CHAPTER VII
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Alcohol and drug use has existed in several cultures, yet today, its rampant abuse and the global network, the money involved, its terrorist links has given it a monstrous global status, infringing strongly in the life of the individual user. Earlier, research focused on the epidemiology, genetic, bio-psycho-social and cultural aspects. However, the focus today is more on broader socio-cultural than micro level factors.

Families and spouses who were focused on as causes earlier are viewed as responders to the problem currently. In realizing that families do not easily abandon their members, focus is now on how members of families deal with the stress of a dependent person, how they cope with the person and the condition. While treatment studies have included families and attributed favourable results, yet few studies have been based at the community level to understand how they cope and adapt to the condition.

SUMMARY OF THE STUDY:

The current study is an attempt in the direction of studying what is the substance abuse pattern in families of alcohol and drug dependents. What are the stresses faced by these families? How do they cope using their resources? What is the cohesion and adaptability in them leading to their adaptation to the problem?

These families have been compared with non-user families living in the same community on the above aspects, to give a picture of how substance abuse exists at the community level. The attempt is to understand the functioning of these families in response to the problem and identifying their cohesion and adaptation as strengths enabling their endurance of the problem.
The universe of the study Kasimedu is a low class neighbourhood of North Chennai, one of the high drug abuse prevalent areas. A random sample of thirty each of alcohol and drug abusers was drawn from the list maintained by ‘Sangamam’ a community based organization working for the cause of substance abusers in the same community. Thirty matched non-users drawn from the same community were studied for reasons of comparison and reference for norms for the local population in conjunction with the instruments used in the study.

Tools for data collection included an interview schedule that was framed by the investigator, covering the background variables and the substance abuse pattern, called Profile of Substance Use Schedule (PSUS). The stress faced by the family was assessed using the Presumptive Stressful Life Events Scale (PSLES, Singh, 1981). The family coping patterns were assessed using The Family Crisis Oriented Personal Evaluation Scales (F-COPES, Mc Cubbin et al., 1981). The cohesion and adaptability of families was assessed using the Family Adaptability and Cohesion Evaluation Scales - II (FACES-II, Olson et al., 1982). Data was collected through personal interviews of the family respondents after obtaining the consent of the dependent person. The data so obtained was analysed using statistical package for social sciences.

The results on the personal profile of the samples revealed younger persons among drug dependents and middle-aged persons among alcohol dependents. Two-thirds of the samples were educated from primary level up-to high school. Alcohol and drug dependents were predominantly seen among sea-related occupation. Most of the samples were married, however, among the drug dependents, many were unmarried and a few separated.
The family profile revealed that most of the sample population came from nuclear families with a family size of less than six members. Half the sample population had families with pre-school and school age children. The drug dependents' group was found more at the launching stage.

The family respondents were distributed over the different age groups with higher age of respondents being more associated with the drug dependent group. Educationally, illiteracy and lower education was more characteristic of families of alcohol and drug dependents. Occupationally, majority were non-workers. Majority of the respondents belonged to the Most Backward Community, Hindu religion and resided in the low class neighbourhood areas of Chennai.

The economic profile reveals a consistently higher mean for drug dependents, their family respondents and family income level. Significant differences are seen at the family respondents and family income level. Overall the socio-demographic status was in keeping with the study area population described earlier.

The respondents revealed a strong family history of alcohol use. Common substances abused among intoxicants and drugs were brandy, whisky, rum and arrack. Among drugs, it was ganja, pills, brown sugar and tidigesic. The mean age at initiation was higher for alcohol dependents. The common reasons for use were relaxation. Friends at social gatherings and public places initiated many of them. The mean years of substance abuse was eleven for drug dependents and fifteen for alcohol dependents. Currently, multiple mode of intake is associated with drug dependents. Lack of availability of the substance and financial constraints were found to be reasons for abusing more than one drug. Habit was
the reason for continuation. Financial sources were multiple for drug dependents - the average amount spent per day was Rs.159/- per drug dependent and Rs.93/- for alcohol dependents.

Most families related family relations were good before use but were affected after dependence. Initially and currently, family reactions were stronger towards drug dependents by both parents and spouses. Among the physiological consequences, weight loss, lack of concentration, jaundice was strongly associated with drug dependents. Ulcer, gastritis was associated with alcohol dependents. Loss of reputation, avoiding social contact, petty thefts and unemployment were statistically associated with drug dependents.

The consequences on the family of orientation revealed poor familial relations, loss of trust/respect and inadequate financial contribution was associated with drug dependents. In the family of procreation, inadequate financial contribution was associated with drug dependents and conflicts, role failure and violence were reported. Similarly, one fourth of the study population had attempted suicide.

Majority of the substance abusers sought help for treatment at hospitals and general practitioners to stop abuse and treat the consequences. Problem behaviour was present among the majority and they had specific needs. There was good awareness of groups helping the families and awareness of welfare agencies and they had received satisfactory help from them.

Given this scenario, the stresses faced by these families over a lifetime and a year, was studied. The stressful life events over a lifetime showed that the total life events were highest for alcohol, followed by drug dependents and non-users
and the groups differed significantly. On the life events over a year, the health and legal aspects revealed significant differences between and within the groups in stressful life events and amount of stress.

The family coping patterns revealed that the families of substance abusers despite the stress, impinging on their lives, showed coping patterns a little lower than non-users, the groups differed significantly between and within the groups on all the domains except acquiring social support.

On the FACES scale, the families of substance abusers are less cohesive as compared to non-users. Between the families of substance abusers, the families of alcohol dependents are more cohesive. The difference between and within the groups is reflected in all domains except space.

The family adaptability revealed that the families were significantly different between and within the groups on overall adaptability. They also differed on aspects as discipline, negotiation and rules. The families of drug dependents revealed more flexibility as compared to alcohol dependents. The cohesion type revealed more disengaged families among alcohol and drug dependent families. Such a cohesion type was reflected in more extreme type of families.

The adaptability type revealed more rigid type of families, which reflected in higher number of extreme families. More number of non-users were connected and very connected in cohesion and more structured and flexible on adaptability, leading to more moderately balanced families.

The correlation results revealed that the age of alcohol dependents is positively associated with income of family, family stage, years of use and lifetime.
total of stressful events. The family stage is also positively related to income of family, years of use and lifetime total. Occupation is inversely related to cohesion, cohesion type and family type on FACES scale. Years of use is inversely related to age of initiation and positively related to overall coping. For drug dependents, age is positively related to years of use, past year total and amount of stress on life events.

Family stage is positively related to occupation and inversely related to age of initiation, past year total of life events and past year stress. Occupation is inversely related to income, age of initiation, one year total life events and one year stress. Occupation is also positively associated with lifetime total of life events. Years of use, is positively associated with the total of life events and one year total of life events.

The correlations for non-users revealed association between family stage and age and lifetime total of life events. Total of life events and past year stress were inversely related to cohesion, cohesion type. F-COPES total was positively related to income, adaptability, adaptability type and family type on FACES.

The correlation results for families with substance abusers showed age was positively associated with age of initiation, years of use and lifetime total of life events. Age was inversely related to adaptability, adaptability type, and FACES family type. Occupation of this group was positively related to family stage. Occupation was inversely related to cohesion, cohesion type, and FACES family type.

Family stage was positively related with years of use. Family stage was inversely related to cohesion and cohesion type. Years of use are positively
related to lifetime total of life events. Age of initiation was inversely related to adaptability. Lifetime total of life events was inversely related to adaptability type and FACES family type. F-COPES was positively related to adaptability and adaptability type.

Regression for the family cohesion of non-users revealed that the one year grand total of life events was inversely related to family cohesion predicting that higher the number of life events over a lifetime, lower the cohesion. The analysis predicted that lifetime stressful life events were inversely related to adaptability. The F-COPES total was positively related to adaptability. The hypothesis one that there is an inverse relationship between stress due to life events and cohesion among non-user families was proved by the study results.

When analysed independently, for the substance abuse group, the years of use and psychiatric illness are two variables inversely related to both cohesion and adaptability, predicting that higher years of use and existence of psychiatric illness contribute to lower cohesion and adaptability.

Regression for the substance abusers' group on family cohesion in line with the second hypothesis, predicted an inverse relation to social consequences, suicidal behaviour, help seeking, medical illness, age of abuser and occupation. This indicated that higher the social consequences, suicidal behaviour, help seeking, medical illness, age of abuser and unemployment, lower the cohesion.

Regression for the substance abuse group proved the last hypothesis of the study and predicted that F-COPES total was positively related to adaptability, wherein higher coping leads to better adaptability. Age at initiation was inversely related, meaning higher the age at initiation lower the adaptability. Help received
and the number of times abstinent was positively related to adaptability predicting that higher the help received from welfare agencies and number of times abstinent had better scope for adaptability in the family. In the substance abuse group it is the variables in relation to substance abuse and coping that determines the family adaptability and cohesion. For the non-users it is the past year life events and number of lifetime stressful life events and coping total that was related to cohesion and adaptability.

The findings of the study set the basic need for the interventions with the families of substance abusers and strengthening of families of the non-users. The same is discussed in terms of implications for social work interventions.

**IMPLICATIONS FOR SOCIAL WORK PRACTICE:**

The substance abusers' families need help to understand the problems allay fears, anxieties or guilt feelings, to help solidify the family unit. Familial adaptation to substance abuse is complex and multi factorial as discussed above and not subsumed to a single linear explanation.

The base for this stems from the current study results summarised above wherein the personal, familial, social and economic profile of the substance abusers' families reveal that they live in unsatisfactory living conditions. These families grow up in a highly endemic area specifically slum pockets near the seashore where anti social activities are common.

Such an ecological scenario could induce people to socialize into drug use. Yet a number of them are staying in their family shows the strength of the Indian culture. These families were less expressive of the psychological consequences
'feeling ashamed'. This has its impact on the family functioning and calls for 'developmental strategies' in the community. These consequences have a direct bearing on the social life of the families of substance abusers.

The social consequences highlight the impact this habit has on the person over a long course of abuse. The medical nature of several of these consequences projects the role of treatment as a viable solution and as a respite or relief from this problem. This warrants for a 'remedial strategy'.

A pure curative medical orientation alone in treatment is unsatisfactory in majority of persons with substance abuse. This however, does not imply that individuals with substance abuse could be totally intervened by social, cultural or developmental services either. A balanced combination of both the approaches is required along with a 'preventive strategy'.

Due recognition also needs to be given to the families of substance abusers who shoulder the burden of the individual with substance abuse. The conviction is that the families do play a vital role in maintaining the person with the problem within the family points out to the need for 'empowerment strategy'.

The profession needs to look at the provision of social work intervention in such situations from the contextual point of view. While viewing from this angle the community and the environment in which the family lives also need to be taken into consideration. Based on the results obtained a social work intervention model (Figure 6) is presented keeping in mind the current philosophies and interventional developments in the professional field. The four strategies presented are: remedial, developmental, preventive and empowerment orientation.
FIGURE 6: SOCIAL WORK INTERVENTIONS WITH FAMILIES OF SUBSTANCE ABUSERS
REMEDIAL STRATEGIES

Working with substance abusers requires understanding of the illness as well as the individuals. In the Indian context treatment for alcoholism is often not attempted until medical conditions warrant it. For drug abuse, treatment is eventually attempted and often earlier than alcohol dependence. Presently because of a poor health infrastructure, inadequate hospital beds and staff and high cost of hospital facilities much of the health care provided are within the family sphere (Shankar and Menon, 1991). In the absence of a social security system and lack of adequate number of social institutions for health care, family based care is inevitable for most. Thus it is important to understand that family support is essential in the treatment of substance abuse.

Multi disciplinary approach:

The results showed that higher the age of the abuser, more unemployment, higher social consequences, suicidal behaviour in terms of number of attempts, higher rate of medical illness, higher help seeking in terms of treatment leads to decreased cohesion.

Specific remedial interventions for the individual under such circumstances need to be with support from a multi-disciplinary perspective. The alcohol and drug detoxification and rehabilitation centres are limited in the country. The mental health institutions and the general hospital psychiatric units with such centres need to strengthen the multi disciplinary team for treatment of the problem from a holistic perspective.

The introduction of detoxification centres through the non-governmental sectors by the Welfare Ministry also need to strengthen the psycho-social
personnel for the reasons above described. Such centres need to encourage families to seek treatment and after care services with follow-up later in the community.

The multi disciplinary group should encompass a number of professionals drawn from different disciplines. These professionals need to look into the issue from a bio-psycho-social and cultural perspective. The team need to comprise of social workers, psychologists, psychiatrist, general practitioner, developmental workers, health educationist, nursing care personnel and rehabilitation workers.

These centres need to apply the methods of working with the groups especially the families of substance abusers. Family analysis and intervention need to focus on nature of problem, action subsystem, target subsystem and nature of intervention needed. The group and family therapeutic approaches based on such analysis would strengthen the cohesion and adaptation in family functioning. Given the long duration required for life style change, continued contact with treatment systems and professionals should be established through group work practices.

The paucity of professionals to work in this area is yet another matter of concern. Regional centres need to be identified to train professionals and para professionals in the care, cure and rehabilitation of persons with addiction. Similarly, the Schools of Social Work and other Faculties involved in the provision of such care need to revise the curriculum based on the needs families of substance abusers

Continuous care programmes, day care centres, residential rehabilitation services would have a definite bearing on the competence – that is the ability of
the members of the family to solve their problems and enhancement of their cohesion and adaptability.

Community outreach programmes:

Remedial interventions for persons with substance abuse problems need to be in settings that are most appropriate for optimal care. Community clinics can be used to deal with the medical complications early and prevent major disabilities and dysfunctions. Such remedial measures could also include friendly health visitors to the homes of the abusers; de-addiction centres in the community to reach out to the addicted populations; family counselling centres to deal with familial cohesion; all women's police stations, wherein the families could get a reprieve for the family violence and problems due to substance abusers.

Social counsellors in such settings need to be encouraged to focus on the strengths of the families besides other aspects of family therapy and interventions. Professionals in such community settings need to further promote development of day care, rehabilitation and after-care services in collaboration with non-governmental and voluntary organizations. Such collaborative efforts need to be strengthened through periodical support and supervision.

Families as partners:

Abstinence as a goal is unquestioned universally. However, it remains an ideal difficult to practice by many. Current developments of harm reduction approach emphasize providing care over punishment. Similarly, the needle exchange programme has favourable implications for the control of spread of HIV infections to the families namely the wives and children and reducing the violence in the families. Educating people on 'sensible drinking' concept is also emerging.
Families are the best vehicles for such education and need to be treated as partners in remedial strategies.

DEVELOPMENTAL STRATEGIES

There is a growing realization that social work should not be unidirectional in terms of curative care alone. Developing countries like India target local populations involving them in development. The means, methods, philosophies and values should have relevance to the person towards whom it is directed. Substance abuse has been linked to poverty and deprivation. Developmental strategy becomes the focus and is relevant under such circumstances.

Basic needs:

Inattention to the basic needs of the community will affect any other interventions. There is a need for community development programmes in the area to build basic amenities such as proper housing, electricity, sanitation and drainage facilities to improve the quality of living so that the layout of the area does not encourage substance abuse and the vices. Better facilities for cold and dry storage for fishes need to be constructed in the area. This would be helpful both in peak and off-season and would enhance their economic conditions.

Families are known to support their sick members even when impoverished; financial resources affect the amount and type of care provided. Poverty groups and marginalized populations are worst affected, as their resourcefulness in prevention, control and coping is limited due to their economic handicap and the general lack of awareness that goes with their economic status.
The study brings into focus the need to identify and encourage alternate off-season employments especially on shore, so that the families are not plunged into poverty. Micro-credit savings schemes can be initiated to help tide over financial difficulties. The savings and welfare schemes for the fisher-folk have failed to create an impact during hardships.

Development through education:

Education is the key to a better future. As educational standards are low a concerted effort has to be made to reach out to these families and their children in schools. They have to be encouraged to continue education and set goals in life. The families should facilitate development of positive interpersonal relationship with one caring parent or adult to prevent them from socializing or resorting to drug abuse after drop out on low educational standards. School education in such areas need to include incentives like midday meals, distribution of free educational materials like books and note books.

Industrial, environmental pollution and degradation and changing climatic condition makes fishing an occupation increasingly difficult thus leading to unemployment. Based on their educational achievements, training by fisheries department and ancillary activities will improve job opportunities as seamen facilitating better income.

Adjustments to stress causing events that threaten the family depend upon the adequacy of the role performance of family members and the response of the community. Stress meeting resources include factors such as family adaptability, family cohesion and the social support system available to the family.
Consequently in developmental programmes for the family, these factors need to be developed to meet these events adequately.

**Welfare oriented development:**

Welfare measures are advocated for the children of alcohol and drug dependents and HIV infected persons. Sponsorship of the children will facilitate education of the children and even if death occurs the children can continue education.

To overcome such problems the employee assistance programmes of companies has helped individuals and families working in the industrial sector. There is a need for assistance for those in the unorganised sector who are more prone to such problems.

**PREVENTIVE STRATEGIES**

Any approach which focuses on promoting healthy lifestyles and on reducing problems rather than on the substance use per se, enables many clients to be reached who would otherwise stay away. This is consistent with outreach services of social workers. Preventive strategies can be effected by means of strengthening the families, eliminating the pathogenic agent and control of contributing environmental conditions.

**Family preservation services:**

Higher levels of coping, higher number of times help received and higher number of times abstinent leads to better adaptability. These findings can be specifically used in terms of encouraging family preservation services. This is implemented by motivating families to seek treatment early, encouraging
accessibility to treatment, strengthening the help received from welfare agencies, increasing the period of abstinence by facilitating families to focus on relapse prevention, after-care and rehabilitation.

This can enable families to break the cycle of hard-core addictive use. By seeking treatment or professional help early even before dependence sets in the families can reduce their deficits or disabilities due to the condition and seek to enhance their cohesion and adaptability thereby increasing the strengths in the family.

**Growth oriented programmes:**

Families have to be encouraged to interact with agencies not just for problem but for growth oriented programmes. The non-users revealed that increased lifetime total of life events was inversely related to cohesion. Similarly higher coping was related to increased adaptability.

Therefore even if stress is high, better coping can facilitate better adaptability and increased coping can also probably improve cohesion. So such interventions can be made for the general population wherein their coping skills can be enhanced and can form part of preventive social work. Knowledge of the various cultural beliefs influencing fatalism can be overcome through slowly drawing families out into the belief system of mastery, facilitating their coping.

**Life skills education:**

In addition to goal-oriented education, the youth should be supported to face the stresses in life so that they have opportunities to develop positive coping skills and self-confidence. Having a purpose in life - having a dream, engaging in long range planning and being able to delay gratification are shown to be
important for resilience. Support with academic, social, and life skills development and promotion of positive normative development through religious involvement, family values education and help in seeking positive friends and activities provides the right ingredients for a drug free life and family, emphasizing preventive social work.

Encouraging family members, children to contribute valued services to their families is more likely to help them become resilient to drug use as they develop competencies and self-esteem and 'adaptively distance' themselves from substance abusing members. Further helping families maintain rituals and routine life can help preserve better family cohesion and adaptability.

Community agencies reaching out to substance abusers should be involved in imparting family life and life skills education and other preservation programmes on a continuum basis. Adapting some of the international activities to the local cultural milieu and training the adolescent boys and girls in such practices would go a long way. These activities need to be on a continuous basis and in combination with the other development strategies reported above.

EMPOWERMENT STRATEGIES

Empowerment philosophy in familial adaptation to substance abuse needs to be the new thrust. Such efforts position the intervention in the context of a social health model. If carers or family members are to become effective partners in the care programme then they must be empowered to do so. This demands a change in attitude and an acceptance of families of substance abusers as partners in the service.
Social support system:

The shrinking support system and social network of the primary family especially in large metropolitan regions and a paucity of institutional supports, strongly undermines the capacity of the family to extend care. Existing resources of family, friends and relatives have to be strengthened. This becomes much evident as the current study revealed that families relied on their relatives and their neighbours for support. Given these strengths we can see resiliencies in these families.

Imparting of vocational skills training and self-employment of the spouses could be encouraged to empower the women to become financially independent to reduce the stress of financial dependency or total lack of income in the absence of the earning of the spouse. This would further expand the social support network for such women at the tertiary level.

Family support groups:

Except for a few drug dependent families wherein the wives separated from the husband, the other families remained together even if marked by separation in alcohol dependent families. This was used as a strategy and sometimes out of desperation. Strong extended families provide additional role models and support for high-risk children (Becerra, 1988) by not condoning excessive alcohol or drug use. Support groups such as Alcoholic Anonymous, Al-Anon, Al A Teen, and Narcotics Anonymous have proved useful and they can be networked with or initiated.

Families can be empowered to take decisions to improve the living conditions of the community by deciding and taking action themselves. Soon this
can extend to substance abuse to deal with illicit brewing and sales of drugs creating community controls as has been experienced in several states as Tamil Nadu, Andhra Pradesh, Haryana, Maharashtra (Bang and Bang, 1991; Saxena, 1994; Chengappa, 1986; Prasad, 1992). Communities can network and collaborate with enforcement agencies to work on a collective level to reduce the availability of drugs and illicit alcohol thereby reducing the criminalisation of the problem.

Advocacy:

The best process of advocacy is the notion of self-advocacy where individuals are enabled, if necessary, to stand up for themselves and play an active role in their own treatment. Professionals do have responsibility to fight for the user's right, particularly of people who find it more difficult to stand up for themselves. This will best be done by ensuring that people know about advocacy services and by supporting them in very practical ways, like funding, making available space and facilities and development of local area net working. Specific target group for advocacy activities needs to be focussed upon. This would include women's group, community level organisations, voluntary organisations and religious institutions.

The diversity of this eclectic social work intervention outlines possible therapeutic options that can be applied in the context of the substance abuser and their familial adaptation. These interventions could be considered along with the other orthodox interventions practised in the field by professional social workers.
POLICY IMPLICATIONS

The above outlined eclectic intervention coupled with advocacy approach needs to lead towards policy reviews and newer policies for safeguarding the interest of the families of substance users. The following suggestions are based on the results of the current study and its implication for the families. Such family policies as an instrument might be able to achieve other larger societal goals.

In the current scenario, policy towards families with substance abusers may be used to achieve labour market objectives. This could be realized by encouraging more women to enter the work force through specific policy formulations with reservations and higher consideration for families with dysfunctional or disabled individuals due to substance abuse. Such consideration not only liberalises the women from the shackle of being tied with the problem situation to be a supporter of the family.

Secondly the country has to review its policies on alcohol and drugs. The NDPS Act, which deals with the problem of substance abuse, has a clause on identification, treatment, education, after-care and rehabilitation. However there is no special mention of the family in any of the current policies.

The Tamilnadu Prohibition Act can be amended to include family interventions. There are several community-based schemes supposed to include the families, unfortunately they are not co-ordinated well and are fragmented.

India’s policies towards the family include the family welfare programme. Several policies include women and children but have not translated them into action. India’s National Health Policy does not mention the family. All these lead to the need for a comprehensive policy on alcohol and drugs.
SCOPE FOR FUTURE RESEARCH

The current research was done from a cross sectional point of view. It highlights the familial adaptation at a point of time in comparison with the non-user families in the same community. There is a need to look at the process of adaptation as it is Circumplex in nature and not static. This would require a longitudinal study of the families of the substance abusers. Such a study would involve the identification of all the persons in the community to determine the community cohort with use and abuse of substance. The natural history of the substance abuse and familial adaptation in terms of the psycho-social-cultural milieu could thus be studied only on a long-term basis.

The transitions and its impact on the cohesion and adaptability types during varied phases need to be studied. The various stresses and changes that impinge on them, their responses and how they face it in the light of the chronic stress of substance abuse will be very useful to develop further interventions.

The focus of research must move away from professional interests and need to start from the experience of users and their needs. To this effect the current study made a small attempt on the familial needs and their help-seeking pattern. Large population studies on the needs of the families, help seeking pattern and the pathways to care would lead to better organization of services.

The current study at a micro level examined the positive features of the families in containing the problem of persons with substance abuse within the system and its adaptation to the problem. A further systematic study on the resilience features of such families would help us develop and nurture natural coping mechanism for families with substance abusers that could be practical.
The study concentrated on substance abusers only. The other forms of use in terms of occasional use, social use and non-dependent abuse among persons in the community were not considered. Familial adaptation to severity of substance use or abuse would give us a gradational effect in familial adaptation.

The study utilized the non-user families both as a comparator and norm for the F-COPES and FACES scales. Specific validation studies with different problem groups and known group validation methods would strengthen the use of the instrument for therapeutic intervention assessment purposes in the country. Such studies would also be able to cull out specific cultural applications in terms of flexibilities that could be a positive way of adaptation for the Indian families.

Having identified that added up stress due to substance abuse leads to an impacted adaptability there is a specific need to look at interventional strategies for reduction of the impact. The efficacy of such interventions could be periodically assessed with a pre designed experimental design.

Special focus needs to be given to the stress of caring by women, as they are the primary care givers. Similarly, the adaptive distancing by the children, their self-esteem and adjustment needs to be studied in detail. This would give us a holistic perspective of the problems faced by the families of substance abusers and would enhance the development of a family unit service.

With burden of disease and economics of health care concept in other areas of health care providing vital information, addition of such dimensions in community cohort studies would provide valuable insights. Finally field based action oriented research with participatory appraisal on the problem of substance could lead to peoples involvement, advocacy and policy issues.