Family Support and Substance Use Outcomes for Persons With Mental Illness and Substance Use Disorders

by Robin E. Clark

Abstract

This paper explores the relationship between direct support from family members and friends and substance use outcomes for people with co-occurring severe mental illness and substance use disorders. Data are from a 3-year randomized trial of 203 patients in treatment for dual disorders. Informal (family) caregivers for 174 participants were asked about economic assistance and direct care that they provided to participants. Associations between family support and substance use outcomes were examined with bivariate comparisons of abstainers and nonabstainers and with regression models using change in substance use and cumulative substance use as dependent measures. Family economic support was associated with substance abuse recovery in bivariate and regression analyses. Caregiving hours were significantly associated with substance use reduction but not with cumulative substance use. Informal support was not associated with changes in psychiatric symptoms. The findings suggest that direct family support may help people with dual disorders to reduce or eliminate their substance use. Further research is needed to confirm this connection and to establish the mechanisms by which support is useful.

Keywords: Family, mental illness, substance abuse, informal care, mental health services, costs, cost analysis.


Family caregivers for people with severe mental illnesses (SMIs) such as schizophrenia are an increasingly important focus of treatment and research. Several studies demonstrate how family interventions can improve the course of illness (e.g., Hogarty et al. 1986; McFarlane et al. 1994). Others explore the general stress (Tessler and Gamache 1994; Solomon and Draine 1995) and the financial burden (Hoening and Hamilton 1966; Stevens 1972) that family caregivers feel. Surprisingly, few researchers have examined the role that instrumental support, such as financial contributions or direct caregiving by families, plays in the well-being of people with mental disorders.

Economic assistance from families could make an important difference in the lives of people with SMI, who are often poor and unemployed (Rice and Miller 1996). A significant percentage of those enrolled in income support programs, such as Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), have mental disorders (Kochar and Scott 1995). Though vital, these publicly funded programs offer meager financial support, allowing some beneficiaries to remain below federal poverty guidelines. Unemployment and inadequate income support often leave people with SMI few resources to meet basic living expenses. Fortunately, many get financial assistance from their families or friends.

Direct assistance with the tasks of daily living is another valuable resource. Many people with SMI receive health care through Medicaid, Medicare, or both, but even the best formal service providers rarely duplicate the concrete, practical, and consistent help that families and friends can provide. Although the significance of families as caregivers for people with SMI is well documented (Franks 1990; Carpentier et al. 1992; Clark and Drake 1994), we know little about how informal care affects mental health and substance abuse. This knowledge gap is particularly apparent for people with co-occurring SMI and substance use disorders.

Send reprint requests to Dr. R. Clark, Dartmouth Medical School, Dept. of Community and Family Medicine, Strasenburgh 7250, Hanover, NH 03755–3862; e-mail: robin.clark@dartmouth.edu.
Co-occurring Substance Use Disorders

Substance abuse is a common problem among people with SMI. Lifetime prevalence of substance use disorders for those with schizophrenia is approximately 50 percent (Regier et al. 1990). Alcohol and other drugs are associated with a wide range of negative outcomes, including increased hospitalization (Kivlahan et al. 1991), higher treatment costs (Dickey and Azemi 1996), poor treatment compliance (Owen et al. 1996), higher rates of arrest and violence (Stedman et al. 1998; Clark et al. 1999), victimization (Mueser et al. 1998), homelessness (Caton et al. 1994, 1995), and increased risk of HIV infection (Cournos et al. 1991). Reducing or eliminating substance use could significantly improve the lives of many people with SMI.

Several approaches to treatment of comorbid mental and substance use disorders have been proposed and evaluated (Blankertz and Cnann 1994; Jerrell et al. 1994; Drake et al. 1998a; Drake et al. 1998b) but almost no attention has been given to the role that nontreatment supports play in recovery. This omission is especially troubling because people with co-occurring disorders tend to be marginally engaged in treatment. Families can easily become the primary source of continuous care. When treatment fails, they may be the providers of last resort.

Still, the consequences of family support are not clear. At least one study suggests that people with comorbid substance use disorders are significantly less satisfied with their family relationships than are those with SMI alone (Dixon et al. 1995). Dissatisfaction could mean that family contact is undesirable or even detrimental. Stressful family relationships are associated with high relapse rates (Kashner et al. 1991; Kavanagh 1992). Relying on family support might exacerbate problems by increasing conflict, by supplying additional money to purchase drugs or alcohol, or by insulating people with dual disorders from the negative consequences of their substance use. On the other hand, informal economic assistance and caregiving could be a vital resource for meeting basic food, shelter, and safety needs.

Several factors have impeded our understanding of informal support: the difficulty of measuring family contributions, the impracticality of developing randomized studies of informal assistance, and a failure of researchers and funding sources to recognize its potential importance. Inattention to family support leaves a large gap in our knowledge about factors that may contribute to or detract from the quality of life for people with co-occurring disorders.

In this article, we use data collected in a randomized trial of formal treatments for persons with co-occurring disorders to explore the relationship between family support—economic assistance and direct care—and substance use outcomes.

Methods

Sample. Data used in this study are from a 3-year randomized trial of treatment for co-occurring SMI and substance use disorders. The study was conducted at seven community mental health centers in New Hampshire between 1989 and 1995. Participants were randomly assigned either to standard case management with enhanced substance use treatment services or to assertive community treatment with integrated mental health and substance abuse treatment. Mental health center clients were eligible for the study if they met the following criteria: (1) DSM-III-R diagnosis of schizophrenia, schizoaffective, or bipolar disorder (American Psychiatric Association 1987); (2) an active DSM-III-R substance use disorder within the past six months; (3) 18 to 60 years of age; (4) absence of additional severe medical conditions or mental retardation; and (5) willingness to provide well-informed written consent to participate in the study. Of the original 223 persons who enrolled, 203 completed the study. Completers were not significantly different from those who did not remain in the study. For results of the trial and a detailed discussion of sample selection and attrition, see Drake et al. 1998a. The study did not find statistically significant differences between the two treatments in the number of persons who achieved abstinence or in the amount of change in substance use during the study.

Study participants were predominantly male (74%), nonminority white (96%), unemployed (82%), never married (61%), and educated at least through high school (63%). Average age at study entry was 34 years (standard deviation [SD] = 8.5). Slightly more than half (53.6%) had schizophrenia, 22.7 percent had schizoaffective disorder, and 23.6 percent had bipolar disorder. All had a substance use disorder as defined by DSM-III-R criteria; 72.6 percent had an alcohol use disorder and 41.8 percent had a drug use disorder. Other than alcohol, the primary drugs of abuse at study entry were cannabis (38.9%) and cocaine (14.8%). Participants lived in a mix of small urban and rural areas. At study entry, 76 percent were receiving SSI or SSDI; 91 percent received these benefits by the end of the study.

Participants were asked to nominate for study participation the family member or friend who gave them the most assistance. Over the course of the study, trained research staff interviewed caregivers for 174 of the 203 participants at least once. The structured interview asked detailed questions about the type and amount of care and economic support provided. Caregivers were interviewed at 6-month intervals. One primary caregiver per participant reported amounts of time and money spent on behalf of the study participant by all family members. Because of a limited study budget and because most patients identified only one caregiver, comparisons of reports across...
caregivers for the same patient were not conducted. In all but three cases (cases in which primary caregivers changed), the same caregiver was interviewed throughout the study. The number of family interviews completed in each time period was as follows: 66 at study entry, 111 at 6 months, 141 at 12 months, 151 at 18 months, 142 at 24 months, 140 at 30 months, and 134 at 36 months. Missing data in early periods were due primarily to limited interviewer time rather than to client refusal. Families completed an average of 5.37 interviews, and 45 caregivers completed all seven interviews.

Due to the large amount of missing caregiver data for the study entry period, our analysis focused on the six periods after enrollment. Comparison of families who completed all interviews with those who completed fewer interviews showed no significant differences in average family expenditures or in average number of caregiving hours per month. Client-reported family contact was no different in periods of missing and nonmissing family reports. However, those with at least one, but fewer than four, interviews received lower amounts of direct care (Wilcoxon Rank Sum, \( z = 7.9, p < 0.01 \)) and less economic support \( (z = 2.5, p = 0.02) \) from their families. Average family caregiving time and economic assistance, rather than total time and assistance, were used in subsequent analyses to address the potential bias associated with this difference.

The majority of caregivers (67%) were parents; 17 percent were siblings. Another 11.5 percent were grandparents, spouses, children, or other relatives; 4.5 percent were not related to the study participants. Caregivers ranged in age from 25 to 88 years \( (M = 56, SD = 12) \); 82 percent were women. In 18 percent of the cases, caregivers and study participants lived together. This percentage is similar to those reported for community-based studies in which family participation was not a criterion for selection \( (17-21\%: \text{Creer et al. 1982; Tessler and Gamache 1994}) \) but much lower than some hospital-based studies \( (40-65\%: \text{Goldman 1982; Mueser et al. 2000}) \) and others where membership in a family support group was required for study admission \( (30-45\%: \text{Franks 1990, Mannion et al. 1996}) \).

### Family Expenditures and Caregiving Hours

Caregivers reported time they spent on behalf of the client in the previous 2 weeks on the following tasks: money management; transportation; speaking with mental health or law enforcement personnel; general care like cooking, cleaning, and assistance with grooming; illness-related care such as assisting with medication compliance or responding to crises; participating in structured leisure activities; shopping; speaking with the client by telephone; and all other care. Family expenditures on behalf of the client were classified in the following categories: food and clothing; client's rent and utilities if client did not live with the family; client's share of family household expenses if the client lived with family; mental health, medical, and dental care; transportation; leisure activities; fines and property damage; and other family expenses. In-kind gifts such as food or clothing were assigned a monetary value and treated as family expenditures. For purposes of this analysis, average monthly family expenditures and average monthly caregiving hours during the study period \( (\text{i.e., after enrollment}) \) were computed for all valid data points. Reports for 2-week periods were multiplied by 2.16 to estimate monthly expenditures. Average expenditures and caregiving time for the various categories are reported in tables 1 and 2.

#### Table 1. Hours of caregiver activities

<table>
<thead>
<tr>
<th>Type of activity</th>
<th>Caregiving hours, monthly mean(^1) (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Money management</td>
<td>1.00 (1.82)</td>
</tr>
<tr>
<td>Transportation</td>
<td>3.51 (4.96)</td>
</tr>
<tr>
<td>Talking with health service</td>
<td>0.90 (1.82)</td>
</tr>
<tr>
<td>Talking with law enforcement</td>
<td>0.23 (0.97)</td>
</tr>
<tr>
<td>General care</td>
<td>9.01 (18.52)</td>
</tr>
<tr>
<td>Illness care</td>
<td>6.71 (11.65)</td>
</tr>
<tr>
<td>Structured leisure activities</td>
<td>9.90 (13.80)</td>
</tr>
<tr>
<td>Shopping</td>
<td>1.47 (2.64)</td>
</tr>
<tr>
<td>Telephone conversations</td>
<td>2.90 (7.10)</td>
</tr>
<tr>
<td>Other</td>
<td>18.32 (23.83)</td>
</tr>
</tbody>
</table>

\( ^1 \text{For all postenrollment study periods.} \)

Note.—SD = standard deviation.

#### Table 2. Caregiver expenditures and client contributions

<table>
<thead>
<tr>
<th>Type of expenditure</th>
<th>Monthly mean(^1), 1995 US$ (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health care</td>
<td>2.13 (8.49)</td>
</tr>
<tr>
<td>Medical and dental care</td>
<td>12.42 (36.72)</td>
</tr>
<tr>
<td>Food and clothing</td>
<td>67.77 (86.98)</td>
</tr>
<tr>
<td>Rent, utilities, and telephone</td>
<td>27.07 (72.08)</td>
</tr>
<tr>
<td>Pocket money</td>
<td>32.34 (52.12)</td>
</tr>
<tr>
<td>Other</td>
<td>122.34 (260.75)</td>
</tr>
<tr>
<td>Transportation</td>
<td>39.28 (44.58)</td>
</tr>
<tr>
<td>Fines and property damage</td>
<td>6.33 (30.61)</td>
</tr>
<tr>
<td>Leisure activities</td>
<td>22.67 (36.83)</td>
</tr>
<tr>
<td>Family household expenses</td>
<td>32.58 (64.97)</td>
</tr>
<tr>
<td>Client's contribution to family</td>
<td>32.46 (101.52)</td>
</tr>
</tbody>
</table>

\( ^1 \text{For all postenrollment study periods.} \)

Note.—SD = standard deviation.
Substance Use Measures. Substance use outcomes were measured by combining information obtained from self-reports, case manager ratings of substance use, clinical records, and laboratory tests. Drug and alcohol use were rated separately on the following five-point scale: 1 = abstinence, 2 = use without impairment, 3 = abuse, 4 = dependence, and 5 = severe dependence (Mueser et al. 1995). Interrater reliability, measured with intraclass correlations, was 0.94 for the alcohol use scale and 0.94 for the drug use scale.

Each participant was also given a Substance Abuse Treatment Scale (SATS) rating (McHugo et al. 1996) for each measurement period. Trained research staff who were blind to the treatment condition assigned SATS ratings. Ratings are based on Osher and Koford’s (1989) model of treatment and recovery, in which 1 = early engagement, 2 = late engagement, 3 = early persuasion, 4 = late persuasion, 5 = early active treatment, 6 = late active treatment, 7 = early relapse prevention, and 8 = late relapse prevention. This rating combined alcohol and drug use outcomes in a single measure. Intraclass correlation for the SATS was 0.93.

Other Measures. Other explanatory variables used in the analyses included diagnosis as determined with the Structured Clinical Interview for the DSM-III-R (Spitzer et al. 1988); psychiatric symptoms as measured with the Expanded Brief Psychiatric Rating Scale (BPRS; Lukoff et al. 1986); gender; mental health outpatient costs as determined from provider records (Clark et al. 1998); average family income across all reporting periods, based on caregiver reports; participants’ self-reported monthly income averaged across all study periods; and the Family Relations Scale from Lehman’s Quality of Life Interview (QLI; Lehman 1988). This scale is based on participant interviews and combines the following four questions concerning the participant’s feelings about his or her family, each question beginning with “How do you feel about”: Your family in general? How often you have contact with your family? The way you and your family act toward each other? The way things are in general between you and your family? Finally, we examined client reports of cash income received from family members in each study period.

Variables related to clients’ demographic or psychiatric status were added to the analysis to account for factors other than family support that might affect substance use. Self-reported family income was included to differentiate the direct effects of family support from those that might be associated with family wealth. Adding outpatient treatment allowed us to examine the independent effects of formal treatment and family support on substance use.

Analysis Plan. For descriptive purposes, we used simple nonparametric statistics and t tests to compare characteristics of those who were abstinent at the end of the study with those who were not. To examine associations between the factors described above and recovery from substance use disorder, we constructed four regression equations. The first two models used ordinary least-squares (OLS) to predict change in treatment stage between study entry and the final measurement period. The second pair used OLS to predict the cumulative treatment score. Cumulative scores were computed by calculating the number of months a participant spent in each treatment stage, weighting months by the stage ranking, and summing these scores for the 3 years following study entry. In comparison to change scores, which emphasize the difference between beginning points and endpoints, cumulative scores give greater weight to participants who reduced substance use earlier in the study and sustained these reductions.

Because family expenses and hours of care were collinear, each of these variables was entered in a separate equation. Expenditures are included in models 1 and 3; caregiving hours are in models 2 and 4. The remaining explanatory variables were the same in all four models.

Results

Participants advanced an average of 2.17 (SD = 1.85) treatment stages during the study, from a mean of 2.79 (engagement) to one of 4.95 (late persuasion or early active treatment). After 3 years of treatment, 15.9 percent of study participants (36) had been abstinent for at least 6 months.

Those who achieved abstinence were no more likely than others to report receiving SSI or SSDI ($\chi^2 = 0.82, df = 1, ns$) or to have a legally designated representative payee who managed their money ($\chi^2 = 1.15, df = 1, ns$). There were no differences in the percentage of clients who reported receiving any cash contributions from a family member ($\chi^2 = 0.59, df = 1, ns$). Exploration of the types of services used did not reveal significant differences between those who were abstinent and those who were not. Participants who achieved abstinence did not receive more assertive community treatment or case management services than nonabstainers ($r = 0.64, df = 192, ns$), nor did their families ($r = 0.13, df = 192, ns$). Scores on the QLI family relations scale and on its individual components were remarkably similar, with no differences between the groups at any of the seven measurement periods or across all periods ($t = 0.40, df = 192, ns$). Psychiatric symptom (BPRS) scores for abstainers and
nonabstainers (44.2 [SD = 13.5] vs. 45.6 [SD = 13.38]) were not different at study entry (ns), but mean symptom scores were significantly different for the entire study period (38.9 [SD = 8.35] vs. 42.9 [SD = 9.35]; \( t = 2.37, df = 198, p = 0.02 \)).

Family caregivers for abstainers were not significantly different from those of nonabstainers in age, income, co-residence, or relationship to the study participant.

All patients received at least some minimal care from a relative during the study. Most (97.5%) also received economic assistance. The percentage receiving financial help from family members within a given 6-month period ranged from 81 percent to 85 percent.

Families of those who had achieved abstinence at the 3-year mark consistently reported giving more financial assistance than did families of nonabstainers (\( t = 2.34, df = 71.7, p = 0.02; \ z = 2.15, p = 0.03 \)). Mean expenses and mean caregiving hours for the study period were highly correlated (Spearman rank \( r = 0.74, p = 0.001 \)). Other comparisons are shown in Table 3.

Regression results in Table 4 show that, taking initial treatment stage into account, clients who were women, who used more outpatient services, who had higher personal income, or who received more assistance from caregivers showed greater change in stage of treatment ratings (models 1 and 2) than did others. Negative coefficients for baseline stage of treatment indicate that those in higher stages at study entry changed significantly less than those in lower stages. In this equation, higher average family expenses on behalf of the study participant were associated with reductions in substance use (\( p = 0.003 \)). More caregiving hours in model 2 were also significantly associated with substance use reduction (\( p = 0.03 \)).

Findings were similar in models 3 and 4, which examined the association between cumulative treatment scores and the same independent variables used in models 1 and 2. When baseline substance use, the amount (cost) of outpatient services used during the study, and participant income were taken into account, family expenditures (\( p = 0.02 \)) were significantly associated with better substance use outcomes. Direct family caregiving (\( p = 0.16 \)) was not associated with cumulative change in substance use.

Standardized coefficients (betas) for family expenditures and treatment costs were, respectively, 0.23 and 0.17 in model 1 and 0.18 and 0.20 in model 2. This suggests that the comparative strength of association with substance use recovery was quite similar for family economic support and for treatment.

To demonstrate the robustness of findings, models 1 through 4 were repeated using logged versions of the dependent variables. These analyses explained a slightly
Table 4. Substance use outcomes at 3 years for persons with severe mental illness (n = 151)

<table>
<thead>
<tr>
<th>Explanatory variables</th>
<th>Change in Treatment Stage</th>
<th>Cumulative Treatment Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1)</td>
<td>(2)</td>
</tr>
<tr>
<td>Diagnosis (0 = schizophrenia spectrum, 1 = bipolar)</td>
<td>0.641</td>
<td>0.715*</td>
</tr>
<tr>
<td>Gender (0 = male, 1 = female)</td>
<td>0.612*</td>
<td>0.455</td>
</tr>
<tr>
<td>Baseline treatment stage rating</td>
<td>-0.601**</td>
<td>-0.613**</td>
</tr>
<tr>
<td>Mental health outpatient costs (log)</td>
<td>0.349*</td>
<td>0.405*</td>
</tr>
<tr>
<td>Average monthly family expenditures (log)</td>
<td>0.318**</td>
<td>—</td>
</tr>
<tr>
<td>Average monthly family caregiving hours (log)</td>
<td>—</td>
<td>0.006*</td>
</tr>
<tr>
<td>Family income ($1,000s)</td>
<td>0.003</td>
<td>0.008</td>
</tr>
<tr>
<td>Participant income ($1,000s)</td>
<td>0.172*</td>
<td>0.162*</td>
</tr>
<tr>
<td>Adjusted R²</td>
<td>0.169</td>
<td>0.142</td>
</tr>
</tbody>
</table>

1 Original study n = 203; table n is lower due to missing data for family caregiving and/or psychiatric symptoms. Family expenses and family caregiving hours are entered separately to avoid collinearity. Regression coefficients are unstandardized.

* p < 0.05; ** p < 0.01

lower percentage of the total variance; otherwise, results were very similar to those in the unlogged versions.

The same set of explanatory variables employed in the regression models were used to predict BPRS scores. These models, which are not shown, were poor predictors of symptom change, accounting for a small amount of variance. They did not show significant associations between family support and psychiatric symptoms.

The largest expense categories were food and clothing in second place and in first, a general category that was composed of relatively large and infrequent expenditures, such as car repairs. Transportation was the third largest category, followed by family household expenses attributable to the client; pocket money; rent, utilities, and telephone; and leisure activities. Mental health care was the lowest category of expenditure.

The categories in which caregivers spent the most time were “Other contact” (which often included unstructured leisure activities) and structured leisure activities, followed closely by general caregiving (providing meals, cleaning, assisting with personal hygiene), caregiving related to illness (e.g., assisting with medications or with crises), transportation, and telephone conversations.

Relatively few clients (36.9%) reported receiving cash assistance from family members. The number reporting such assistance declined slightly, from 72 at study entry to 64 at the end of 3 years. Less than 10 percent of the financial assistance given by families was described as “pocket money,” defined as small cash gifts for general purposes.

Discussion

Assistance from family and other informal caregivers was associated with reduced substance use in people with dual disorders. Direct financial assistance was a stronger and more consistent predictor of change than was the average amount of informal care given. Greater amounts of family economic assistance and higher outpatient treatment costs during the study period were related to reduction in substance use and to lower cumulative substance use over 3 years.

Although family expenses and caregiving hours are highly correlated, the former were more consistently associated with reductions in substance use than the latter. Assistance in securing basic necessities, primarily through in-kind contributions, may have a greater impact on substance use than does nonpecuniary help from family and friends. The implication is that clients with dual disorders can address substance use problems more effectively when their basic economic needs are met.

An alternate interpretation of the abstinence findings might be that families are more willing to support a relative who is engaged in substance abuse treatment. However, the effects of family support remained strong when baseline stage of treatment ratings were taken into account in the analyses of change and cumulative substance abuse treatment scores. This suggests that family support is not simply a function of how well the client is doing in treatment.

The positive association between substance use reduction and economic assistance is particularly interesting in light of concerns among treatment providers that clients will use such contributions to purchase alcohol or other drugs. Abstainers were no more likely to have a representative payee than were nonabstainers, but families may have played an informal role as resource managers. Although the data do not allow a definitive analysis of family-reported cash versus in-kind contributions, the low frequency of cash assistance reported by clients and the...
relatively small amount of pocket money reported by families suggest that most family economic assistance took the form of in-kind contributions, which would be more difficult to convert to substances of abuse.

Formal treatment providers may have helped families manage clients' substance abuse more effectively. It is difficult to determine how much treatment providers influenced family caregivers. Treatment teams were trained to help clients and families manage money, and some families attended psychoeducation groups that included information on substance abuse. This assistance may have helped families manage their involvement with clients more effectively and avoid "enabling" behaviors.

It is important to note that the amount of family expenditures, not family income, was a significant predictor of outcomes. Many of the families had relatively low incomes but spent a high proportion of them in support of a relative with dual disorders (Clark 1994). While spending is certainly limited by total income, family income did not appear to be an important factor at the levels of support observed in this sample. Higher personal income for clients was associated with greater reductions in substance use.

There were no clear differences in families of abstainers and nonabstainers. The two family groups were quite similar in age, kinship, gender, and baseline measures of family relations.

Although it was associated with less substance use, direct family support appeared to be unrelated to improvement in psychiatric symptoms. One interpretation is that psychiatric symptoms are more intractable than substance use in a sample that is receiving adequate treatment.

Participants with schizophrenia appeared to have lower rates of abstinence and improvement on substance use measures than those with bipolar disorders. These results suggest that we need more research on how specific psychiatric diagnoses, and the associated symptoms, affect response to substance abuse treatment. Such studies should include a larger number of people with bipolar disorder than was available in this sample.

The data have some limitations. Even though we focused on postbaseline periods where higher percentages of family caregivers were interviewed, missing data on family caregiving may have affected results. We cannot completely rule out the presence of undetected bias.

A number of analyses were conducted, particularly in analyzing the effects of abstinence. It is possible that some statistically significant relationships were due to chance. However, the association between family economic assistance and substance use reduction appears to be robust.

All study participants received significant amounts of high-quality, publicly funded mental health treatment. Results may be different in areas where access to formal care is more restricted. Homogeneity of ethnicity and the mix of urban and rural settings could also affect the generalizability of these findings to groups with different characteristics. Additional research is certainly needed to replicate these findings in other locations with different populations before firm conclusions can be drawn.

Conclusions

The findings suggest that both direct family economic support and engagement in targeted treatment play an important role in helping people with dual disorders reduce substance use. The results highlight the often-ignored fact that access to economic resources and informal assistance can have a significant impact on clinical outcomes. People without family support are at a significant disadvantage and may require more formal treatment services and public assistance than those whose relatives give such support.

More research on how family support affects the long-term recovery and well-being of people with SMI is clearly needed. If the effects observed in this study are substantiated in others, then a critical re-examination of treatment policies and practices may be in order. Current practices, at best, tend to view involvement of family caregivers as an adjunct to clinical improvement. At worst, family involvement may be seen as a barrier to achieving independence. These findings suggest that concrete family support is far from a barrier to improvement. In fact, it may be an important contributor to recovery from substance use disorders. Helping to support and sustain family caregivers could be one of the most important functions that formal treatment providers can serve.

References


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The Author

Robin E. Clark, Ph.D., is Associate Professor of Community and Family Medicine and of Psychiatry at Dartmouth Medical School, Hanover, NH.