



Lankelly Chase



Understanding the whole family

The role of families in the lives of people with severe and multiple disadvantage

Part three of a series of literature reviews on severe and multiple disadvantage

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Acknowledgements

We thank the following for their helpful comments and expertise: Dr Carole Wright and all Revolving Doors Agency colleagues and Lived Experience Forums. Special thanks to our steering group: Francesca Albanese, Carol Hedderman, Debra Hertzberg, Nick Maguire, Helen Mathie, Jane Millar, Oliver French and Cathy Stancer.

Table of Contents

Background to this review	p.4
Introduction	p.4
Prevention and Early Intervention	p.8
Intervention and Treatment	p.17
Maintenance of Recovery, Desistance and Change	p.23
Review of Research Gaps	p.26
Conclusion: Where next for research, policy and practice?	p.27

Revolving Doors research network on severe and multiple disadvantage

We are pleased to host a national research network into severe and multiple disadvantage in partnership with and funded by the Lankelly Chase Foundation. The network brings together 200 members from academia, public and voluntary sectors from different disciplines who are working collaboratively to further our understanding of severe and multiple disadvantage. Our research network seeks to build the clearest-ever picture of the 'whole person' and the total of their experiences. If you would like to know more, please contact Revolving Doors.

Background to this review

Last year, Revolving Doors Agency published "Understanding the Whole Person", a literature review that explored the common concepts for recovery and desistance across mental illness, substance misuse and criminology (Terry & Cardwell, 2016). The role of other people, in particular the family, was found to be a common factor across all of these fields. This literature review expands upon Terry and Cardwell's work, continuing to encourage the move away from siloes, and focusing on the role of the family in the lives of individuals facing severe and multiple disadvantage. This review is a narrative literature review that focuses on a range of topics relating to the role of families. Due to the narrative nature of the review we are limited in the number of mechanisms, pathways and causal relationships, etc. that can be discussed. As such we do not aim for this paper to be a comprehensive answer to all questions about the role of the families in the lives of individuals facing severe and multiple disadvantage (SMD), rather we hope this paper provides a springboard for further conversations and research. This paper was also informed by workshops on the subject of 'family' held with our Lived Experience Forums.

Introduction

Families have multiple and sometimes conflicting roles in relation to people facing severe multiple disadvantage (defined as the coincidence of disadvantage such as homelessness, drug and alcohol misuse, mental illness, cycles of violence and abuse, and chronic poverty (Duncan & Corner, 2012)). There is a tension between the conceptualisation of aspects of families and family lives as 'protective factors' versus 'risk factors'. This complexity is also reflected in research with those with lived experience (Terry, 2015: discussing the often complex nature of familial relationships). This literature review aims to examine the strengths and protective

factors families can offer as well as the barriers or problems within families that can have a negative impact on individuals facing severe and multiple disadvantage. This literature review will also examine some of the implications that this tension poses for policy and practice.

For the purpose of this review, severe and multiple disadvantage (SMD) has been limited to five key areas: offending behaviour, mental illness, substance misuse, housing problems and victims of domestic violence and abuse. In reality, a household affected by one or more of these needs is likely to face other challenges, including poor physical health, entrenched poverty, distance from the labour market, difficulties at school (where applicable), learning difficulties and disabilities, and a range of socially excluding factors. To consider all of these would go beyond the matters most salient to Revolving Doors Agency's population of interest, and would broaden the scope of this review to an impracticable extent. It is also important to note that we have had to be selective with regards to the discussion of mechanisms by which family traits/behaviours can trigger/cause certain outcomes to occur. For example, attachment theory is discussed, but other developmental mechanisms are not. Inclusion of all mechanisms would have broadened the scope of this review to an impracticable extent. As such, this literature provides an insight into the role of families in the lives of individuals facing severe and multiple disadvantage without providing an exhaustive exploration of mechanisms and pathways.

It is important to consider the impact families can have in order to tackle multiple disadvantage: an individual may develop a range of multiple needs as a result of systemic family dynamics (Sutherland & Miller, 2012). Evidence suggests that there are various associations between a range of parental, familial and/or environmental factors (such as adverse childhood experiences including parental offending and parental substance misuse) and the development of disadvantages in an individual's life. However, there has been for over a century a political (and fringe academic) narrative that posits the heritability and transmission of a range of other problems, such as attitude to work, employment and poverty (Bromfield, Sutherland & Parker, 2012; Cleaver, Nicholson, Cleaver & Tarr, 2007). This narrative risks the omission of structural factors and determinants that are so important to health and social wellbeing.

Definition of family used throughout the review:

Defining the term ‘family’ is not easy. There are many different types of families, as well as definitions and understandings of the word. We may think of the “nuclear family” unit, referring to a spouse and their wife/husband and dependent children (Oregon State, 2017); the “extended family”, referring to individuals related by blood or by marriage; the “family of origin”, referring to the biological or adopted family in which an individual was raised; or the “blended”/“reconstituted family”, referring to families made up of two adults plus their children from previous relationships (Godelier & Maurice, 2011). What unites these various forms of family is the concept of a more – or less – intimate domestic group made up of people related to one another by blood, sexual or legal ties (Scott & Marshal, 2009). These different forms show how an individual’s definition of their family is likely to change through the various stages of their lives. It is also important to note that traditional uses of “family” have often been viewed as excluding same-sex relationships and the family/domestic groups built around them.

The definition of what constitutes a family and the family make-up can also be determined by cultural influences. For example, cultures can have different rules with regards to where a couple lives after marriage; which parent’s relatives the children interact with the most; and whether divorce is supported or not (just to name a few) (Georgas, 2003; Georgas, Berry, Van de Vijver, Kagitçibasi & Poortinga, 2006).

For the purposes of this literature review we will consider the role of an individual’s “family of origin”, “nuclear family”, “blended family”, or “extended family”. This presents a limitation of this literature review as it will not consider the role of “families of choice” (people in an individual’s life that may not be related but who fulfill the caring and supportive roles of a family); “looked after children” (children in care) (Council, 2014; Weston, 1991); or the differences or similarities between families with heterosexual versus same-sex relationships; and because it is a western view of the term “family”. It is however important to acknowledge that the family structures we do not explicitly discuss in this review may face both similar and different challenges to the families we will be discussing in this review. Further research into the role of the types of families outside our scope would be highly beneficial.

The paper will take a life-course approach, exploring the role of the family in three processes: i) prevention and early intervention; ii) intervention and treatment; and iii) the maintenance of recovery, desistance and change. Examples of interventions will be referenced throughout the review. We hope that taking a life course approach will demonstrate how both the development of and recovery from disadvantages are processes rather than events (Terry & Cardwell, 2015). Furthermore, we hope that the review will encourage a move away from seeing connected problems as being unrelated, and instead see the commonalities between a range of issues. This will promote a more multi-systemic and multidisciplinary approach to families and SMD including recovery.

It is important to acknowledge that the terms 'recovery' and 'desistance' and their definitions are disputed (e.g. Leamy, Bird, Le Boutillier, Williams & Slade, 2011). This literature review is not however defining the end goal of any of these processes, only reviewing how the family may play a role and how the processes can be encouraged/hindered. The terms 'recovery' and 'desistance' will be discussed further at the start of the 'Intervention and Treatment' section.

Furthermore, while we chose to speak generally about SMD (rather than individual disadvantages so as to encourage a multidisciplinary approach), the role of families in the lives of individuals experiencing domestic violence and abuse is often different to the role of families in the lives of individuals facing other forms of disadvantage. Firstly, although violence can, and is, committed by women towards men and other women, the overwhelming majority of violence is committed by men towards women and children. Evidence suggests women are twice as likely as men to experience some form of interpersonal violence and abuse across their life course, with one in every 20 women experiencing extensive physical and sexual violence across their life course, compared to one in every 100 men (Scott & McManus, 2016, p. 2). Women tend to suffer more repeated violence with more severe injuries, fear, sexual violence and coercive control (NICE, 2014; Debbonaire, 2013; Scott & McManus, 2016). In England, the British Crime Survey reported that 48% (n94) of all female homicides had been committed by a partner or an ex-partner, compared to 5% (n21) of all male homicides (Debbonaire, 2013). Secondly, when domestic violence and abuse is experienced in families, the role of the family member(s) in prevention, intervention, treatment and recovery is extremely limited. Bancroft, Silverman and Richie (2011) explored how abusers are often family members, who are manipulative and controlling, and have a distressing and damaging effect on the rest of the family. Often the ever-present fear, along with the threat of repercussions, prevents family members from disclosing violence and abuse. By the time it is disclosed, the damage to family members may have already occurred, and it is professionals

who are best placed to coordinate support and recovery services (Bancroft, Silverman & Richie, 2011). As such, the role of the family in the lives of individuals with domestic violence and abuse can differ to the role of the family in the lives' of individuals facing other forms of disadvantage. Therefore, at times this review will speak about domestic violence and abuse to some extent separately to the other forms of disadvantage, as appropriate.

Prevention and Early Intervention

Childhood environment plays a significant role in psychological and behavioural development (Bornstein & Bradley, 2014). An individual's development is therefore greatly impacted by whether the family environment as a child was a nurturing one or not (Biglan, Flay, Embry & Sander, 2012). Consequently, the potentially causal/preventative effect of the family on the development of disadvantages will strongly depend on the type of environment promoted by the family (Biglan, Flay, Embry & Sandler, 2012).

Intergenerational transmission

Intergenerational transmission with regards to psychopathology and behaviour is when the psychopathology and behaviour of one generation is inherited by the next generation through various pathways and mechanisms (Liefbroer & Elzinga, 2012). It is important to note that the pathways describing this transmission are extremely complex, involving a wide range of factors including genetic components (e.g. Bevilacqua & Goldman, 2013; Briand & Blendy, 2010; and Lohoff, 2010); behavioural genetic components (e.g. Baker, Bezdjian & Raine, 2006); and environmental components (e.g. Silberg, Maes & Eaves, 2010). As such, it is important to read this section as a means to understand the general role of the family in the lives of those facing severe and multiple disadvantage (SMD) and the importance of preventative interventions, rather than a detailed explanation of each possible pathway of transmission. Furthermore, in order to understand how to prevent the development of disadvantages one needs to understand the reason difficulties may have arisen in the first place.

The following are various examples of evidence of intergenerational transmission. Children of individuals involved in the criminal justice system face a wide range of issues and are negatively affected in various ways (Ministry of Justice & Department for Children, Schools and Families, Children of Offenders Review, 2007). This includes an increased likelihood of being involved in the criminal justice system themselves in later life (Petersilia, 2003); social exclusion (Houchin, 2005), experiencing loneliness, fear, embarrassment (Hale, 1988), being bullied as a

result of social stigma (Murray & Farrington, 2008) and displaying anti-social behaviour (Ministry of Justice & Department for Children, Schools and Families, Children of Offenders Review, 2007). Children of parents with substance misuse problems are also at significant risk of developing complex problems often due to neglectful parenting (Dunn, Tarter, Mezzich, Vanukov, & Kirillova, 2002). These problems include a range of emotional, behavioural and/or social problems (Kelley & Fals-Stewart, 2002) such as childhood psychiatric disorders (Moss, Lynch, Hardie, & Baron, 2002), experiences of violence (Velleman & Templeton, 2007), substance misuse (Advisory Council on the Misuse of Drugs, 2003), fear of abandonment, helplessness, hopelessness and guilt (Dore, Kauffman, Nelson-Zlupko, & Granfort, 1996). Children of adults with mental illness often experience shame and a feeling of guilt for the parent's mental illness and therefore can go on to experience low self-esteem (Oestman & Kjellin, 2002) and social isolation (Larson & Corrigan, 2008), which in turn can lead to low levels of social capital (Kawachi & Berkman, 2000). Children who grow up homeless have higher levels of chronic health problems (Cutuli, Herbers Rinaldi, Masten & Oberg, 2010); have higher rates of learning disabilities (Perlman & Fantuzzo, 2010); are more likely to have experienced domestic violence and abuse (Fantuzzo & Perlman, 2010); have higher rates of mental illness (Cowan, 2007); and are more likely to go on to experience adult homelessness (Caton, Dominquez, Schanzer, Hasin, Shrout et al., 2005). Finally, some research suggests that there may be an association between children who grow up in households where domestic abuse is prevalent and going on to face a wide range of complex problems (Holt et al., 2008). These range from emotional problems (e.g. low self-esteem, post-traumatic stress symptoms and difficulty feeling empathy - Huth-Bocks, Levendosky, & Semel, 2001), to behavioural problems (e.g. physical aggression – Jackson, 2003) and social problems (e.g. peer aggression and bullying – Baldy, 2003).

However, it is not enough to know that intergenerational transmission can occur in order to prevent the development of disadvantages in an individual's life, as not all individuals who have a family member facing SMD go on to develop various disadvantages themselves (e.g. Perlman, Cowan, Gerwartz, Haskett & Stokes, 2012). This can be seen in the vast difference in the number of children exposed to 'risk factors' associated with poor parenting (250,000-350,000 children, as quoted by ACMD in Hidden Harm, 2003) and the number of people who end up as adults in selected multiple systems (60,000, Bramley & Fitzpatrick, Hard Edges, 2015). An example of this is how not all individuals who grow up homeless go on to face homelessness, and not all individuals who are homeless grew up homeless (Perlman et al., 2012). This may be due to the child having resilience to the development of further issues as a result of protective factors such as individual characteristics (e.g. emotional regulation – Alvord &

Grados, 2005) and social networks (e.g. in the form of family or community supports – Alvord & Grados, 2005; Benzies & Mychasiuk, 2009) (Zolkoski & Bullock, 2012). Furthermore, not all individuals who face SMD come from a family that experienced similar disadvantages. As such, one needs to understand the factors of an individual's physical and psychological environment and how these impact the development of SMD.

Gender differences in the development of SMD

Research has found that there are gender differences in the types of disadvantages developed (e.g. Bennett; Farrington & Huesmann, 2005; Card, Stucky, Sawalani & Little, 2008; Holmila & Raitasalo, 2005; Olff, Langeland, Draijer & Gersons, 2007). Although boys and girls may face the same problems during childhood, they tend to react to these problems in different ways (McNeish & Scott, 2014). For example, boys are more likely than girls to exhibit conduct disorders, to face peer pressure around violent and criminal behaviour; to be excluded from school; to be arrested young; and to become estranged from family (McNeish & Scott, 2014). On the other hand, girls are more likely than boys to enter sexual relationships at a young age (increasing the likelihood of facing violence and abuse); are more likely to internalise problems (increasing the likelihood of facing mental illness); and are more likely to become young parents who are responsible for their child(ren) (McNeish & Scott, 2014). The way in which parental stress affects children differently depending on their gender is a possible pathway to various forms of social exclusion and disadvantage.

The type of SMD men and women face varies as a result of the development process. For example, a recent study by Scott and McManus (2016) reported how men are more likely to meet common indicators of SMD such as poor housing, homelessness, substance dependency, financial crisis and contact with the criminal justice system. However, women who have experienced extensive violence and abuse exhibit the same indicators of SMD in similar numbers to men (Scott & McManus, 2016). These same groups of women also experience high rates of other disadvantages such as poverty, ill health and disability (McNeish & Scott, 2014). Gender differences can also be seen in the variation of specific disadvantages experienced. For example, in the case of mental illness, women are more likely than men to develop mental illness problems such as anxiety and depression, and men are more likely to develop anti-social personality disorder and alcohol dependency (McManus, Meltzer, Brugha, Bebbington & Jenkins, 2009).

Therefore, it is important when examining both the development and possible interventions of SMD that the gender of the individual is taken into account, and interventions are made specific to the needs of the individual.

Structural factors that can influence the development of severe and multiple disadvantage

The environment can have significant effects on an individual's psychological and behavioural development (Ferguson, Cassells, MacAllister & Evans, 2013).

Structural factors experienced by families can impact family members' ability to prevent the development of SMD (Dawe, Harnett, & Frye, 2008; Holt, Buckley, & Whelan, 2008; Murray & Farrington, 2008). Socioeconomic factors such as poverty can cause families to face disadvantages such as poor quality housing, overcrowding issues and potentially even homelessness (Buchholz, Malte, Calsyn, Baer & Nichol et al., 2010; Butterworth, Leach, Pirkis & Kelaher, 2012; Gauffin, Vinnerljung, Friedell, Hesse & Hjern, 2013; Lund, Breen, Flishers, Kakuma, Corrigan et al., 2010). Poverty is known to be a strong driver in the development of SMD (JRF, 2016). Although 'good parenting' can happen regardless of family income, poverty does put a strain on the family (JRF, 2016). Parents often have to make large sacrifices in order to protect their children from the impact of poverty. For example, parents often skip meals, work very long hours for little pay (consequently impacting their ability to socialise) and rarely purchase new clothes (Women's Budget Group, 2005). This does not however always prevent children being unaffected by family poverty. To name a few ways children growing up in poverty are impacted, these children have lower-birth weights; are more likely to suffer from depression; and often have score lowers on cognitive, social and behavioural development tests (Goodman & Gregg, 2010). Growing up in a family facing poverty has the same risk level of developing mental illness as growing up with parents suffering from substance misuse (Elliot, 2016). Income deprivation in childhood and adulthood even accounts for major differences in life expectancy (Woods, Rachet, Riga, Stone, Shah et al., 2005) and, across the social gradient in adulthood (Marmot & Bell, 2012).

Other forms of structural barriers and disadvantages that can encourage the development of SMD are in fact forms of early intervention and prevention strategies. For example, although the child protection system is set up to prevent and respond to "protection-related risks", including the development of SMD, the child protection system can in itself act as a barrier to its goal (United Nations Economic and Social Council, 2008).

The structural factors can also be compounded by personal/family factors, such as having a parents incarcerated. Having a family member incarcerated and therefore not present in the home setting can lead to the development of psychological and behavioural problems. In the case of incarceration, parents in prison are often unable to financially contribute to the household (Aaron & Dallaire, 2010; Geller, Garfinkel & Western, 2011), leading to financial insecurity and poverty (Smith, Grimshaw, Romeo & Knapp, 2007). This financial insecurity can lead to family homelessness (Wildeman, 2014), which in turn can lead to a wide range of disadvantages such as chronic health problems (Bassuk, DeCandia, Beach & Berman, 2014); barriers to education (Perlman & Fantuzzo, 2010); increased rates of anxiety, depression and post-traumatic stress (Cowan, 2007); and homelessness as an adult (Caton, Dominguez, Shanzer, Hasin, Shrout et al., 2005). An incarcerated mother has other effects on children, such as not being able to claim benefits for their children (putting the pressure on other people to take this responsibility); and due to mothers often being sole carers maternal incarceration leaves 91% of children living away from both their mother and fathers; and takes 95% of children out of the family home (Citizen's Advice, 2007; Ministry of Justice, 2007). Furthermore, having a mother incarcerated can lead to attachment problems; increasing the risk of a range of psychopathological problems (to be returned to in a following section on psychological environment) (Murray & Murray, 2010). This in turn can lead to, and is related to, a range of disadvantages such as substance misuse (Townsend, Flisher & King, 2007), anti-social behaviour (Kokko, Tremblay, Lacourse, Nagin & Vitaro, 2006), mental illness (Daniel, Walsh, Goldston, Arnold, Reboussin et al., 2006), and homelessness (Aratani & Cooper, 2015).

Parental incarceration is just one example of how personal/family factors can compound structural factors which can affect an individual's development, but is a useful one as it depicts how financial insecurity and poor education can also impact the development of SMD. A further example may be how women who experience domestic violence and abuse from childhood into adulthood have often grown up away from the family and have spent part of their time in institutional care (Scott & McManus, 2016). This has also been found to lead to experiences of SMD later in life (Zlotnick, Tam, Soman, 2012).

As such, it is important when considering how to prevent the development of SMD that both structural factors, such as poverty, *and* compounding personal/family factors, such as parental incarceration, are taken into account in order to design effective forms of early intervention and prevention programmes.

The impact of the family's psychological environment on the development of severe and multiple disadvantage

As noted earlier, not all individuals brought up in an environment where SMD is present go on to develop disadvantages themselves. Furthermore, it is important to note that not all individuals who face SMD come from families facing the same multiple disadvantages. The difference between those who do and those who do not develop disadvantages may partly be explained by the psychological environment a child is brought up in.

Nurturing environments that result in healthy development, rather than the development of psychological and behaviour problems, can be generally understood as environments that “minimize biologically and psychologically toxic events”; “teach, promote and richly reinforce prosocial behaviour”; “monitor and limit opportunities for problem behaviour”; and “foster psychological flexibility” (Biglan et al., 2012: 257).

One psychological concept that can help explain resilience is “emotional regulation,” defined as “internal and external processes involved in initiating, maintaining, and modulating the occurrence, intensity, and expression of emotions” (Thompson, 2004). The family can greatly impact the ability of a child to develop strong and healthy emotional regulation as emotional regulation is learned through one's environment (Morris, Silk, Steinberg, Myers & Robinson, 2007).

Environments that encourage strong emotional regulation include those with a strong attachment (positive parent-child relationship) between parent and child, and those with positive parenting practices (with regard to emotional management) from both mothers and fathers (Luyckx et al., 2011; Meunier, Roskam & Browne, 2009; Neppl et al, 2009). Insecure, anxious, avoidant and disorganized attachment styles in childhood are strongly linked to patterns of relating and pathology, such as mental illness and problems with emotional regulation both in childhood and in later life (Lee & Hankin, 2009; Murray, Arteché, Fearon, Halligan, Goodyer et al., 2011; Shorey & Snyder, 2006), which can lead to a variety of disadvantage in later life. The attachment a child has to their mother is often different to the attachment they have with their father (Grossman, Grossmann, Kindler & Zimmermann, 2008). Strength of attachment between parents and children can vary depending on levels of parental involvement (e.g. children of more involved mothers than fathers often experience a stronger attachment towards the mother than the father – Williams & Kelly, 2005) or via socially constructed gender differences (e.g. girls often experience stronger attachment to their mothers, and boys often experience stronger attachment to their fathers – Diener,

Isabella, Behunin & Wong, 2008). Therefore, factors that influence attachment will vary depending on whether it is a relationship between a mother or a father and their child, and whether it is a relationship between a daughter or a son and their parent. Common factors that affect attachment in a negative way are parental depression (McMahon, Barnett, Kawalenko & Tennant, 2005); parental incarceration (Shlafer & Poehlmann, 2010); and exposure to domestic violence and abuse (Sousa, Herrenkohl, Moylan, Tajima, Klika et al., 2011). Other potentially harmful family environments that affect emotional regulation can be identified by high levels of aggression; and a lack of warmth, support, attention and family cohesion (Repetti, Taylor & Seeman, 2002; Wagner, Silverman & Martin, 2003).

A lack of emotional regulation (influenced by weak/unhealthy attachment, poor parenting practices, high levels of aggression, a lack of warmth, low levels of family cohesion and high levels of neglect) is closely linked with the development of a range of disadvantages including criminal activity, substance misuse, mental illness and homelessness (Bögels & Brechman-Toussaint, 2006; Bornstein & Bradley, 2014; Bosmans, Braet & Van Vlierberghe, 2010; Kim & Cicchetti, 2010; Nelson, Stage, Duppong-Hurley, Synhorst & Epstein, 2007), so it is important that a positive psychological family environment is encouraged if one is to prevent an individual from experiencing SMD.

Social capital – combining one’s physical and psychological environment

Social capital has been defined as one’s “networks together with shared norms, values and understandings that facilitate cooperation within or among groups” (PECD, 2001, p.41). It is important to note that this definition does not define social capital as either a positive or a negative, just refers to the embeddedness of the individual in their social networks. The more social capital an individual has the more embedded that individual is into their social networks. This can influence the individual’s physical and psychological health and wellbeing through social influence, engagement and support (Berkman & Glass, 2000). The family is often an individual’s main source of social capital as it can influence one’s social engagements and can provide support or a lack thereof (Pearson, Carr & Shaw, 2008; Wakefield & Poland, 2005). One can apply the concept of social capital to the previous sections (addressing physical and psychological environment) as the family environment can offer both positive and negative social capital through physical opportunities and psychological influences.

Quantity and quality of social capital is strongly related to mediating daily and chronic life stressors (Taylor & Lynch, 2004). Positive social capital is both protective and supports recovery. Those lacking it tend to be at greater risk of developing disadvantages and face a more difficult and less certain route away from it. Positive social capital has been related to

decreased criminal activity, substance misuse, mental illness, and homelessness (Barker, 2012; Bruinsma, Pauwels, Weerman & Bernasco, 2013; Calsyn & Winter, 2002; Padgett, Henwood, Abrams, & Drake, 2008; Turo, Tulloch & Ouellette, 2008). However, it is important to note that social capital can also increase the likelihood of facing SMD if one's social network and family may contribute to SMD (e.g. family providing work opportunities of a criminal nature - Bottoms, Shapland, Costello, Holmes, & Muir, 2004).

The accumulation of positive social capital can be a helpful tool to address both the physical and psychological influences of the family. A range of early interventions and programmes can encourage this and promote the prevention of SMD.

Early interventions

Given the likelihood of an individual who grew up in physical and psychological instability going on to face SMD, it is vital that early interventions are in place to prevent this (Perlman, Cowan, Gewitx & Haskett, 2012). "Whole family approaches" are important in the case of SMD which rarely impacts just one member of a household, and the family may be a source of disruption, which through family interventions can be turned around, or may be a source of support, which can be utilised through family interventions (Straub, 2012).

Interventions that aim to prevent the development of disadvantages can do this in various ways. Some interventions focus on one disadvantage, in turn helping prevent the development of subsequent disadvantages; other interventions target specific groups of individuals that can influence the lives of others; and some larger scale interventions do not target either specific individuals or specific disadvantages. An example of a family intervention that focuses on one disadvantage, but in turn helps prevent the development of various disadvantages, are youth homelessness prevention interventions. Homelessness interventions often include mediation services, information, advice and emergency accommodation (Centrepoin, 2016). This style of intervention enables family involvement through mediation and can help prevent the development of other disadvantages (such as criminal behaviour) through offering shelter.

An example of a family intervention that targets a specific group of individual is the 'nurse-family partnership' (Eckenrode, Campa, Luckey, Henderson, Cole et al., 2010). This intervention is an evidence-based programme (originating in America) provided to support new young mothers, helping them to improve their health-related behaviours, and parenting skills; helping them with family planning; continuing education; and finding work. This intervention draws from the theory of emotional regulation (referred to earlier) as it promoted positive parenting practices with regards to emotional regulation, and promotes

secure attachment between mother and child. An evaluation of the intervention in Doncaster lead to recommendations in various NICE guidelines including “the need for staff to take responsibility for both the young woman and her baby,” and the need for “the provision of opportunities for the baby’s father to be involved” (NICE, 2016).

Other family interventions are specifically aimed at fathers taking a more positive and active role in parenting their children, especially with their sons (Ruxton, 2009). There can be a number of potential benefits to men becoming more involved in parenting: men become more nurturing; positive parenting roles are modelled to children; and a shared-care culture is developed. These kind of parenting interventions can be used to help prevent future domestic violence and abuse; and may also help to ameliorate some of the disadvantages on education, employment, income etc., that women with caring responsibilities have traditionally experienced throughout their life-course (Ruxton, 2009). However, there are risks associated with some parental interventions. For example, the ‘boy-friendly’ type of parenting approaches run the risk of reinforcing or reifying differences between boys and girls (Ruxton, 2009; Wright & Cowburn, 2011). More specifically, parenting initiatives do not usually have a domestic violence and abuse element, and tend to assume an existing equality within parent partnerships that may not be there (Guy, 2014; Coy, Thiara, Kelly & Phillips, 2011; Eriksson & Hester, 2001; Harne, 2011; Morris, 2009).

The two previous examples show how some interventions can pick a target group based on characteristics identified by risk assessment or association with poor outcomes as the criteria for early interventions. However, it is worth noting that there can be a large difference in scale between specialist and universal early interventions. Universal interventions tend to try to reach more than one target group and often target more than one disadvantage. Universal interventions that tackle more than one target group are often much larger interventions that address multiple members of the family. Of course this may be seen as an advantage as disadvantages faced by one family member is often a symptom of a more systemic family problem. These initiatives include Sure Start (Glass, 1999); Children’s Centres (Lewis, 2011), and Health Visiting (Luker & Orr, 1992). These interventions have the same aim as the more specific interventions which is to tackle disadvantages in their early stages and prevent the development of disadvantages of for young children. An example of NICE guidance relating to these types of interventions are the guidelines relating to Health Visiting (NICE, 2014). This guidance includes the ways in which trusting relationships can be developed with vulnerable children and their families; how to reduce “unnecessary hospital admissions”; and how to prepare “people for parenthood and supporting families in the early weeks after birth”.

However, sometimes these universal interventions do not result in fully successful outcome. For example, Family Intervention Projects (FIPs – White, Warrener, Reeves & La Valle, 2008) and the Troubled Families programme (Bate, 2017) are intended to be targeted family interventions that address the whole family. Despite some success related to both of these, both have faced criticism with regards to their varied success (Gregg, 2010; and Hayden & Jenkins, 2014) (see references for intervention evaluations).

A possible way to incorporate multiple family members in an intervention is to use an intervention that is not designed with the purpose of prevention, but results in prevention as an additional outcome. Some interventions that result in prevention will be designed to help another family member desist from criminal activity, recover from substance misuse or mental illness, or move away from homelessness in a sustainable way. This may result in the prevention of the development of disadvantages in another family member as a byproduct, as if one family member moves away from their own disadvantages faced, a positive effect on the family as a whole may result (e.g. Farrington, 2011). Family interventions that address an individual facing SMD will be discussed in the following section, however it is important to acknowledge these interventions in the prevention and early intervention stage of development as no individual lives in isolation within a family, rather they are part of a bigger family unit, affecting, and being affected by other members of the family.

Intervention and Treatment

Throughout this literature review the role of family in the lives of individuals facing severe and multiple disadvantage (SMD) has been discussed, specifically with regards to criminal behaviour, substance misuse, mental illness, homelessness and domestic violence and abuse. In order to explore the role families play in the intervention and treatment of these specific disadvantages, we need to define recovery from these disadvantages.

Recovery/desistance/moving away from these disadvantages are all “processes that take considerable time and effort [...involving] deciding to change [...] then consistently maintain[ing] that decision in the face of stigma, anxiety and fear, barriers to opportunities and social exclusion” (Terry & Cardwell, 2016). Desistance from crime is not simply the “termination of criminal activity” but is the causal process of the deceleration of offending (Laub & Sampson, 2001:1). The definition of recovery from substance misuse offered by UK Drug Policy Commission is that “the process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and

wellbeing and participation in the rights, roles and responsibilities of society” (UK Drug Policy Commission, 2008: 6). Recovery from mental illness has been described as “empowerment and reclaiming control over one’s life”; “rebuilding personal and social identities”; and “connectedness” (Tew, Ramon, Slade, Bird, Melton et al., 2011: 445). Recovery from homelessness has no universal definition, but will be spoken about in this literature review as moving away from homelessness in a sustainable way, in a similar fashion to the other disadvantages discussed this is a process with various stages (Dordick, 2002). Recovery from domestic violence and abuse has also been described as a long process of rebuilding one’s life and removing oneself from the ‘coercive control’ (Kelly, Sharp & Klein, 2014; Stark, 2007).

‘Recovery’ from disadvantages are processes that take place over a period of time, with different stages that require different forms of help. The family can play a critical role in these processes, offering different forms of support in a range of ways. In this section we will discuss the role of the family in helping an individual engage with interventions and treatment services in the early stages of recovery.

Families – a catalyst for change?

As discussed in the previous section, the role of the family is often being a key player in an individual’s social network, and therefore influencing an individual’s social capital (Pearson et al., 2008). Families can act as a catalyst, influencing the process of recovery in both positive and negative ways. Literature on desistance from crime identifies two categories of factors that influence desistance (Cid & Martí 2012; Giordano, Cernkovich, & Rudolph, 2002; Maruna, 2001): a ‘cognitive transformation’, which is internal to the individuals who decide that they will not reoffend, and does not involve external stimuli; and a change which is brought about as a reaction to external motivations, such as the individuals’ families and employment, who can act as a catalyst for change. The second aspect of desistance (reaction to external stimuli) is a factor that also greatly affects recovery from substance abuse, recovery from mental illness, and sustainably moving away from homelessness (Battjes, Gordon, O’Grady, Kinlock & Carswell, 2003; Ochocka, Nelson & Jansen, 2005; Taylor, Lydon, Bougie & Johannesen, 2004). This is often where the family comes into play as they can be external stimuli that provide a range of both positive and negative external motivations (Cid & Marti, 2012). Families providing a form of external motivation is something that can also be seen in recovery from substance misuse (NTA, 2012), mental illness (Bonney & Stickley, 2008), homelessness (Barrow & Laborde, 2008) and domestic violence and abuse (Beaulaurier, Seff, Newman & Dunlop, 2006; Hien, & Ruglass, 2009).

The type of external motivation provided by family members may differ depending on their relationship with the individual facing SMD. Although all family members may provide a similar motivation to those facing SMD (in that not recovering/desisting can damage relationships and therefore recovery/desistance is promoted in order to improve family relationships) there may be differences between various relationships. For example, a child may motivate a parent through a sense of duty and guilt/loss if they were to lose care of their child (e.g. McIvor, Trotter & Sheehan, 2009); whereas a parent may motivate a child through providing opportunity (e.g. through financial support), therefore providing fear of losing that financial support if the relationship with a parent was lost (e.g. McNeill, Farrall, Lightowler & Maruna, 2012).

Furthermore, the type of motivation a family can offer also varies depending on the type of disadvantages the individual and the family members are facing. If an individual has strong positive social bonds he/she may be provided with strong incentives not to continue with criminal activity and substance misuse (so as to maintain family ties), and may be offered the emotional and physical support, encouragement and guidance to recover from mental illness and move away from homelessness (Farrall, 2002; Mezzina et al., 2006; Milburn, Rosenthal, Rotheram-Borus, Mallett, Batterham et al., 2007; Padgett, Henwood, Abrams & Drake, 2008; Spaniol et al., 2002). An example of this incentive working in recovery was reported by the National Treatment Agency (NTA) as it was found that adults who live with their children are less likely to have “drug-related issues” during treatment and are more likely to complete the treatment programme, than adults living away from their children (NTA, 2012). The NTA suggested that this was because parents who live with their children have a stronger motivation to recover and may have a greater sense of how their problem affects those around them – in this case their children. This was the case for both mothers and fathers, however more women recovering from substance abuse report living with their children (NTA, 2012). As such, the benefit of living with children is more accessible to women in recovery than men.

Having a weak relationship with the family can have a negative impact on the individual’s recovery/desistance process. For example, in the process of desistance from crime, if an individual is lacking in social capital (especially social trust) criminal activity may be encouraged (Putnam, 2000). When recovering from substance misuse, if one does not have family, one misses out on the support the family is able to offer (Rowe, 2012). In the case of recovery from mental illness not having family may result in a lack of hope and encouragement (Mezzina, Davidson, Borg, Marin, & Davidson, 2006; Spaniol, Wewiorski, Gagne, & Anthony, 2002). Finally, with homelessness, without family, an individual who might otherwise use their family

as a source of shelter cannot (Kelly & Caputo, 2007); something that is a big issue in the housing of prisoners on release (Roman & Travis, 2006).

However, it is important to note that having family available to provide social capital is not always a positive thing. Firstly, the family may be facing the same disadvantages as the individual, and therefore either do not have the capacity to support the individual (especially in the case of mental illness and homelessness – Gould & Williams, 2010; Rasic, Hajek, Alda & Uber, 2013) or they may provide the incentive to continue with a destructive behaviour as it is the norm within the family (especially in the case of criminal behaviour and substance misuse – Halpern, 2005; Kroll 2007). Secondly, if the family is unsupportive, critical, and abusive towards the individual, the individual may experience an accelerated loss of self-confidence and self-worth, leading to a low motivation to ‘recover’ from the disadvantages faced (Cid & Martí, 2012; MacDonald, Sauer, Howie & Albiston, 2005; Mallett, Rosenthal & Keys, 2005; Padgett et al., 2008). This demonstrates how through negative social capital the family can hinder the recovery process (Portes, 2014).

The negative impact of the family is especially apparent in the intervention and treatment of domestic violence and abuse. Individuals often do not report domestic violence and abuse or engage with health and other social services due to the nature of the relationship between the victim of domestic violence and abuse and the family as it is often the case that the perpetrator of domestic violence and abuse is a family member (Barnish, 2004). As such, family members can act as a barrier (e.g. the perpetrator or the family member who is aware of domestic violence and abuse occurring but does not report the domestic violence and abuse), firstly as there may be fears related to reporting domestic violence and abuse, such as the fear of further violence and fear of losing children; and secondly as there may be physical dependencies between the victim and the perpetrator (such as housing and income) which recovery from domestic violence and abuse would put in jeopardy (Barnish, 2004; Kelly et al., 2014; and Scott & McManus, 2016).

Families can also experience barriers to helping the family member who is facing a disadvantage. Similar to the effect of distance of the family on prevention, the effect of distance on intervention and treatment can act as a barrier to help. In the case of desistance from criminal behaviour, the distance of the prison an individual is incarcerated in with their family home can act as a barrier to the family supporting the individual (Christian, 2005). This is especially prevalent in female prisoners as there are far fewer female prisons than male prisons, consequently taking female offenders further away from their families than male offenders

(Hansard, 2010). The stigma sometimes attached to having a family member facing SMD can act as a barrier to the family when seeking support (Christian, 2009; Corrigan, Watson & Miller, 2006; Greene-Shortridge, Britt & Castro, 2007; Kidd, 2007). The perceived stigma experienced by a family member can lead to the avoidance of social situations (as such lowering social capital of the individual with mental illness) and experiencing 'feelings of guilt, shame and anger' (Larson & Corrigan, 2007; Topor, Borg, Mezzina, Sells, Marin et al., 2006).

Therefore, family can help an individual in the 'recovery' process if they have the right assets to do so. However, if the family does not have these tools or if there are barriers that impact the way in which the family can be of help, the family can hinder the intervention and treatment of disadvantages. Nonetheless families can be helped into playing a supportive role through various interventions that include the family through various mechanisms such as being listened to and consulted as carers; and/or being offered help in undertaking what can be an extremely stressful role and responsibility.

Interventions

As the family often plays a major role in one's life, and as previously demonstrated can have both positive and negative influences on individuals, it makes sense that families should be included in the recovery process to help support and promote recovery/desistance (Larson & Corrigan, 2008). Not including family into the treatment of disadvantages is a major drawback of many interventions (Centre for Substance Abuse Treatment, 2004). Family interventions can be a useful tool in the recovery/desistance processes as they can not only harness the positive support that families can offer to individuals facing SMD, but they can also rebuild family ties among those for whom family bonds are weak or negative (McNeil & Weaver, 2010).

It is important that interventions address the range of disadvantages faced by the family, rather than one aspect of SMD and there are commonalities among the family interventions addressing the different disadvantages. Interventions to tackle SMD that have a primary feature of working with it often work with the family as part of a wider social network. Examples of these types of interventions include Social Behaviour and Network Therapy (SBNT – Copello, Williamson, Orford & Day, 2006: implementation and evaluation report), Community Reinforcement and Family Training (CRAFT – Roozen, Waart & Van Der Kroft, 2010: RCT comparing CRAFT to 12-step models of recovery), and Multi-Systemic Therapy (MST – Littell, 2005: systematic review). Positive results have been found when this style of family within a community style intervention is used. For example, MST is a family-focused programme based in the community to help individuals with severe psychological and behavioural problems

(Leschied & Cunningham, 2002) and is used in each of: desistance from criminal behaviour; recovery from substance misuse and mental illness; and the sustainable moving away from homelessness (Baldwin, Christian, Berkeljon & Shadish, 2012; Faw Stambaugh, Mustillo, Burns, Stephens, Baxter, Edwards et al., 2007; Rubin, Federico & Coutts, 2008; Slesnick & Prestopnik, 2009), as well as being a tool address the complexity of multiple needs (Terry, Scott & Khan, 2015). Positive results have been found in relation to the use of MST, possibly because MST aims to improve family structures and family cohesion through a range of tools, including opening lines of communication, developing skills to deal with conflict and engaging in activities as a group (Huey, Henggleler, Brodino & Pickrel, 2000). As such, MST aims to repair family dynamics that may have contributed to the development of a disadvantage in the first place.

Family interventions with regards to domestic violence and abuse are slightly different as the role of family members in the lives of those facing domestic violence and abuse is often as the perpetrator. Unfortunately, there are still barriers around the recognition of domestic violence and abuse from professionals. Because the professional focus tends to be on child protection, there can be a lack of understanding regarding the power dynamics associated with domestic violence, and unrealistic expectations can be placed on mothers about their ability for intervention (Cleaver, et al., 2008; Hester, 2010; Radford & Hester, 2006; Scott & McManus, 2016). Child welfare workers may hold intrinsic or explicit beliefs that mothers are responsible for stopping the violence, and/or that mothers must leave their violent partner if their children are to remain with them (Douglas & Walsh, 2010). As such, interventions do not often include the family as the aim is to remove the individual from the abusive relationship. However, there are interventions that aim to change the behaviour of the perpetrator and will not always result in the victim leaving the relationship, these are known as domestic violence perpetrator programmes (DVPP – Bates, Graham-Kevan, Bolam & Thornton, 2016: review of current DVPP provision). DVPPs are primarily designed for men, and are intended to increase the safety of victim/survivors and their children. A commitment to changing behaviour from the abusing family member is important to the maintenance of recovery, and it is usually a condition that partners and children are supported alongside this with an integrated service. DVPPs encourage men to confront gendered attitudes that maintain violence, and help them to develop different, non-violent strategies in their intimate relationships (Bates et al., 2016).

It is important to remember that disadvantages are often closely related, and that therefore it is important to not address just one disadvantage at a time. A clear example of this can be seen in the case of domestic violence and abuse. Although it is the abusing family member who

has initiated the development of disadvantages for other family members, there is some recognition that abusers may experience SMD themselves (Galvani, 2010a; Galvani, 2010b; Radcliffe & Gilchrist, 2016). Indeed, there is evidence to suggest that the rates of physical and sexual violence committed by men receiving treatment for substance misuse are four times higher than men in the general population (Radcliffe & Gilchrist, 2016). As such, it is essential that intervention services recognise the multiplicity of disadvantages and try to address SMDs as a whole. While there is some guidance available for those working with families where poverty, mental illness, alcohol and/or drugs misuse is also a factor, research suggests, that in practice, there are very few referral routes or services designed to support people in a holistic or integrated manner, and questions about domestic violence and abuse are not routinely asked (Galvani, 2006; Galvani, 2010a; Galvani, 2010b; Radcliffe & Gilchrist, 2016).

Therefore, providing family interventions that address the multiplicity of problems faced by the individual and the family help both the individual and the family to recover can help in both the prevention and treatment of disadvantages.

Maintenance of Recovery, Desistance and Change

The type of support and relationships needed in recovery may vary depending on the stage of recovery (Tew et al., 2011). For example, in the case of recovery from mental illness earlier stages of recovery often require an individual to view the family as 'being there' and 'standing alongside'; whereas later stages often require greater independence and sense of equality with family members (Topor et al., 2006).

However, many of the same skills are required within a family to support the family member at different stages in their recovery. In the maintenance stage (as with the treatment and intervention stage) these include family cohesion, family communication, effective management skills, parenting skills and generally positive parental influence (Black & Lobo, 2008; McKenry & Price, 2005). Furthermore, similar to the role of environmental factors (such as social capital and family skills) in prevention and early intervention, the environment can also aid or hinder the maintenance of recovery. Therefore, programmes that promote the maintenance of recovery can also help prevent the development of severe and multiple disadvantage (SMD) in another family individual.

Family, social capital and maintenance of recovery, desistance and change

Social capital can play a large role in providing the support needed to encourage an individual towards greater independence and an increased sense of self-efficacy, both of which are important in later recovery (Chiu, Hsu & Wang, 2006; Tew, et al., 2011). Social capital can be enhanced in various ways, including offering housing, employment and incentives to maintain the 'recovery process'. Families can provide these incentives to recover from disadvantages as they can offer the physical and emotional benefits of social capital and consequently "raising the stakes" of relapse (Verbruggen, Blokland & van Der Geest, 2012).

Research has demonstrated the beneficial influence of social networks for obtaining employment (Calvó-Armengol & Zenou, 2005). Stable legal employment and housing are both important if one hopes to maintain desistance from criminal activity, recovery from substance misuse problems, recovery from mental illness and find a sustainable solution to homelessness, and recovery from domestic violence and abuse and are both ways in which families often help (Dunn, Wewiorski, Rogers, 2008; Halpern, 2005; McIntosh, Bloor & Robertson, 2008; Min, Wong & Rothard, 2004; Opsal, 2012; Padgett et al., 2008; Schön, Denhov & Topor, 2009; Tsemberis, 2010). The family's ability to offer stable housing is especially useful if the individual is not able to work.

Not only can the family offer employment and housing, but families are also often the main/only source of support for housing and employment (Mills & Codd, 2008: 12; Ming et al., 2004). However, SMD often pushes families to breaking point and can result in an individual facing SMD losing contact with their families (Orford, Coppello, Velleman & Templeton, 2010; Schulz & Sherwood, 2008). This reliance on families to provide support can create problems. If an individual does not have the support of a family the individual will not have access to the potentially beneficial influences having a family can bring, and therefore the maintenance of recovery is not supported by the family (Tew et al., 2012). For example, the family may be facing their own problems which can act as a barrier to support, such as having substance misuse problems or being homeless themselves (Centre for Substance Abuse Treatment, 2004; Mayock, Coor & O'sullivan, 2011). Disadvantages faced by the families can lead to structural and social barriers (such as incarceration, a lack of housing, and poverty) to the family playing a supportive role in the lives of individuals facing SMD (as previously discussed). In addition to families not always being able to provide support such as housing to the individual facing SMD, in the case of domestic violence and abuse family can even hinder the process of obtaining housing support, as the perpetrator is often a family member and has

their name on the lease, therefore leaving the victim homeless if they try to leave the relationship (Baker, Billhardt, Warren, Rollins & Glass, 2010).

Families can also offer incentives to return back to a problem. For example, in the case of desistance from crime, the family may offer a form of employment that is criminal in nature, and therefore making it hard for the individual to maintain desistance as not only would denying the “job” mean a lack of employment, but it may also cost the individual the relationship with their families – this is sometimes referred to as ‘criminal social capital’ (Farrall & Maruna, 2004: 60; Halpern, 2005: 119). This can mean that in order for an individual to maintain recovery, breaking ties with the family is required. This shows how the family can hinder recovery through firstly offering negative incentives, and secondly not being there to provide support once an individual has broken the ties (Dingle, Start, Cruwys & Best, 2015).

Similar to the way in which continuing to be around family members who are engaging in criminal behaviour or substance misuse can lead to a return of these behaviours, keeping contact with the perpetrator of domestic violence and abuse can lead to a further violence and abuse, such as the exertion of control and manipulation on women and children, and further violence being experienced during the handover of children (Coy, Perks, Scott & Tweedale, 2012). The manipulation can come from ‘maternal alienation’, a framework that has been used to describe the way that men can try to alienate mothers from their children by deliberately undermining their trust and emotional relationships, preventing the mother and child forming an alliance (Morris, 2009). This is an example of the revolving and cyclical nature of SMD as this alienation can negatively impact the attachment between the mother and child, which has been linked to various negative outcomes for the child (as referred to earlier) (Ben-Ami & Baker, 2012; Morris et al., 2007). As many women facing SMD come from abusive relationships, these positive family relationships that could aid recovery and/or desistance are not always available for women (Corston, 2007; Scott & McManus, 2016). Therefore, it is often community programmes and services that help women maintain recovery from domestic violence and abuse rather than families (Roberts, 2007; United Nations, 2010).

Therefore, it is vital that if the family is to support the individual to maintain their recovery that the family is also offered support, of both a physical and psychological nature. This can be done in a similar way to the prevention and treatment of disadvantages through family interventions and recovery programmes (Culhane et al., 2011; McNeil & Weaver, 2010; Patterson et al., 2010).

Review of Research Gaps

Although early interventions that can have a positive impact on preventing the development of severe and multiple disadvantage have increased during the last twenty years, knowledge around what works is limited and still in its infancy. There are multiple reasons for this, including a lack of understanding of which contributing factors are open to change and an over-emphasis on single factor solutions. These last two elements are inter-related, such that although addressing multiple disadvantage appeals to the common sense of professionals, without rigorous and consistent programme monitoring and evaluation it is difficult to find explanatory causes, and effects and to understand what works for whom, and in what contexts. The literature, much like the services, adopts a siloed approach that discusses the role of families in a fragmented way, focusing on individual issues and problems.

When the literature does look at the family there are gaps as to who in the family the literature addresses. Firstly, the literature most often addresses individuals' facing SMD with reference to the impact on childhood development, life changes, and inherited disadvantages. The literature seldom addresses the role of the family in the life course of adults facing SMD. Long-term interventions and evaluations with longitudinal resources and funding need to be put in place in order to gain insight. Secondly, whilst the literature often looks at individual family members, there is a need for research to address all members of the family as a systemic family. This would help treat the whole family, and promote a full family recovery. Thirdly, the research rarely addresses the diversity of family structures. The research continues to focus on portraying families in their traditional sense. This appears to contribute to an approach that overlooks how heterogeneous families are (e.g. with regards to ethnicity, parental sexual orientation, fragmentation of families etc.). There is consequently a need to understand the effects that different types of family structures may have on individuals experiencing SMD. Finally, the literature does not always specify the relationship between the individual and the family (e.g. child/parent). This means that the specific needs of different family members is not always being taken into account, and as such services cannot use the research to inform the way they work with specific individuals.

Further research into the role of families in the lives of individuals facing SMD, addressing the research gaps, would therefore help guide policy and practice to aid the outcomes of individuals and families facing deep social exclusion and disadvantage.

Conclusion: Where next for research, policy and practice?

This review has brought together research on the role of families with regards to supporting and inhibiting positive outcomes for individuals with severe and multiple disadvantage. The paper used a life-course approach to address this, exploring the role of the family in prevention and early intervention; intervention and treatment; and the maintenance of recovery. The areas of disadvantages focused on were criminal behaviour, substance misuse, mental illness, homelessness and domestic violence and abuse (domestic violence and abuse).

It is important to fully understand the role that families play in an individual's life as families do not only influence the development of a child, but are often the focus of an adult's social bonds and physical environment. The attachment and relationship between an individual and the family is therefore often a key factor in an individual's journey into, and out of, severe and multiple disadvantage.

It became clear while reviewing the literature that despite a bias for current literature to focus on the positive effect families have, the family can have both positive and negative influences on individual family members with SMD. The positive influence is often due to the love, trust and reliance an individual can have on the family. Families are often the first to be turned to in times of crisis. As such, this offers an opportunity for families to support a family member emotionally and financially. However, the reliance on family members can also inhibit positive outcomes for an individual with SMD. For example, if the family cannot afford to financially support a family member, or if members of the family are facing their own problems (therefore less able to provide emotional support), the needs of the family member seeking support will not be met. Consequently, positive outcomes may be inhibited.

The negative influences a family can have on an individual facing SMD need to be considered to guide the formation of policy and practice. Family interventions and family therapy that address the family systemically (not just focusing on individual family members) is essential if effective prevention, early intervention and long-term family recovery are to be achieved. This has been made apparent by the cyclical effect of one family member facing SMD disadvantage impacting the development of disadvantages in another family member's life, which in turn may have a negative effect on another family member, or on the original family member facing SMD. Therefore, it is important to acknowledge that at the point of presenting to a 'service', policy and practice cannot accurately predict the type of family support needed by individual. Responses need to be informed by a true understanding of the family picture rather than

taking it for granted that the family in the background is either the solution or the source of the problems presented.

It also is clear that there is a very siloed approach to addressing families and individuals experiencing SMD in the research literature. Research tends to discuss one type of disadvantage and how the family relates to this problem, without addressing the relationship between problems and individual may face. Furthermore, literature tends to speak of individuals within a family, rather than a family structure with individuals. It is vital while addressing the role of families in the lives of those facing SMD to remember that the individual facing a problem is also a family member, influencing the lives of others. This literature review has tried to address both of these by using a life-course approach, demonstrating how an individual experiencing SMD has been influenced, and may go on to influence other family members, while also addressing the different disadvantages together. The review has hopefully encouraged a less siloed view on families facing SMD.

In order for effective prevention, intervention and recovery to occur for both the individual and the family, it is vital that the services aiming to help those with severe and multiple disadvantage look at the multiplicity of issues being faced. This is especially important given the evidence that having one type of severe disadvantage in the family drastically increases the chances of another type of severe disadvantage developing. As such, it is important that all services (substance misuse, domestic violence and abuse, housing, homelessness, education, employment support, health etc.) work together to create a multidisciplinary approach to tackling severe and multiple disadvantage within families.

Research into the role of families in the lives of individuals facing SMD has been used to influence policy and practice in various ways. One of the more striking ways has been the significant policy attention that early intervention receives. Two of these policy driven initiatives are Family Intervention Projects (FIPs – Gregg, 2010) and the Troubled Families programme (Bate, 2017) (as briefly discussed earlier). These initiatives have raised the profile of family interventions nationally. Other initiatives that have also used research into the role of the family to inform practice include (and are far from limited to) the Family Drug and Alcohol Court (Alrouh, Ryan & Tunnard, 2014); Mellow Parenting (Puckering, 2004); and Strengthening Families (Templeton, 2014). All of these intervention programmes have the same overarching aims as those of FIPs and Troubled Families. As such, research is having an impact on policy and practice. However, if the research does not continue to challenge policy and practice; does not consider the wide demographics of families; and works in siloes, a knock on effect will be seen in the services available to help those facing severe and multiple disadvantage.

We do acknowledge that this literature review is limited in various ways. For example, this review is limited by the definition of family used, the areas of disadvantage that culminates into SMD discussed, and the mechanisms by which the family influence the lives of one another. As such, we do not expect this paper to be a complete answer to all questions relating to the role of the families in the lives of individuals facing SMD, rather we hope this paper provides a springboard for further conversations and further research. In addition, we hope that this paper has moved the debate on from highly individualised perceptions of SMD to responses that are able to grapple with complex family dynamics and manage a variety of risks and protective factors from different relationships and across different times. From here services can be developed that can more effectively help both those facing severe and multiple disadvantage, and their families, so as to achieve a full family recovery and end what otherwise can become a vicious revolving door.

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