending support was raised by some participants.

> "*you can't just go to your meeting and leave the kids at home with someone going ballistic because they're off their face, you know, you have to stay. So at a time when you're in crisis and need the most support, you can't actually get it*" (P8).

This lack of choice has implications for service providers and family members. Indeed, Duggan (2007) contends that while there are a number of treatment centres around Ireland, they "operate as stand-alone agencies, each operating within its own philosophy, providing specific services and with largely self-determined eligibility criteria" (p. 61). Availability of a range of supports is crucial as family members have different needs and preferences.

Another significant barrier to engagement with services for the majority of participants presented itself in the form of reluctance: reluctance to attend and reluctance to speak. Participants cited different reasons for this. P4, for example, maintained that she did not have the language within herself to know what to say, others reported not having courage to speak or felt too upset to share and were afraid they would be reduced to tears. Others commented that they were nervous and afraid as they didn't know what to expect especially entering a group for the first time.

> *"It was hard going in the door because I didn't know what I was going to meet. I didn't know who I was going to meet"* (P5)

Participants raised their concerns also regarding anonymity and confidentiality. In many cases, their concern was for the substance user rather than for themselves. The overriding necessity for privacy, loyalty and dignity for their family and the substance user presented as a significant barrier to seeking support.

Perceived Stigma

The perceived stigma around substance use disorder emerged as a significant obstacle to family members accessing support. These findings are reflective of the literature regarding family members experiencing stigma as a barrier to support-seeking. Research suggests that people stigmatise not only the person with a history of substance use disorder but also, by association, their family members. Research conducted by Adfam (2012) suggests that stigma inhibits families from seeking support and leads to increased social isolation and concealment. All participants strongly emphasised their shame, guilt and embarrassment stating that especially at the initial stage of support-seeking, stigma prohibited them from accessing both formal and informal support. "*We bury rather than discuss*", reported one participant. Another expressed her fear of the neighbours being aware of her situation. Others expressed embarrassment that substance use disorder permeated every aspect of their lives, for example, one sibling emigrated and no longer carried the tag of being associated with a "*druggie*" (P2). Others found it stressful that the user "*brought their behaviour into the street*" (P7), therefore making it impossible to keep up the façade of normality within the family. One participant stated that:

> *"I think people are more likely to tell you there's somebody in the family who took their own life by suicide than they will be to say my father is alcoholic"* (P9)

Interestingly, participants described their experience of stigma and shame differently within the context of rural versus urban settings, yet the research concludes that all participants experienced stressful levels of these negative emotions:

> *"there is a huge element called shame…especially rural, especially country people, everything has to be seen to be normal, what the neighbours think is actually much more important than what is actually happening you know…we bury rather than discuss"* (P6)

> *"They're afraid Mary-Jo down the street knows what's going on and might know my business but yet they know…everyone knows about it…It's a shame;*

shame and privacy. What goes on inside these four walls stays in these four walls, do you know?" (P7)

A number of participants spoke of substance use disorder being a "*taboo*" topic in Irish society. They referred to their feelings of shame and embarrassment and guilt with a sense that they should have been able to resolve the situation or that they had done something wrong. The findings from this research highlight the frustration experienced by family members seeking support. The participants reported feeling "*lost at sea*" and wanting to be able to "*latch onto*" an appropriate point of contact. Information, signposting and emotional support were identified as crucial to their support needs.

Participants spoke about breaking the cycle of stigma around substance use disorder. One commented that "*if I had known then what I know now…I'd go in* [to formal support services] *I'd have no problem talking*" (P1). She attributed this change in her thinking to "*awareness through education*". The implications of this finding clearly places an onus on service providers, policy makers and other professionals to de-stigmatise substance use disorder.

Overcoming barriers in accessing support services; Opportunities and Recommendations

Despite the variety of barriers presented, participants also reflected on opportunities for learning and what could be done differently to provide more accessible responsive services for the families of those with a substance use disorder. These strategies can be broadly categorised under three areas: education, promotion, and integrated care pathways.

Education

All participants offered recommendations around education involving schools, the community and professionals such as GPs. The research found that most participants felt that schools could do more to provide education and supports to young people. P8 stated: "*I think it's very important to educate kids, on the facts that there are supports out there, I mean they are one's that are most vulnerable*". Others suggested that drug and alcohol awareness programmes be offered in primary and post-primary schools. This could create awareness and understanding of substance use

disorder and its consequences for the wider family and community and provide information of support services available to all family members. P2 reflected on her experience of drug education;

> *"I found all those lectures back there very, very supportive and very informative, very educational and I wish that my other children and all that I knew were in there".*

Other participants suggested that young people should have access to formal support in schools such as counselling where children can feel safe to talk about the impact of substance use disorder without having a parent present.

Community spaces such as libraries, parish halls and community centres were suggested as "safe" and neutral spaces for the delivery of public talks and lectures on drug and alcohol issues. Several participants highlighted the need for public talks and consultation sessions which would inform people on substance misuse and support availability. Other participants recommended the need for more community guards and the need to build relationships between guards and the public. P10 believed "*if guards had a rapport with everyone in the community…there wouldn't be that fear…it might support parents*" (P10)

The importance of professionals having a greater insight into substance use disorder issues was mentioned by several participants. Some indicated quite strongly that further training was required by medical practitioners in the context of substance use disorder.

> "*You shouldn't have to ask your GP…can I have a name of a place or…or do you know anything about drugs?*" (P6)

> "*The GPs should learn. They should do some kind of course about drugs because they're giving out tablets*" (P5)

One participant also recommended education for psychiatrists as her son was prescribed medication which had an adverse effect on his behaviour, given his substance use disorder.

Promotion

Overwhelmingly, all participants identified promotion of services as critical for the development and enhancement of drug and alcohol family support services. Many suggestions included poster campaigns, helplines and awareness programmes. The majority of participants were critical of the lack of reporting within the media and suggested that both local and national media had a serious role to play in highlighting the plight of substance use disorder on families which in turn could reduce stigma and shame.

> "*you don't see anything, like in a doctor's clinic…on the news, I mean the media don't deal with it*" (P1)

Local radio was also highlighted as an important route to promoting family support as it is viewed as private yet "*you get into people's bedrooms*" (P4). This view was echoed by most participants. Some of the younger participants highlighted the importance of the internet and social media and suggested greater use of Facebook, Skype, and online chat rooms. P8 emphasised the importance of utilising a medium that appealed to younger audiences also and suggested that "*things need to be very plain, simple...Is there addiction in your household. Ring this number for support*"

Many national support services have promoted their organisations through high visibility campaigns: mental health awareness, Childline[3], crisis pregnancy supports to mention just a few. It appears from the findings in this research that visibility around substance misuse is somewhat lacking in the public arena. Lack of visibility was found in this research to be a barrier to accessing support for family members. Another opportunity to improve visibility lies in one participant's observation that "*you never see the name "Family Support" anywhere*".

Coordination of services could be strengthened at the local level to enable access to appropriate supports for families and reduce stigma. Policy makers and organisations with a national remit can play central roles in identification and enhancement of service provision, development of national awareness campaigns, workforce training, education programmes, online supports and ensuring

[3] Childline is a telephone based call facility delivered by the IPSCC for children in need of support in Ireland, available at: https://www.childline.ie/

the needs of families are reflected in the new national drugs strategy. Further investment and resources are required to expand drug and alcohol family support services; at a minimum this must include increased budget allocation, wider availability of family support services, increased workforce capacity with expertise in working with family members.

Integrated Care Planning

Perhaps there is an onus on service providers to ensure that when an individual approaches a service for support they are immediately advised on all possible sources of help and the process of care planning is initiated. Doyle and Ivanovic (2010) assert that "*If services are not co-ordinated, service users can have difficulty negotiating the complex service network, 'fall between the cracks,' fail to receive the help they need, and/or be subjected to unnecessary delays, frustration, trauma, and intrusion into their lives* (p. 5). The National Drug Rehabilitation Implementation Committee (NDRIC) has developed a rehabilitation framework and a series of protocols to develop greater co-ordination between services and integrated ways of working to enhance drug and alcohol family support services. This model was developed in 2010 and has since been piloted in different parts of the country. This framework has not yet been rolled out in the area where the research took place. Successful implementation of this framework could support family members in the following ways: increase recognition for the needs of family members affected by substance use disorder; create greater awareness of available supports for both family members and other service providers; enhance co-ordination between services and develop integrated care pathways to increase family support service and accessibility; and finally, highlight and identify gaps in service provision for families with a view to improving same.

Conclusion

The help-seeking experiences of family members when accessing support in relation to substance use disorder have been thoroughly examined with the prohibitive factors and barriers explored. Recommendations offered by participants have been assessed with respect to existing service provision and this has signalled possibilities for the enhancement of service design and delivery for those family members impacted by substance use disorder. Key findings discussed were (i) pathways to referral and the lack of coordination between services, (ii) the need to reduce, at a

national level, the curse of stigma; (iii) the relevance and adequacy or otherwise of informal, semi-formal and formal supports; (iv) the comprehensive list of positive experiences and outcomes reported by participants upon engagement with formal support services; (v) the unfortunate ad-hoc nature of support access and finally (vi) the desire to reciprocate and champion the cause of family support by participants. Of note also is that many participants received help for themselves while seeking help for their family member. The overarching finding in this study implies a responsibility on service providers, local and national representatives, educators and other professionals to protect and promote the well-being of families that are adversely affected by substance use disorder.

This research is not without its limitations. The sample size is small though the depth of insight provided by each participant is significant. There is a gender imbalance within the participating cohort. This may be due to the fact that fewer males than females access support services within the geographical region researched. The findings may vary for males who have experienced substance use disorder in a family member. Further research is warranted to broaden understanding of Irish males and the concept of help-seeking, and furthermore, their experiences of support seeking. Another area of interest outside the scope of this research is the possible link between the type of substance being used and the level of shame and stigma experienced.

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