The emergence of the affected adult family member in drug policy discourse: A Foucauldian perspective

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Abstract

The affected adult family member has increasingly received attention in drug research, policy and practice fields; however, this development has received limited critical and theoretical examination with respect to the presuppositions underpinning its rationale. Using a Foucauldian theoretical perspective, this article traces how families have been problematised in the treatment and rehabilitation domains of Irish drug policy and considers the political implications. A poststructuralist method, Bacchi's (2009) "What's the Problem Represented to Be?" approach, is applied to the analysis of eight drug policy documents published in Ireland between 1971 and 2009. Families are constructed as contributing to both the problem and solution of adolescent drug use. They are imagined as a key resource in treatment of adult drug use but as needing support in this role; and, as such they are constructed as service users in their own right. Families are governed through responsibilisation. The behavioural policy solutions are individualising and preclude alternative solutions that address political, socio-economic and gender inequalities that shape the experiences of affected families. The findings may be used as a starting point for critical reflection on the assumptions and privileged forms of knowledge and expertise that are shaping policy and practices relating to affected families.

Key words: drug policy, families, governmentality studies, Foucault, sociology

Introduction

Adult family members affected by alcohol and other drug [AOD] use (as distinct subjects from affected children) have increasingly received attention in research, policy and professional practice. This development has received limited critical and theoretical examination with respect to the presuppositions underpinning its rationale. This article aims to critically analyse this development from a Foucauldian perspective, placing emphasis on the forms of knowledge and power that enable the construction of the affected family member as a governable subject, as an object of knowledge, and as a target for policy intervention.

Families are understood as governable subjects across drug policy domains. In areas of law that intersect with drug use, families are governed through criminal law as victims or witnesses, or through child welfare and protection practices. Drug prevention conceptualises the family as a key socialising institution and both a risk and a protective factor for drug use, often targeting and governing the "high-risk" family through normalising interventions. The scope for this article, however, is limited to the treatment and rehabilitation domains of drug policy.

This study is situated within an emerging body of international drug policy research that understands realities – e.g. addiction, drugs or people who use drugs - as constituted through policies and practices (Bacchi, 2009; Fraser, Moore and Keane, 2014; Fraser & Moore, 2011; Lancaster & Ritter, 2014; Lancaster, Duke and Ritter, 2015; Martin & Aston, 2014; Moore & Fraser, 2013; Pienaar & Savic, 2016; Seear & Fraser, 2014). The purpose of such research is to diagnose and to make visible the normative assumptions that operate behind taken-for-granted and self-evident ideas and to open up a space for thinking differently about how governing of subjects could take place (Bacchi, 2009; Miller & Rose, 2008).

The findings reported in this article are drawn from a larger study that aims to examine unintended consequences for families of contemporary approaches to illicit drug policy using

Ireland as an example. This article aims to critically interrogate how affected families have been problematised in drug policy and trace how the problematisations "came to be". It makes visible the underpinning assumptions of the problematisations and considers the political implications in terms of how relations of power are shaped and how families and professionals are governed.

Before presenting the findings of the analysis, a background to the research is provided and the theoretical and methodological perspectives adopted in this study are discussed.

Background

In the past two decades empirical research has examined the impacts on adult family members of a close relative's alcohol and/or drug use. In this body of work, while some studies do not differentiate between alcohol and drug-related impacts, others consider them separately. Notably, there is a recent interest in harm to others from alcohol (Hope, 2014; Laslett et al., 2015; Room et al., 2010, World Health Organization, 2010). Arguably, the separation of literatures reflects the regulatory divide of legal and illegal substances, but also early disciplinary differences (e.g. a psychological and medical sciences dominance in alcohol research with a stronger influence of criminology in drugs research) and the social and political organisation of the AOD research field (Barker & Hunt, 2004; Hunt & Barker, 2001).

Reported impacts include stress related problems, general ill-health, financial problems, isolation, interpersonal conflict, family disharmony and domestic violence (Butler & Bauld, 2005; Copello & Orford, 2002; Duggan, 2007; Hope, 2014; Laslett et al., 2015; Murphy-Lawless, 2003; O'Gorman et al., 2016; Orford et al., 2010a; Orford et al., 2013; Room et al., 2010). Family members can experience stigma by association, be blamed for the onset and enabling of drug use, or be held responsible for relapse (Corrigan et al., 2006). Families bereaved by a drug-related death can experience stigma when dealing with professionals and

others (Templeton et al., 2017; Walter et al., 2015). Those who are socially and economically disadvantaged are at risk of further marginalisation and social exclusion, becoming the "disadvantaged of the disadvantaged", particularly vulnerable when drug use by a family member is linked with criminality and gang feuding (Hourigan, 2011). Furthermore, families are at risk for drug-related intimidation as a consequence of an unpaid drug debt, which can occur in the form of verbal threats, destruction of property, sexual assaults, physical violence and murder (Connolly and Buckley, 2016; Jennings, 2013; O'Gorman et al., 2016; O'Leary, 2009).

There is a broad absence of positive accounts in the literature. Arguably, this reflects broader research concerns in the field drawn from dominant discourses such as medicine, psychology and public health that primarily focus on risk and harms associated with drug use while precluding subjugated knowledges such as the association of drug use with caring practices, benefits or pleasure (Duff, 2008; Moore, 2008; Race, 2008). A recent exception is Fotopoulou and Parkes' (2017) work on Greek families' coping strategies which highlights caring practices such as active harm reduction work, tolerance and accommodation of a close relative's drug use in the home.

While the body of empirical research on family and AOD use is large, the "family" as a concept has not been subject to much theoretical examination. Barker and Hunt (2004) suggest that the dominant conceptualisation of the family in the literature is normative, simplistic and unproblematic, and primarily informed by quantitative methodologies. Early models of family and alcohol use, drawing on biomedical and psychological scientific knowledge and expertise, view families as pathological and as contributing to the problem and the solution (Barker & Hunt, 2004; Orford et al., 2005). Perspectives such as family pathology, co-dependency and systems models dominate, and family involvement in treatment in the form of interventions such as family therapy and self-help groups designed to address individual and family

"dysfunction" are promoted. In contrast, Barker and Hunt (2004) suggest that the literature on family and illicit drug use is primarily rooted in criminology and underpinned by the concept of deviance. Families are thought to contribute to the problem indirectly through having certain attributes that associate with youth delinquency and drug use. They add that families are often represented in the literature as unable or not willing to engage with a close relative who uses drugs.

A group of UK-based researchers has developed a more recent model of families and AOD use grounded in health psychology, the stress-strain-coping-support model. This model does not blame or pathologise families; instead, AOD use in the family is understood as a long-term stressor with potential to cause strain that, as ordinary people, relatives are trying to cope with (Orford et al., 2010b). Quality social support is considered key for effective coping. Quantitative instruments measures are used to measure impacts, social support and coping (Orford et al., 2010c; Toner & Velleman, 2014), and an intervention has been developed, the 5-Step Method, for use in family support and AOD services (Copello et al., 2010). The 5-Step Method is designed for affected family members in their own right; however, although it does not aim to help close relatives to change, the authors note that this can be a possible outcome of the intervention.

At the same time as affected families are recognised as needing support in their own right, there is also increasing interest in recognising families as a potential resource in treatment. As the "recovery" paradigm has gained traction in drug policy and treatment services in countries such as Scotland, Wales, the UK, and the USA, the concept of recovery capital is often used to inform the design of recovery interventions and pathways (Cloud and Granfield, 2008). In this construct, families are understood as important social capital.

The last decade has seen the emergence of the affected adult family member in AOD policy and practice guides. In a review of UK policy documents, Velleman (2010) observes that affected families have become more visible in policy in the 2000s; however, affected children and parental AOD use are the primary concerns. While acknowledging the importance of this focus, he notes the need to expand the policy remit to also include affected adult family members. This is taking place in some jurisdictions. A review of contemporary drug policy documents[1] finds references to affected adult family members as service users in their own right in Ireland, the UK and its devolved administrations (Wales, Scotland and Northern Ireland), and Australia (Commonwealth of Australia, 2010; Department of Community, Rural and Gaeltacht Affairs [DOCRGA], 2009; Department of Health, Social Services and Public Safety, 2011; HM Government, 2010; The Scottish Government, 2008; Welsh Assembly Government, 2008). Elsewhere, drug policies in Spain, Hungary, Croatia and the USA make brief references to the need to support adult affected family members (Gobierno de Espana, 2009; Hungarian Parliament, 2013; The Government of the Republic of Croatia, 2012; The White House, 2012). Affected families are not visible in European drug policy (European Union, 2013).

Due to the regulatory divide, it is more common for governments to have separate alcohol and drug policies, although this is evolving with one-third of European strategies addressing both (European Monitoring Centre for Drugs and Drug Addiction [EMCDDA] 2016). In contrast, except for substance-specific interventions such as opioid substitution treatment, clinical guidelines tend to address both alcohol and drug use. National guidelines for AOD services in countries such as the UK, Norway and Ireland reflect a dual understanding of families as social recovery capital and as needing support in their own right and recommend the provision of services and interventions that address the dual roles (e.g. Department of Health, 2015; National Institute for Clinical Excellence, 2007; Schanche Selbekk and Sagvaag, 2016).

However, the implementation of family oriented interventions in AOD service provision remains limited (Lee et al., 2012; Orford et al., 2013; Orr et al., 2014; Schanche Selbekk and Sagvaag, 2016).

A limited body of research has critically examined how the family is theorised in drug policy. Brook (2002) investigates how families are enlisted in governmental efforts to address illicit drug use in Australia within a broader framework of governing 'family failures'. Analysing Swedish drug prevention policy, Roumeliotis (2014) analyses changing relationships between the family and the state as Sweden shifted from a welfare state to a neoliberal mode of governing. The focus on the affected adult family member in this study adds to the literature that critically examines the theoretical space where drug policy and family intersects.

Theoretical perspective

This paper adopts a poststructuralist sociological perspective and is framed by studies of governmentality, introduced by Foucault (1982, 2007) and further developed by scholars such as Dean (2010) and Miller and Rose (2008). Governmentality refers to ways of governing the conduct of populations and individuals through regulation of behaviour and individualisation of responsibility, often taking place through a network of sites and agents 'at a distance' from the state. This perspective identifies the rationalities for and the technologies of governing, and aims to critically interrogate ideas that seem 'taken-for-granted'. It enquires into the processes, such as the use of power and expert knowledge, of how humans are made into particular types of subjects and subjects into objects of knowledge (Foucault, 1982). It analyses the processes of how people are shaped into self-governing subjects - active, autonomous, resourceful and responsible citizens that act in the name of freedom and the best interest of society (Miller and Rose, 2008). The questioning of how something - a certain conduct or a group of people - becomes a 'problem' is central to governmentality (Bacchi, 2009). Here a 'problem' is

understood as something that needs to change. The process of problematising is closely linked to the process of devising responses to remedy the 'problem', for example through policies. Bacchi (2009, p. 31) suggests that 'we are governed through problematisations rather than through policies'; hence, the way a problem is represented in policy serves to justify responses that may seem self-evident and make certain forms of governing possible.

Methodology

A poststructuralist method of policy analysis, the 'What's the Problem Represented to be?' approach is used in this study (Bacchi, 2009). This Foucauldian-influenced approach adopts the position that 'problems' are produced, or constituted, through policy instead of the conventional assumption that policy represents government's best efforts to address problems that exist 'out there'. The focus in this approach is on how 'problems' are shaped by forms of knowledge and expertise in the process of policy making, and how problematisations enable particular forms of governing which in turn produce effects. The effects are not understood as measurable 'outcomes', rather they are seen as 'political implications': discursive effects (the 'limits on what can be thought and said'), subjectification effects ('how they are produced as specific kinds of subjects'), and lived effects ('the ways in which discursive and subjective effects translate into people's lives') (Bacchi and Goodwin, 2016, p. 23). The point of analysis is not to condemn certain policy solutions or to suggest deliberate intent in how 'problems' are shaped; instead, the goal is to make visible the assumptions contained in the solutions and to identify potentially detrimental effects.

The approach comprises a set of six interrelated questions (Bacchi, 2009, p.2):

1. What is the 'problem' represented to be?
2. What presuppositions or assumptions underlie this representation of the 'problem'?
3. How has this representation of the 'problem' come about?

4. What is left unproblematic in this problem representation? What are the silences? Can the 'problem' be thought about differently?
5. What effects are produced by this representation of the 'problem'?
6. How/where has this representation of the 'problem' been produced, disseminated and defended? How could it be questioned, disrupted and replaced?

Reflexivity is built into the approach as the last step in the analysis is the application of the WPR approach to one's own recommendations. Self-problematisation is necessary as policy analysts are themselves immersed in contemporary dominant discourses and governing practices that shape how they think about and act on themselves, others and the world.

In this article, these questions are posed to key Irish drug policy documents listed in Table 1; in addition, other relevant texts such as other social policy documents, official reports, research reports and clinical guidelines are included to provide context to the analysis.

Table 1 here

Policy context

It is beyond the scope of this article to provide a review of Irish drug policy developments (see e.g. Butler, 2002; 2007; EMCDDA, 2013; O'Gorman, 1998; Pike, 2009). However, a brief overview of the 2009 National Drugs Strategy [NDS] will provide a contemporary context. The overall strategic policy objective is:

> To continue to tackle the harm caused to individuals and society by the misuse of drugs through a concerted focus on the five pillars of supply reduction, prevention, treatment, rehabilitation and research (DOCRGA, 2009, p. 6).

The policy includes a proposal to include alcohol in a combined substance misuse strategy, which has not been achieved during the lifetime of the strategy. The document is managerial

in style, with strategic aims and objectives, priorities, objectives, key performance indicators and an action plan with 63 actions and named actors organised under the five pillars. Responsibility for the NDS fell under the Department of Community, Rural and Gaeltacht Affairs in 2009; however, following a change in government, this was transferred to the Department of Health in 2011 suggesting that drugs and drug use are dominantly being thought about as public health rather than community issues. Current policy comprises law enforcement, prevention, and a spectrum of treatment responses including harm reduction. The emphasis on rehabilitation in policy rhetoric has increased following the publication of the *Report of the Working Group on Drugs Rehabilitation* (DOCRGA 2007) and the *National Drugs Rehabilitation Framework* (Doyle and Ivanovic, 2010).

Findings and discussion

This section traces how the affected adult family member has been constituted as governable subject in Irish drug policy since the 1970s, uncovers the underlying assumptions of the representations of the 'problem' and considers the political implications of the problematisations.

Evolving definitions

The way that families have been represented as a 'problem' has been redefined as drug policy has evolved. Early drug policy constructed families as obstacles to the state's efforts to address drug use as treatment was considered to be the exclusive responsibility of the state and psychiatric expertise. Families were called on to exercise its sovereign power to hand over the 'abnormal' person to the authorities for normalising interventions, a key function of the family in a disciplinary society (Foucault 2006).[2] An early policy document referred to a lack of compliance with this expected practice:

> relatives (usually parents) are frequently unco-operative either by refusing to make the necessary application for admission or by seeking the discharge of the patients against medical advice (Working Party on Drug Abuse, 1971, p. 42).

Families were considered resistant and part of the problem. A Foucauldian perspective acknowledges the potential for resistance in every relation of power. Instead of understanding this non-compliance as an anti-authoritarian act, it can be understood as an opposition to the 'effects of power linked with knowledge, competence, and qualification: struggles against the privileges of knowledge' (Foucault 1982, p. 781), in this case as attempts to challenge psychiatric power and expertise.

As the prevalence of opiate drug use increased in the late 1970s, families were visible in community-based responses to drugs from the 1980s through grassroots community activism and the formation of family peer support groups (CityWide, 2016; Cullen, 2003; National Family Support Network, 2016b; O'Gorman 1998). Yet, families were absent from the 1991 and 1996 drug strategies (DOH, 1991; Ministerial Task Force, 1996). However, a discursive shift occured in the 1997 drug policy document where families again became visible, albeit problematised in a different way, with the recommendation of family therapy as a response to young people's drug use (Ministerial Task Force, 1997).

From this point forward families are imagined as being part of both the problem and the solution. This reflects a construction of affected families as pathological and 'dysfunctional', requiring professional intervention to improve relationships, functioning and communication. This problem representation is shaped by knowledge from the psychological sciences and professional expertise from a new sub-discipline, family therapy, which was established in Ireland in 1980 (Carr, 2013). Through this specific technology the family is governed 'at a distance' to normalise its conduct. At the same time it is prompted to become a self-regulating

and responsible unit capable of transforming itself into a normalised ideal of family according to the expectations of an advanced liberal society (Rose, 1999). There has been continuity in this representation of adolescent drug use as a 'problem' in contemporary drug policy. The 2001 NDS viewed family involvement as 'a crucial component in the treatment of the young people' (DOTSR, 2001, p. 118), and the 2009 NDS recommended further development of family therapy services (DOCRGA, 2009).

The new focus on the affected family as a site for intervention in 1997 is situated within an intensified focus on the family in European social policy during the 1990s (Daly and Clavero, 2002). This occurs in the context of a broader post-welfarist ideology where responsibility for social 'problems' is shifted from the state to communities, families and individuals (Miller and Rose 2008). In Ireland, policy developments included the establishment of the Commission of the Family in 1995 and a Department of Social, Community and Family Affairs in 1998 (Fahey, 1998). Family support services were underdeveloped in Ireland until the early 2000s, however, the *Strengthening families for life: Final report of the Commission of the Family* (1998) and a key report on family support (McKeown, 2000) paves the way for the Family Support Act and, in 2001, a new statutory agency - the Family Support Agency. Family support is now established as a key intervention and technology for governing socio-economically disadvantaged and 'at risk' families (Daly, 2013).

Another drug policy shift took place in 2001, when harm reduction became official government policy and the reduction of 'harm caused by drug misuse to individuals, families and communities' was communicated as a strategic aim in the new NDS (DOTSR, 2001, p. 4). However, no specific recommendations pertaining to supporting affected families were contained in the policy. This changed following a review of the NDS in 2005 when a dual problematisation of families as an untapped resource but also as needing support in their own right emerged, and family support became a new key drug policy priority (DCRGA, 2005).

The political commitment was evidenced through a significant increase in funding towards family support projects across statutory, voluntary and community sectors (DOCRGA, 2009).

This new problematisation of affected families is shaped by the developments in family policy in Ireland as previously outlined. However, it is also influenced by scientific knowledge with the emergence of a body of research on drug-related impacts on families in the late 1990s and the 2000s. In the UK, the 'Hidden Harm' concept (impacts on children of parental drug use) was introduced in 2003 (Advisory Council on the Misuse of Drugs, 2003), with a broader scope to also include parental alcohol use in Scotland and Northern Ireland (Public Health Agency/Health and Social Care Board 2009; Scottish Executive, 2003). The 'Hidden Harm' concept was broadened to include affected adults, with the UK Drug Policy Commission producing seven policy reports and evidence reviews on affected adult family members between 2009 and 2012.

Experiential knowledge and expertise were also influential in shaping policy discourse, with the formation of a new advocacy organisation for affected families, the Family Support Network [FSN], in 2000 which contributed to the 2005 mid-term review of the NDS and the policy consultation process for the 2009 NDS (NFSN, 2016a).

Following the review of the NDS (DOTSR, 2001), a stronger focus on rehabilitation emerged and a Working Group on Rehabilitation was formed. The Working Group's report, in 2007, noted activation and community 'reintegration' as key factors of successful rehabilitation; and it contained several references to the imagined active and untapped role of families as social recovery capital, exemplified here:

> Families of problem drug users have the potential to be key to the rehabilitative effort. Sometimes they are not adequately involved in the treatment/rehabilitation of family members. As many problem drug users live at home, families should be seen as partners

> and be centrally involved in the recovery process. Families can also be a valuable resource in terms of childcare (DOCRGA, 2007, p. 41).

The report provided five recommendations relating to families – three referring to affected families as service users in their own right and two referring to the potential role of families in rehabilitation. These were adopted in full by the 2009 NSD, with Action 41 aiming to 'Support families trying to cope with substance related problems' (DOCRGA, 2009, p. 101). The suggested interventions include: respite, counselling, alternative therapies, mediation, marriage/relationship guidance, information, support and advice. This suggests that the 'problem' of affected families is represented as 'coping difficulties', and that the 'difficulties' are represented as mental health and family relationship issues.

It is clear that affected adult family members are constructed as service users in their own right. However, this conceptualisation is nested within a representation of affected families as social recovery capital. Bacchi (2009) notes that multiple and sometimes conflicting problem representations are often embedded in policies. This dual representation is clearly articulated in the extract below from the NDS contained in a section entitled 'Role of families in rehabilitation':

> The active encouragement of family participation is recommended, subject to the agreement of the individual, and the reconciliation of problem drug users with estranged family members should be pursued. Families should be seen as service users in their own right (DOCRGA, 2009, p. 50).

It is an implicit assumption in this problem representation that family participation and reconciliation are important components of the recovery process. This evokes normative assumptions of an 'ideal' family that takes moral responsibility for and carries out expected duties and obligations in caring for dependents. These assumptions reflect a sociological

conceptualisation of the family as theorised by Parsons and Bales, where the family serves two basic societal purposes: socialising children into prevailing societal norms and values so that they become active and contributing citizens, and providing psychosocial support to adults (1956 in Chambers, 2012, p. 12). These function to meet the economic needs of a capitalist society and to maintain social order. With the focus on activation and social inclusion in drug rehabilitation, the family is here understood as a key factor in facilitating the transformation of the close relative using drugs to an ideal active and productive neoliberal citizen. Although Parsons' model of the 'ideal' family has since been discredited in sociological theory (Chambers, 2012; Marsh et al., 2009), its presuppositions continue to underpin policy discourse. The discourse also reflects the symbolic importance of the institution of the family in the Irish Constitution, where it is constituted as the cornerstone of Irish society. The emphasis on reconciliation denotes a will to safeguard the normative family ideal. The use of terms such as 'active encouragement' and 'be pursued' in the policy document works discursively to make the work of encouraging family participation and family reconciliation a legitimate part of professionals' roles.

Affected families are constructed as participants in the rehabilitation process and are therefore allocated shared responsibility for its success with other actors. At the same time, they are seen as needing interventions to build their capacity for coping, with the implicit assumption that when coping improves, they are better placed to support the family member using drugs. This works to legitimise professional interventions with family members. Through technologies of self (Foucault, 1988), family members are thus encouraged to transform into self-governing neoliberal subjects who assume responsibility for their own health and for that of their families. Families are prompted to responsibly support their close relative to access and progress through treatment; and, consequently, the close relative using drugs is thus governed through the family.

After the publication of the NDS in 2009, discursive practices such as family support policy templates for AOD services and the inclusion of affected families into drug rehabilitation protocols have followed (DOH, 2015; Drugs.ie, 2015). New governmental technologies (programmes aimed to shape the conduct of subjects in specific ways) have been introduced, for example the 5-Step Method, which attempts to govern the conduct of professionals as they are prompted to work with affected families in prescribed ways.

Political Implications

Harms linked to drug use are not evenly distributed as they tend to be concentrated in the most disadvantaged areas of society (O'Gorman et al, 2016; Stevens 2011). Impacts on families are mediated by factors such as social class, age, gender, family position, place and culture (Duggan, 2007; Orford, 2017). However, in the NDS these mediating factors are not visible. The analysis finds that affected families are constituted as individual 'problems' of behaviour, such as difficulties with family functioning and coping. At the same time they are assigned shared responsibility for successful outcomes of the drug rehabilitation process of their close relative. The suggested behavioural solutions place responsibility with individuals to improve family relationships, improve coping skills and engage with their close relative without consideration of different families' resources to do so. This precludes alternative policy solutions that address the political, socio-economic and gender inequalities that shape the experiences of affected families.

Understanding affected families as joint agents of recovery designates shared responsibility for successful outcomes with families without considering the 'complex, shifting, nuanced assemblage of beliefs, structure, function and emotion that comprise family and social life' (Barker and Hunt, 2004, p. 352). Furthermore, the emphasis on normative expectations of care, support and reconciliation ignores alternative accounts of families, such as families who do not

wish to carry out their expected obligations (Pahl and Spencer, 2004; Ribbens McCarthy, 2012). The interactions and relationships between the person who uses drugs, the family and professionals are produced as unproblematic and rational. This ignores the roles of emotion and pleasure in interactions and relationships. It also leaves asymmetrical relationships of power based on gender, generation or family position in families, or those between service users and professionals unchallenged.

Having traditionally focussed on the individual, the role and remit of AOD services have been reconfigured to also include working with families, and this is assumed to be an unproblematic and rational activity. For example, the right to privacy and confidentiality for the individual undergoing treatment is only briefly referred to once in the policy, with the dominant discourse being the benefits of family involvement. However, privacy and confidentiality are likely to be key issues for professionals, service users and families as policy is enacted. Prevailing stereotypes, stigma, concerns about the autonomy of the person in treatment, and different professional values and beliefs in relation to if and how families contribute to the 'problem' of drug use influence and constrain family involvement (Lee et al., 2012, Orr et al., 2014, Schanche Selbekk and Sagvaag, 2016).

Family support work has become increasingly professionalised with the implementation of standardised and accredited programmes such as the 5-Step Method into family peer support practice. Professionalisation can be understood as a strategy for governing conduct (Fournier 1999). These types of programmes are underpinned by psychological expertise and are framed as evidence-based, which privileges expert scientific knowledge over experiential knowledge. In contrast, knowledge based on experience has been the cornerstone of the bottom-up organised and community-based peer family support groups in Ireland since the 1990s. The possible effects of professionalisation are a dilution of such forms of knowledge and expertise, and a de-politicisation of community development activities (Meade 2012).

Conclusion

This article has applied Bacchi's WPR approach to analyse and theorise the space where drug policy and affected families intersectIn the context of adult drug use the analysis has identified a dual and discursively linked problematisation of families as social recovery capital and as service users in their own right emerging in the mid-2000s. A further problematisation of families as contributing to both the problem and solution of adolescent drug use has continued after its introduction in the mid-1990s. Implicit in these conceptualisations are assumptions about the 'ideal' family and active neoliberal citizenship.

As a result, affected families are increasingly placed under the professional gaze and governed 'at a distance' as the roles of a wide network of professionals are reconfigured to include affected families in their remit. Following the logic of Foucault (2007), the family has become more persistent in drug policy discourse because it is imagined as an effective medium both for governing individuals and for achieving biopolitical goals such as a healthier population and activation of excluded members of society. Rose notes that 'the modern private family remains intensively governed, it is linked in so many ways with social, economic and political objectives' (1999, p. 213).

Families are governed through responsibilisation, a key feature of contemporary neoliberal governmental rationalities (Rose 1999). The behavioural focus of the proposed solutions and the lacunae in drug policy around factors that impact on and mediate experiences of drug use in the family - such as class, gender, family position, place, stigma, marginalisation, and access to material and political resources - individualise complex social issues such as drug use and its consequences. Consequently, contemporary drug policy discourses are likely to reproduce inequalities, and reinforce existing asymmetrical power relations within families, and between families, the state and its network of actors.

Bacchi (2009) prompts the analyst to reflect on alternatives to existing problem representations. Policy makers and professionals may use the findings in this article to reflect on the assumptions that underpin policy and governing practices that relate to affected families; the privileged forms of knowledge and expertise currently shaping drug policy; and, the normalising processes shaping the current narrow structural-functional conceptualisation of families. This form of reflection can encourage further questioning; for example, could alternative policy solutions that have been foreclosed by this particular focus on families and by the silences in the policy be considered? Could different conceptualisations of and theories about families, using different forms of knowledge and expertise, be used to shape policy?

Studies such as the one reported on in this article aim to theorise. They do not seek to understand how discourse is interpreted, negotiated and operated by professionals and affected families. An investigation into the lived effects of drug policy using empirical material complements the findings reported in this article, and this work is currently being undertaken by the author.

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[1] A limited review of drug policy documents in other jurisdictions was conducted. This was restricted to European countries that had documents in English published on the EMCDDA website, the US and Australia.
[2] In Psychiatric Power, Foucault (2006) discusses this function of the bourgeois family in 19th Century France.