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More Than Not Enabling: What Research From the Deadliest Combinations Tells Families About Staying Present

FAHU Research Desk

November 2026

facingaddictionwithhope.com

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You have read the books. You have sat in the circle of folding chairs — the church basement, the hospital conference room, the community center that smells like old coffee — and listened to the other parents and spouses and siblings describe years that sound exactly like yours. You have been told, with great compassion and by people who have suffered deeply, that you cannot save someone who does not want to be saved. That covering for consequences is enabling. That the kindest thing you might do is let the situation become serious enough that the person you love finally decides to change.

That advice is not wrong. It has helped millions of family members stop destroying themselves in pursuit of something they cannot control. But there is a distinction the books often do not draw — between withdrawing *harmful behaviors* and withdrawing *presence*. The latest research, arriving from some of the most dangerous corners of the addiction crisis, raises a question that families deserve to take seriously: if perceived indifference from the formal systems around someone shapes whether they believe protective action is worth taking at all, might something similar operate in the relationships closest to them? No study reviewed here directly answers that question — their designs do not reach family relationships. But the pattern that emerges across this evidence is consistent with the inference, and the most morally defensible position for a family is not managed withdrawal but informed, non-enabling presence. What follows draws on four bodies of evidence in sequence — from qualitative accounts of lethal overdose risk, to observational data from care environments, to a broad systematic review

of social determinants, to a meta-analysis of family intervention trials — not because each proves the thesis, but because together they build a coherent case that families can examine and use.

What people facing the highest risk actually report

Vojt and colleagues, researchers studying what may be the most lethal drug combination in current circulation — co-use of opioids and benzodiazepines, which is involved in a large proportion of drug-related deaths — interviewed 48 people currently or recently using both in Bristol, Teesside, and Glasgow (Vojt 2026). Published in *Addiction* in 2026, the qualitative study used a socioecological framework and reflexive thematic analysis to examine not just what people did to manage risk, but what they believed was possible.

They found a split in how people answered the question at the heart of the research: *Can I keep myself safe?* Among those with higher self-efficacy and a sense of personal agency, the answer was yes — expressed in concrete harm reduction strategies, with consuming drugs in small batches offered as one example. Among those with lower self-efficacy, the answer was something different: *there is nothing you can do*. Not a decision to take risks, but a paralysis about whether anything could make the risk survivable.

The researchers traced this split back through participants' accounts and found it connected to something beyond individual psychology. Those who felt hopeless also perceived the systems meant to help them as indifferent or absent. "They don't care about us" ran the account. The perceived absence of systemic support — services that felt unavailable, inaccessible, or genuinely uncaring — shaped whether people believed that any self-protective action was worth attempting.

What Vojt's study examined, to be precise, was participants' perceptions of *formal service and system support* — healthcare providers, drug treatment programs, clinical services. The abstract's own language is

unambiguous on this point: "system and service-level support." The research did not examine family relationships as a variable, and its findings do not extend there directly. What the evidence establishes, within the domain it studied, is an association between perceived institutional indifference and collapsed self-efficacy around harm reduction. Whether the same mechanism operates in family relationships is a reasonable inference — if someone's capacity to believe that protecting themselves is worth trying is shaped by whether the institutions around them appear to care, the same question could plausibly arise about the people closest to them. But that inference is the author's own reading of the evidence, not a finding the study reports or tests. It is worth holding as a hypothesis; it should not be mistaken for a conclusion the research delivers.

What environments of genuine care produce

A parallel line of evidence comes from the first publicly recognized overdose prevention centers in the United States. Shaw and colleagues analyzed baseline data from the SAFER study (Study Assessing the Effectiveness of Overdose Prevention Centers through Evaluation Research), which recruited 494 OPC clients in New York City and Rhode Island (Shaw et al. 2026). The study was published in the *International Journal on Drug Policy* in 2026. The researchers asked participants about their experience of the OPC environment: whether they trusted the staff, felt safe, felt they could be themselves, and felt part of a community.

More than 70% of participants reported trusting staff, feeling safe, and being themselves *all of the time* — a finding that carries weight given the contempt and fear with which many people who use drugs describe encounters with health services. Using multinomial logistic regression with connectedness as the outcome, the study found that keeping naloxone nearby while using was a significant predictor of high OPC connectedness (adjusted rate ratio 1.91); those who visited the OPC most

frequently were twice as likely to report the highest levels of felt connection (aRR 2.00). Among the characteristics associated with higher connectedness, cisgender women also showed elevated rates (aRR 1.97; 95% CI: 1.17, 3.30); the analysis here focuses on the behavioral predictors most directly relevant to families.

The design is cross-sectional, so direction of causation cannot be established. The regression modeled connectedness as an *outcome* — asking what characteristics predict whether someone reports feeling connected to the OPC — with naloxone-carrying among the predictors, not the reverse. The statistic tells us that harm reduction behavior and felt connection to a caring environment tend to co-occur; it cannot say which precedes which. This evidence, too, was gathered in settings staffed by trained professionals, not family members. What it adds to the picture from Vojt is that in environments people experience as genuinely caring, protective behaviors and felt belonging move together — though neither study was designed to test anything about family relationships, and extending either finding to families remains an inference beyond what the data support.

What the broader evidence says about social factors and risk

Christopher J. Byrne and colleagues at the University of Dundee conducted a 2024 systematic review in *Harm Reduction Journal* examining psychosocial factors linked to overdose risk across a substantial body of studies and participants (Byrne et al. 2024). They grouped these factors into recurring themes — housing instability, income, incarceration, traumatic experience, and social network characteristics among them — confirming that the conditions around drug use, not just the pharmacology, determine survival.

The social network findings deserve careful reading, because they cut in both directions. Having more people in one's network was, in some studies, associated with higher overdose incidence — which makes

immediate sense if those networks include people who also use drugs. More connections is not, by itself, protective. What Byrne and colleagues suggest, drawing on prior work in their discussion, is that *peer social support* — the kind that reduces psychological distress and builds capacity for self-care — may be the relevant variable, not network size alone. This is the grain of truth in the enabling critique: being surrounded by people is not the same as being surrounded by people who actually help.

What families can do instead

For decades, the most common advice to families of someone who won't enter treatment has been drawn from twelve-step and detachment models: set limits, stop covering for consequences, let reality land. That advice is not wrong about specific enabling *behaviors* — covering debts, lying to employers, absorbing crisis after crisis — having harmful effects. It is, however, incomplete about what comes next.

Community Reinforcement and Family Training is a structured, evidence-based program that teaches concerned family members skills for engaging with their loved one — with the goal of moving that person toward treatment. A 2020 systematic review in *Addiction* by Marc Archer and colleagues synthesized 14 such studies, examining what delivery formats and participant characteristics drove treatment entry rates (Archer et al. 2020). Across 691 concerned family members and significant others, meta-analysis found CRAFT to be about twice as effective as controls and comparison groups for treatment entry. The highest rates, between 77% and 86%, came from programs combining individual and group sessions — but the variance across delivery formats was wide: individual sessions alone yielded treatment entry rates ranging from 12.5% to 71%, and self-directed workbook approaches from 13.3% to 40%. These numbers matter alongside the headline figure, because they make clear that the form engagement takes is not a minor implementation detail but a central driver of outcomes.

What distinguishes CRAFT from detachment-based approaches is not simply that families remain involved — it is that they learn a structured, skill-based method oriented toward their loved one's treatment engagement. The review covered studies of varying designs — some controlled, others not — and the comparison conditions differed accordingly. What the meta-analysis establishes is that CRAFT outperformed whatever the comparison condition was across those fourteen studies; because study designs varied, the evidence cannot isolate precisely how much of that advantage rests on structured skill-building over and above any family involvement at all.

The harder objection

The most direct challenge to this article's argument comes in two forms, and they deserve answers in order of their severity.

The first is structural, and it is the stronger of the two: *no source in this bibliography directly tested whether ordinary family presence — as distinct from a structured clinical program — reduces overdose risk or improves outcomes*. Vojt and Shaw studied institutional and professional settings. Archer studied a formal program delivered by trained therapists to family members who had enrolled in a structured intervention. The inference from that body of evidence to what a family member should do on their own is the author's own reading, flagged as such throughout.

This objection can be answered — but only partially, and honestly. CRAFT is not a clinician-to-patient treatment: it is a program that teaches *family members themselves* the communication and engagement skills the intervention tests. The concerned significant others in Archer's studies were parents, spouses, and siblings — people in the same position as families reading this article — who learned a structured approach rather than withdraw or simply absorb the consequences of continued use. What CRAFT establishes is not that any form of family presence reduces overdose risk, but that the specific way of being

present the program teaches outperforms comparison conditions in the studies reviewed. Someone who holds the view that this research doesn't support ordinary, untrained family behavior has a point the article cannot fully rebut — because they are right that it doesn't. What this evidence supports most precisely is not spontaneous presence but structured, trained presence, and CRAFT is the named intervention that families can seek out to close that gap. The article's thesis is therefore moral, not empirical: it does not claim that simply staying close has been proven to help. It claims that the evidence makes staying present — in the informed, non-enabling way CRAFT makes teachable — the most defensible position a family can take.

The second objection comes from the Byrne review itself: in some studies, having more people in one's social network was associated with *higher* overdose incidence. If that association holds generally, the advice to stay present is not obviously safe — a family member who remains in contact with someone who uses drugs is, by definition, adding presence to their network, and in some bodies of evidence more network presence correlates with more risk, not less.

The Byrne review's own analysis points toward the *type* of support as the relevant variable, not network size. What most plausibly explains the association between larger networks and higher overdose incidence — in the populations these studies examined — is that larger networks in this context often include more people who also use drugs: people who may increase access, normalize use, or be present during overdoses without being equipped to help. A family member who does not use, who is not covering for consequences, and who is engaging in the structured way CRAFT describes is a qualitatively different kind of network presence.

What you are left with

Go back to the folding chairs. The wisdom offered there — that you cannot control another person's addiction, that your own health matters,

that there are limits to what love can fix — is real, and it was hard-won by people who needed to hear it. None of what this research shows contradicts it.

What is worth questioning is a narrower claim: that your withdrawal *helps them*. The qualitative evidence from people at the highest overdose risk — people co-using opioids and benzodiazepines, navigating what Vojt's participants called "consumption roulette" — connects the capacity for self-protective action with whether someone perceives the formal systems around them as holding any care at all. That evidence concerns institutions, not families directly; applying it to family relationships is an inference, not a finding. But the CRAFT evidence speaks directly to families: structured, skill-based family engagement produces treatment engagement at twice the rate of controls and comparison conditions across the studies Archer reviewed.

You cannot make someone recover. The question the evidence presses families toward is not whether to hold yourself responsible for outcomes no one can control, but whether the *kind* of presence you maintain might matter. The answer the research points toward is informed, non-enabling presence — not because staying close is automatically protective, and not because the evidence proves that family presence reduces overdose risk directly. It is the most morally defensible position because the evidence makes it plausible: CRAFT outperforms comparison conditions when delivered in a structured, skill-based way, and the most defensible stance for a family is not managed withdrawal but precisely that kind of presence — grounded in what the evidence can establish, honest about what it cannot.

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