A Toolkit

Working with the children and families of problem alcohol users:

A Toolkit

comprising:

- A user-friendly and practical resource for professionals;

and

- Detailing a range of specific ways of working with the children and families of problem alcohol users[1].

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[1]This toolkit will focus on alcohol. Many services whose materials will be used will also work with problem drug use, and where appropriate this will also be covered. But the main focus will be on developing services for children and other family members affected by alcohol misuse.

[2]**Acknowledgements.** We would like to extend huge thanks to all individuals and organisations who gave valuable time and information, without which it would not have been possible to produce this Toolkit. We would also like to thank the AERC, who funded the work, Dr Jane Powell of the University of the West of England in Bristol, who was a co-grant holder and who provided the detailed information on economic evaluation, Alcohol Concern, particularly Bethany Williams who facilitated the Children & Families Forum, and Sue Fairhurst for her invaluable input into the design and production of the finished toolkit.

Introduction

A major barrier to organisations wishing to develop services to children and families of problem alcohol (and drug) users is the lack of collated information on **how to do so**. Organisations (specialist and generic) wishing to set-up a service or dedicated post have no guidance available on how to undertake such work. **This Toolkit has been designed to provide all the guidance needed to set up such a service and keep it going.** Not all of it will be relevant to you; it will largely depend on the type of service that you want or are able to set-up, and the kind of help that you want to be able to offer children and families affected by alcohol and drug misuse.

How was the Toolkit developed?
This Toolkit has been prepared by Lorna Templeton, Sarah Zohhadi and Professor Richard Velleman, who work for the Alcohol, Drugs and the Family Research Programme at the Mental Health Research and Development Unit (MHRDU – http://www.bath.ac.uk/mhrdu), a joint unit between the University of Bath and the Avon & Wiltshire Mental Health Partnership NHS Trust; and Dr Jane Powell from the University of the West of England in Bristol.

However, it has been developed largely from those who have spoken to us, e-mailed us and provided content for this Toolkit. We primarily used our existing networks to collate the information that is contained within the Toolkit. We were struck by the extraordinary passion with which everyone spoke to us and cannot emphasise enough how important this is for many of you who want to develop services in this area.

This Toolkit:

- Provides guidance on developing and delivering services to children and families who are affected by substance misuse.

- Will be of use to:
  - Specialist alcohol services;
  - Generic health, social care, and both adult and child mental health services/ organisations; and
  - Others (e.g. charitable organisations) interested in, or in the process of, developing a service for children and families who are affected by substance misuse.

There are four further sections to this Toolkit:

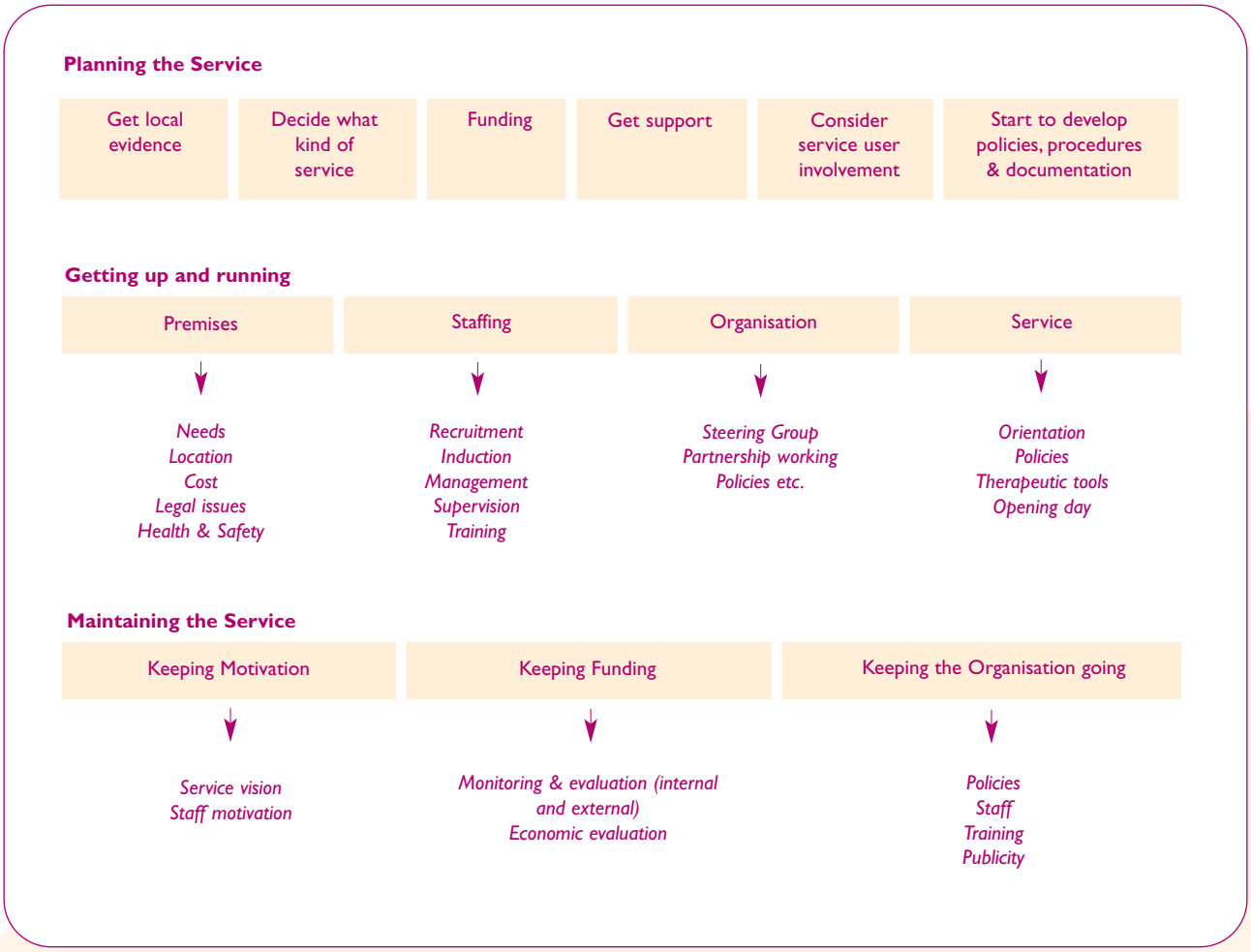
1. Planning the service
2. Getting up and running
3. Keeping going
4. Resources

Figure 1 maps the first three of these: the overall process of planning, setting up and maintaining a service. The next three sections in the appendices have two parts: a summary of the key issues to consider, alongside fuller details and examples from those who have contributed to the Toolkit. The Resources section includes useful reference lists and a checklist, covering all the issues highlighted in the toolkit, for use as a practical aid. The resources section also includes three case studies, from Wendy Robinson, Joan Anderson and Paddy Rafferty who share with us their journeys to establishing a service for family members, and some information on working with three special issues – domestic violence, child protection and children from black and minority ethnic groups.

It is important to emphasise that setting up a service for children and families is not an individual venture, nor should it be attempted in isolation. Potentially there will be issues of financial planning, building rental or purchase, health & safety, human resources or personnel, research & evaluation, and many others to consider. We recommend that, as much as possible, you should ask for help from others who are more familiar with these areas. This could be from colleagues, staff in generic alcohol (or drug) services, the Council, the Charities Commission or your local Council for Voluntary Services.

Figure One:

"Keep it simple, keep it understandable and keep it human."
Tessa Barrett, Families Plus.



We have not been able to speak to every single person or service in this field; nor was it necessary to do so. The examples in this Toolkit are a selection from a much larger pool that is out there. They are not intended to be the gold standard, but to provide guidance on some of the ways that some services have gone about dealing with some of the issues which we highlight need to be thought about when developing services for children and families, so that you are not completely starting from scratch.

If you decide that you might want to use some or all of parts of the documents contained within the appendices, then please ensure that they are referenced / acknowledged in the correct way, contacting the service or worker where necessary to clarify these details.

Furthermore, everything contained within this Toolkit does not need to be in place on the day that you launch or open your service! In a sense, the Toolkit collates what we suggest are the minimum standards necessary to be able to operate, alongside other, aspirational, standards that can aid the future development of your work with children and families. Where possible, we will try to illustrate those parts of this resource that relate to minimum standards, and which areas are more aspirational. Whatever you are able to do to help children and families affected by alcohol misuse, you can't be 'all things to all people'. **Whatever you do will undoubtedly make a difference.** It is important to acknowledge this, as it will enable you to move forward without over-extending yourself or minimising what you have been able to achieve.

It is also worth bearing in mind that it is not within the remit of this Toolkit to provide detail on how to work with children and families affected by substance misuse, nor to provide detail on therapeutic interventions. What is provided is an overview of some ways of working, and ideas of where to search for further information in this area.

A focus on Alcohol

Alcohol does not have the 'glamour' or external interest of (illegal) drugs. It is a long-term, complex issue and as such politicians, commissioners, funders and some practitioners are wary of it. Some have tackled the 'unpopularity' of alcohol by applying for funding to do work on 'drugs and alcohol'; this dilemma may arise for you. The focus of this Toolkit is on offering help and guidance to those who wish to develop services for children and families affected by alcohol misuse. However, we know that many alcohol services are also drug services, and that there is usually a degree of overlap between these issues. Therefore, whilst the focus is on alcohol, we hope that the Toolkit may also be of use to those working in drug services. Indeed some of those who have contributed to the Toolkit work within alcohol and / or drug services.

Key messages

There is no panacea to meet the needs of children and families affected by alcohol misuse. The Toolkit contains contributions from a wide range of services, including from the statutory and non-statutory sectors, alcohol services, child focused services, family focused services and support groups. It will be up to you to decide what kind of service you wish to develop, that fits in with how you think and work, the community in which you operate, and the attitudes of commissioners to what they might be prepared to fund. **Whatever you do will be well received by children and families in your community.** What stands out is that children and families need help, that this is (slowly) being increasingly recognised, and that they benefit from the help that is available to them. However, often the development of services to children and families is in conflict with national policy, and national / regional / local priorities and pressures, and this will sometimes make your job a particularly challenging and demoralising one. It is to the credit of those working in this field that they are engaged in a non-stop battle to move the policy agenda forward and demonstrate motivation and passion is doing so.

How to get the Toolkit

Limited numbers of the Toolkit in 'hard copy' are available from Lorna Templeton. The Toolkit is also available online, from the MHRDU at the University of Bath, and from the AERC (Alcohol Education & Research Council), who funded the work. Finally, sections of the Toolkit are also available, in whole or revised form, as web pages on the ENCARE (European network for children affected by risky environments within the family) UK website.

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Contributors

Although we have written this Toolkit, we have used material and ideas from a variety of services.

AWP Specialist Drug & Alcohol Services
There are eight drug and alcohol teams serving the Avon & Wiltshire Mental Health Partnership NHS Trust. The West Wiltshire team is working with the MHRDU to develop a more family focused way of working. Heather Steers is Team Manager. Joan Anderson runs a family support service at the Bristol Area Specialist Alcohol Service.

CASA, London
Offers a range of services for people with alcohol problems in North London. Hazel Jordan is CASA Manager.

Drinksense, Cambridge
Drinksense is a registered charity providing counselling, information and support for people with alcohol-related problems with their carers and families. Christine Greer is Drinksense Manager.

Family Alcohol Service, London
A joint initiative between the NSPCC and the Alcohol Recovery Project, which integrates child and alcohol services through a multi-disciplinary team to work with children and family members. Wendy Robinson is a Consultant and former Specialist Advisor to the NSPCC. Pat Ridpath is FAS Manager and Ann Waller is former FAS Manager.

Option 2, Cardiff and Vale
Option 2 works with families where childcare practitioners are concerned enough to be seriously considering the need for the child/ren to be accommodated. Rhoda Emlyn-Jones is Option 2 Manager and Mark Hamer is an Option 2 therapist.

MISSION imPOSSIBLE
(Trafford Alcohol Family Support Group)
This is a support group for adult family members, set up in 2002 and developed by Paddy Rafferty (who now facilitates the group), Linda Rigby and Colin Hughes (all Trafford Alcohol Service). While the group still draws Paddy's expertise and support, the family members have, with the help of Barbara Bleaker (Trafford CVS), recently gained some level of financial and managerial autonomy by forming themselves into an independent group with their own constitution.

CAFADS, London
CAFADS provides a service in London for the parents and children who are affected by substance misuse. Anniemae Shaw is CAFADS Manager.

Corekids, London
CoreKids helps children deal with the emotional and physical realities of having an addicted parent, whilst also supporting the parent and the family as a whole. Ian May is Project Director.

Families Plus, Salisbury
Families Plus is a part of the charitable organisation, Clouds. Nick Barton is Chief Executive of Clouds, Tessa Barrett is Head of Families Plus and Pippa Clarke is former Head of Families Plus.

KWADS, Bristol
KWADS (Knowle West Alcohol and Drug Service) is in one of the most deprived areas of Bristol. Originally established as a support group for mothers looking for mutual help to deal with drug problems in the area, the transition was made to a charitable organisation (Knowle West Against Drugs) in 1994. Kate Croucher is Chief Executive.

STARS, Nottingham
STARS is a national initiative, which seeks to support the development of, and sharing of good practice locally, regionally and nationally in regard to children affected by adult drug use. Karl Lonsdale is Team Leader and Sara Mayer is former Team Leader.

Wendy Robinson
Wendy Robinson is an independent consultant, trainer and clinical supervisor specialising in children, families and alcohol misuse. She is a qualified counsellor and play therapist, and has worked in front line services within the alcohol field for 12 years. Her work has focused on expanding the choice and effectiveness of services to children and families affected by alcohol misuse, and she has been involved in the design, development and running of a number of specialist services, most recently the NSPCC/ARP Family Alcohol Service in London.

Section One

Planning the Service

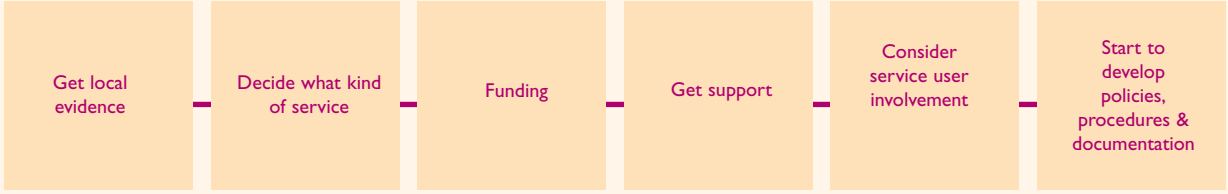
"After we finish talking today, obviously I am going to go back to my office and you will do your routine – whatever you need to do the rest of the day, such as feeding the children, looking over their homework, watching TV or whatever. And of course later it will be time to go to bed. And when all of your family members are sleeping and the house is very quiet, in the middle of the night, a miracle happens – and the miracle is that the problems you might have with your family, or other people think that you have, all the problems you face are solved.....Poof! Gone! But because all this happens when you and your family are asleep, nobody knows that the problems are all solved.....So when you are slowly coming out of your sleep, what differences will you notice that will make you wonder if there was a miracle overnight and the problem is solved?"

Taken from Mark Hamer, Preventing Breakdown, (2005, p53-54), Russell House Publishing

How do people come to think that a service for children and families might be needed? What gets the ball rolling? Once the basic seed of an idea has germinated, there are some general principles that need to be considered in order to develop or extend services into this area.

"There was a need for something in local communities that could start off the process of seeking help and change, provide information and ongoing support. This was the rationale for starting the family groups – it came out of an awareness that different types of treatment or support options are needed to suit the differing needs of different personalities at different stages in the process."

Nick Barton, Clouds.



Get local evidence to support your need

If you have decided that children and families in your area who have been affected by substance misuse are in need of a service, it is vital that you collate evidence to support this. You will need to use this evidence when you develop your proposal and present your arguments to potential funders. This section summarises some of the evidence and how it could be presented. Some of the literature listed in the Resources section will provide sources for much of the evidence that you might need. Some examples of how others have gathered evidence of need can be found in the Appendix for this section of the Toolkit. It is important to bear in mind that this process could, and probably should, include talking to family members themselves who, when asked, are very clear about what is needed.

Background

There are believed to be many millions of children and family members in the UK who are affected by the problem alcohol use of a close relative. These children and family members often have many needs, needs that are not currently matched by service provision or adequately recognised by key Government policy documents, such as the National Alcohol Harm Reduction Strategy for England (2004) and the National Treatment Agency's draft Models of Care for Alcohol Misuse (2005).

Services for people with alcohol (and drug) problems have historically tended to be very individualistic in their approach to treatment, viewing clients in a vacuum isolated from their families, friends, networks and communities. Where specific services that incorporate a wider vision have been established, they tend to be in their infancy and are few and far between. Generally, alcohol services struggle to grasp to what extent working with children and families should be part of their remit, and how they should best respond. On the other hand, recent moves within national child care (as opposed to substance misuse) policy (see Every Child Matters: Change for Children [http://www.everychildmatters.gov.uk], a cross-governmental programme of change to **improve outcomes for all children and young people**), are much more oriented towards proactive services working with all children and families. The overall aim is to ensure that, wherever possible, children can make the most of the opportunities that are available to them, with the central focus being holistically on the child rather than focused on any specific problems that they might be having. At the present time it is not clear that these differently focused childcare and substance misuse policies are being integrated.

It is known that:

- Parental substance misuse has an enormous negative impact on the family (children and other family members, for example grandparents), as well as on the misusing parents themselves.
- Problems can develop in all areas of life – physical health, psychological health, education and employment, finance, family life and relationships, social life, child development and parenting.
- Mental health problems, domestic violence and drug problems (with both illegal and prescription substances) can be particular issues for this group of families. There may be differences for families according to a number of variables, for example, ethnicity, geographical location (urban versus rural), social class, and age / development of child.
- It is extremely hard to calculate just how many families / family members / children have been and are being affected. However, with more concrete data becoming available on how many people are problematic users of alcohol and other drugs, it has been estimated that there are some millions of affected family members, in the UK alone.
- The needs of family members have largely been neglected, within a historical focus on the treatment of those individuals with alcohol or drug problems due to their own personal use. Political attention (and therefore resources) has also been similarly focused.
- The impact of substance misuse on the family, and the needs of family members, has in recent years been climbing up the political agenda, within a broader recognition of the importance of working in a more holistic and systemic way. Similarly, research and service development in this area has been on the increase.
- There is a range of research and evaluation projects, and service developments, in this area, that are indicative of the potential for supporting children and families affected by substance misuse.

- Whilst the vast majority of children and families will be affected by the substance misuse of a relative, not all will develop the same type or degree of problems. This has led many workers in this field to suggest that some children and families seem to be **resilient**; some have attempted to research and describe how this phenomenon might operate in this population group. Following on from this, and linked in with the underlying message behind recent policy initiatives in the child and social care field, services are starting to consider how resilience could be developed and promoted in children and families affected by substance misuse.

Why it is important to work with the Family

Growing evidence suggests the importance and value of approaches that incorporate a focus on social support or the involvement of families and networks, either to offer support to family members in their own right or to include them more directly and overtly in treatment.

Generic health and social care professionals (such as teachers, health visitors, GPs, youth workers, etc.) may frequently come into contact with children who are affected by problems at home, and this can include substance misuse. Often, the first actions of these professionals may be to ignore the issue (feeling that it is too complex or that they do not possess the skills, knowledge or experience to respond) or hastily refer elsewhere (usually Social Services), citing child protection concerns. However, these professionals **generally do not need t**o refer that child on to child protection agencies, although this may be appropriate after further assessment. The argument here is that these children should not be treated any differently from children who may be experiencing other problems at home (for example, parental illness, parental separation or bereavement).

Instead, the focus should be on the child and their distress, by using some basic skills (which the professional should recognise that they already possess as part of their general professional training, and the pastoral role that they may have towards children and families) to give the child support and space to talk (and be listened to), to help them cope and make decisions about what to do. These simple skills include active listening, helping the child explore what they are doing now, and can or could do in the future, to reduce their distress, and helping the child recognise and access support from other adults in their lives.

What services are already out there?

A recent national mapping survey, undertaken by Alcohol Concern (Williams, 2004, available via the Alcohol Concern website), found that there are 59 projects or initiatives, largely in the alcohol service sector, that provide help to children and families affected by alcohol misuse. These services can be further broken down into the following typology:

Open access	Responds to all needing help
Specific aspect	A specific worker or team within an existing service
Specific service	A service specifically for children and / or families
Add-on	A substance misuse service but families are welcome
Co-ordinated	A substance misuse service but co-ordinated referrals welcomed
Spare capacity	Will work with families in any spare capacity

There are several key points to have emerged from this mapping survey:

- Three quarters of respondents reported that they are not meeting the needs of children and families.
- Whilst the number of services offering help to children and families has increased (which is an incredibly positive shift), it is important to highlight that this level of provision remains inadequate.
- Only 10% of services specifically offer help to children and families; yet over a quarter of those who responded to the survey spoke about work that they do with this group.
- There is widespread commitment to work with this group, yet numerous barriers prevent more being done.

What evidence to look for and how to present it

Consider the context described above and the general evidence that exists (see also the literature listed in the Resources section). What general arguments and specific, applied, local evidence, do you need to support the development of services to children and families affected by alcohol misuse? For example, local statistics on alcohol misuse, numbers in treatment (and what this might indicate about the numbers of children and family members who might be in need of support?), numbers of children on the child protection register (it is known that a primary contributory factor is alcohol / drug misuse in the family), data from the hospitals, prisons or police that could be applied to support your argument. Be creative in how you collate and present the data, so that it is as reader-friendly and clear as possible to those who you want to support you.

Consider also whether locally based researchers could help with the collation and presentation of evidence, for example, by conducting a needs assessment study. Wendy Robinson and Jenny Hassell did just that ('From Stigma to Solution', available from the Family Alcohol Service in London) as background work to support the development of a family focused alcohol service in two boroughs of North London. Their report contained a detailed literature review, which included evidence of effective interventions, a national mapping study, and a local needs assessment that further highlighted the real needs for the service in their locality.

Decide what kind of service you want to run

Three broad issues to consider here are:

a) Whether you want your service
   - to be one that is integrated with, or an add-on to, an existing service,
   - or for it to be a stand-alone or independent service in its own right.

b) Whether you want the service to be
   - completely voluntary (for example, volunteers running a support group),
   - or staffed by volunteers but where there are significant costs (for example, using volunteers to staff a telephone help-line, or using trained volunteers to offer counselling within a funded agency),
   - or a fully funded service.

c) Whether you want the service to be based within the statutory, or the non-statutory, sector.

Further detail to consider here includes the following.

- Even if you decide to run the service as a part of another existing one, it is preferable for work with children and families to be seen as a discrete part of the overall work of a service, with the appropriate allocation of time and funding. If time and funding is not allocated for this aspect of the service, it becomes very difficult to maintain. It may be that the work is started as an 'add-on' because one or more staff members have a particular interest in it. Many such services are started in this way, and get 'off the ground' through such a person's individual interest. However, it is much harder to sustain such a service in the longer term, because it relies solely on good will and the effort of workers who are probably already stretched, and (usually) when this interested person leaves the service (due to a job change or retirement) the work stops, as it is not embedded into the structure of the agency.

- Providing support groups for family members, or using volunteers for a variety of aspects of the service, can be cost-effective and accessible ways to offer help to larger numbers of families. However, it is important not to under-estimate what needs to be in place, even if this is 'all' that you are doing. Hence even using these cheaper methods will require other resources to be in place (premises, facilitators, policies, etc.). However, you may find that commissioners react more positively to something that is cheaper, and if you have already managed to develop elements of the service without approaching commissioners, you may find that they also react more positively to a service where parts are already in place, being used, and hence demonstrating need.

- It is important to consider what kind of theoretical model (or mix of aspects from several models) you will want to use and hence what kind of service you might offer. We look at this in more detail later in the toolkit (under 'getting up and running') but it is useful to consider at the outset what orientation and range of services you want to adopt, which might include individual work (with adults or children), art/play therapy, specific approaches to build resilience, network based approaches, family therapy or interventions, couples-based work, solution-focused approaches, motivational work etc. Existing knowledge, reading and discussions with others will be of great help.

To a certain extent, a relatively basic awareness and review of local evidence, needs and existing services (if any), along with your decision as to whether you can, or want to, secure funding, will influence the initial decision as to the nature of the service that you want to develop. Dovetail this with discussions with as many people as possible, to get their ideas and their support. This includes discussions with your current team members, community groups, local alcohol and /or drug services, mental health services, social services, user / carer groups, and even preliminary discussions with local commissioners. Often, individuals are highly aware of the needs of families, and the gaps in service provision, but feel too stretched to be able to respond. Working as a team could be a more manageable solution.

Get funding

"We believed in the group whole-heartedly but we needed backing – financial and organisational in order to really get it going…you need an infrastructure to draw from…in the end if the group had not gone independent, it would have fizzled out without that support."

Paddy Rafferty, Trafford Family Support Group.

First, it is important to highlight that funding may not be (immediately) necessary. For example, if you decide that you want to set-up a support group and you can facilitate it from within your own paid time (or do it as a voluntary extra), and if you can use existing premises for no extra cost, then funding may not be an issue straightaway.

However:

- It may be that you will need funding in the future, to keep going or develop your new service, so it always needs to be at the back of your mind.

- As outlined above, funding may mean that the new service is more secure (if it just relies on your voluntary effort, then if you go, the service collapses).

- It is always worth thinking about what you might be able to get funding for. For example, even a support group or help-line could benefit from some money to support publicity, literature, training, rental of premises, rental of 'phone line, etc. And if you are unable to secure any funding, then it is still important to be clear that what you are doing still has high value to it, to the family members who are the recipients of the service. Plus, it is worth thinking about how you can demonstrate the effectiveness of what you are doing, to collect evidence with which to try and get some funding in the future, to keep going, develop or expand.

Second, if and when you do need funding, do not under-estimate the amount of time that is needed for this, and get help wherever possible! The following points may be helpful to you:

- Have a really clear idea of what you want to do, and then try and find a funder that matches your values and ideas. Try to be a 'political animal' and match what you want to do with local or national funding priorities. Be creative in thinking about where you might go for funding; you never know who might be interested in supporting work in this area, or who may have it as a priority at any particular time. You can't have a sales pitch; you need to understand the people you are speaking to and pitch your proposals appropriately. Think about alternative ways of phrasing what you want to do that may make your plans fit in better with the funder's priorities. Use their language where possible and appropriate.
- Funding from statutory sources (Health, Social Services, etc) can bring security for longer periods of time than from other sources, so can be beneficial. However, accessing this funding can be very time-consuming so take time to develop good relationships with, for example, the National Treatment Agency for Substance Misuse, your local Drug (and Alcohol) Action Team, Community Justice Partnership, Primary Care Trust or Social Services.
- Detail on drawing up core service costs can be provided by services on request (for example from the STARS National Initiative). Dr Jane Powell from the University of the West of England has written a section for this Toolkit on economic evaluation and this is in the appendix for this section.
- Your local Council for Voluntary Services (CVS) will offer guidance on seeking funding, alongside many other aspects of running a voluntary (i.e. non-statutory) service.
- There are usually helpful guidelines from each funding body as to what they will fund and how to calculate your costs, but have a detailed list of what you want funding for (premises and associated costs [lighting, heating, furniture, insurance, phones, computers, other equipment, stationery], staff costs, supervision, training [including purchase of literature, conference fees, training courses], overheads [for example, management costs] etc.).
- Consider having volunteers as part of your staff team as these will also reduce some of your costs. However, remember that they will still need to be trained, managed, and supervised, and there will still be other costs for premises, running costs, policies, and so on. And although volunteers may keep your costs down, it is vital to make them feel valued and to integrate them as core members of your team (they are still 'staff' even if they do not get paid).
- Be as detailed as possible when drafting the funding plan; base your plan on what you think things will actually cost and gather evidence (estimates, last year's electricity bills, etc) to back up those costs. Try to avoid plucking numbers out of the air and then retrospectively deciding how the money can be spent.
- Consider identifying funding for evaluation as well as for the service itself.
- Keep copies of your application letters, forms and proposals so work for future grants can be reduced by cutting / pasting and adapting information from previous applications. And back-up all your computer work!
- Get an accountant to assist with financial monitoring and management (for example, funders will want details of how their money has been spent and the Charities Commission mandate the annual auditing of accounts). Training for you and any support staff (for example, administrative staff) in managing finances, databases etc. might be helpful. Furthermore, many funders will only release money in arrears, and this can bring additional challenges in terms of financial management.

Some examples from KWADS in Bristol and Option 2 in Wales of funding proposals that they have written and submitted are given in the Appendix to this section of the Toolkit.

"Get an accountant! The costings can be very complicated – funders may require detailed returns and records and this can be quite a challenge for someone without the appropriate experience, it is also very time consuming."

Christine Greer, Drinksense.

Get support

"When you are starting out, go to anybody and everybody with experience of families… The process consolidates your own understanding of the issues…but also raises awareness amongst the community and professionals who may later point family members in your direction."

Paddy Rafferty, Trafford Family Support Group.

We've already indicated that getting wide-ranging local and national support for your service is very important, and may make aspects of your work a lot easier. Suggestions for securing good positive support include:

- Nationally through organisations like Alcohol Concern, Adfam, Drugscope, the National Council for Voluntary Organisations, Association for Chief Executives for Voluntary Organisations, the Federation of Drug & Alcohol Professionals, and the Charities Commission (details of all these organisations are given in the Resources section); and

- Locally through links with other (statutory and non-statutory) agencies. Try and talk to anybody and everybody who has an interest in this area, and has experience of working with children and families (for example, health visitors, youth workers, Relate, child & adolescent mental health services (CAMHS)), and /or substance misuse (for example, statutory and non-statutory alcohol and drug services). This is an important part of the process as it consolidates your own understanding of the issues but also functions to raise awareness throughout your own community of the needs that family members of people with substance problems have.

- Invest in long-term relationships (for example, with your local Area Child Protection Committee or Strategic Partnership). Depending on your orientation, organisations like NIMHE (National Institute for Mental Health in England), the Association of Directors of Social Services or the National Probation Service may also be helpful.

- Talk to members of your team, visit and talk to local services, organisations and charities, try to attend a meeting of a service user group, make contact with partners of former clients to ask about their needs and vision for a service for children and families.

- Try to get as much support from people with the skills that you will need, who may be able to offer help for free or at reduced cost. You will need, for example, legal, and personnel, and possibly financial help, so getting a lawyer, someone from human resources and an accountant could be very helpful.

- A longer-term goal for your group or service might be to appoint a 'champion', a celebrity who has himself or herself been affected by the alcohol or drug misuse of a relative, and can add support and weight to your work. For example, Sarah Ferguson is a champion of Families Plus whilst footballer Tony Adams, journalist Fergal Keane and the late Mo Mowlam are just some of those who actively support/supported NACOA (the National Association for the Children of Alcoholics).

Service user involvement

When planning a service it is important (and many funders will require it) to involve some of the people who the service is being set up to help. So the 'service users' in this context are children and family members. This may cause some people to be confused, as many people will think that 'service users' are the people who use services because of their problems with their own use of alcohol or drugs, thinking of family members as 'affected others' or as 'carers' (the term favoured within the mental health field). But when you are planning a service for these family members, they become the 'service users' who need to be involved at all stages from planning onwards. It is vital to talk to children and families in the initial stages of developing and setting up your service, and it is important to consider the involvement of service users in the further development of your service (for example, as members of the Management committee, etc).

"Engaging family members from the start was fundamentally important not only because it allowed us to have a clearer idea of what family members needed, but also because it gave us a real sense of being in partnership with the family members as they strove for greater recognition of their situation and needs. Involving family members added a great deal of energy and seriousness to our attempt to establish support for family members of problem drinkers in Trafford."

Paddy Rafferty, Trafford Family Support Group.

Developing policies, procedures and documentation

Many documents need to be in place, some before you open (these are the basic minimum standards, without which you should not launch your service), some in the early days of running your service and some as part of keeping the service going. The table below indicates the whole range of policies, procedures and documentation, with those in purple the ones we suggest are minimal standards and those that you need before you open your service for the first day. Further detail of these, along with examples (which can be found in the Appendices to this and the next section of the Toolkit), is given in the next section of the Toolkit.

Service delivery
Mission statement – aims, goals, objectives, values, beliefs
Annual reports
Client information packs/leaflets – Internet and paper forms

Specific service policies
Confidentiality
Emergency procedures
Code of ethics and practice

Organisational structures
Accountability structures
Equal opportunities
Meetings
Processes – referral, assessment, recording, service delivery completion / exit
Organisational diagrams

Human Resources
Recruitment and selection, Job descriptions
Appointments and Contracts, including terms & conditions
Orientation and training
Supervision
Health and safety (include a lone working policy)
Grievance, disputes and dismissals

Board / Management Committee
Roles
Processes
Executive
Delegations

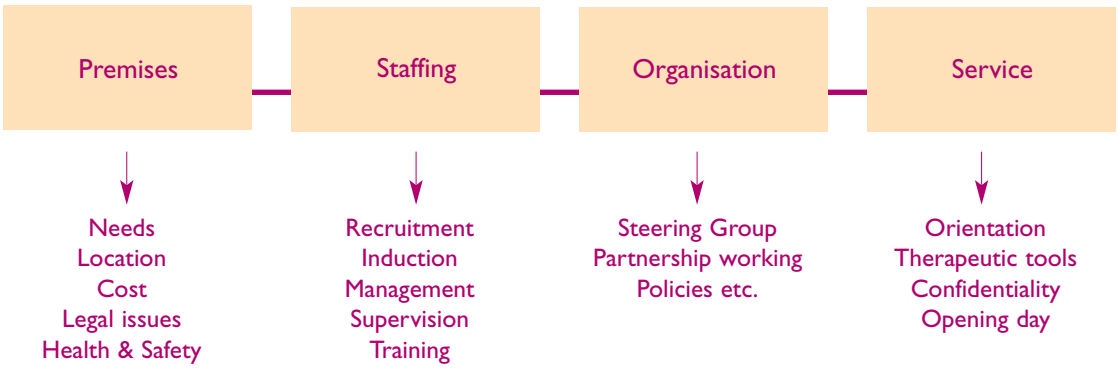
Administration
Financial planning
Insurance
Budgets
Paperwork – files, recording data etc.

Evaluation
Audit / inspection etc.
Evaluation policy, plan and strategies
Outcome monitoring, e.g., linkedto core funding requirements

Section Two

Getting up and running

This section will add detail to some of the content in the previous section, and will look at some of the issues that will arise as you move from initial planning of your service to the detail needed to actually launch the service and survive the early days.



Premises

An example from Families Plus of how they consider premises for their services is given in the Appendix to this section of the Toolkit. There are various things to consider:

Needs

Your decision as to what kind of service you want will leads on to clarifying your needs in terms of premises. For example, do you need a building with several rooms (for one-to-one counselling sessions plus admin support, staff space etc.) or do you need a room for a few hours a week to run a support group? If you already work with, or have good contacts at, a local alcohol (and drug) service (or at a local child/family service), then you may be able to use some of their space. Consider also what your needs are with regard to staffing, furniture, equipment (computers etc.), although you should have done this already in terms of your financial planning (see the previous section).

Location

We have already suggested that an early decision you will to make, based on the type of service that you want to develop, will be whether you need separate premises or whether you can integrate with an existing service. If you go for separate premises, it will be necessary for you to think about the actual location of your service and what this might mean for children and families travelling to and then finding your service. For example, is it possible to rent or buy premises on a bus route or close to a train or bus station or local car park? Can you get somewhere with some parking spaces of its own? If you intend to use the premises in the evenings (for individual work or to run a group), then are the premises in a 'safe' area of town or on a well-lit street?

Cost

Premises and Staffing (if you decide that you need either or both) will probably be the most expensive aspects of any budget that you need to put together. Where possible, seek help and advice from colleagues and financial experts, so that you can put together a realistic financial plan for your service, that will cover your needs in terms of premises, bills, staffing as well as costs associated with offering therapeutic interventions to your clients.

Legal

There are all sorts of legal requirements that you will need to fulfil, and areas where you will need legal help. Firstly, in relation to leasehold or freehold issues around your premises, negotiating the rental or purchase price, drawing up the legal documents, etc. Secondly, there are many laws (mainly relating to health & safety, insurance, etc, see below) that you will need advice on if you are offering a service to the public from your premises.

Health & Safety

It will be essential for you to ensure that the premises, and any facilities and equipment within the building, meet the required health and safety standards. If your service is part of an existing service, or you are renting or buying rooms within a shared building, then you should be able to identify who is responsible for health and safety and get their help to check your environment. A further option would be to contact your local council for advice. Information from the Charities Commission or your local CVS (Council for Voluntary Services) might also be able to help.

Staffing

Your decision as to what kind of service you want to establish will lead on to clarification about your staffing needs. Do you need paid staff or will you recruit and train volunteers (as counsellors, admin support, group facilitators, etc.), or are you planning on employing a mixture of both? Consider your team make-up and the possible benefits of being creative – for example employing a mix of substance misuse professionals and child workers. There will be various things to consider here. Seek advice from someone working in Human Resources or Personnel where possible. Written advice from your Council, the Charities Commission or CVS will be invaluable. Examples relating to aspects of staffing a service are given in the Appendix to the section of the Toolkit.

Recruitment

The recruitment process will require you to:

- Decide what posts you wish to appoint (options will include: manager, counsellors, admin support, psychologist, alcohol workers, family workers, child workers, volunteers, group workers / facilitators, trainers);
- Write job descriptions, person specifications and adverts;
- Set up and run an interview panel; and
- Offer jobs and appoint staff, which will include the need to write job offer letters and contracts.

Having (and adhering to) an equal opportunities policy will be important. Consider also whether you want to ensure that your staff are affiliated to appropriate professional bodies (for example, the British Association for Counselling and Psychotherapy) or have been trained appropriately (for example, that a volunteer has been trained under the VACTS scheme or meets the necessary DANOS standards).

Staff, particularly those working with children, will be required to have a full criminal records check, so make sure that you leave enough time for this, and for following up references. Consider how you will recruit, train and support volunteers. The majority of non-statutory agencies will be familiar with this so do ask questions and get help wherever possible.

Induction

It is vital to ensure that your employees / volunteers feel part of a team, and an induction process is a helpful way to structure this. If you are a new service, then you will need to develop such an induction pack / programme, but the advantage is that you will have the opportunity to induct all your staff in one go, which could be valuable for development of team spirit in the early days. On the other hand, if you are attached to an existing service then that organisation should be able to help with the induction process of your staff. Ideas for inclusion in any induction process are: an introduction to how the service will operate, details of all the little things that new staff need to know (for example, where to store personal belongings, where car parking might be available, how to use [and rules about acceptable use of] computers and the internet [if available], codes to use the photocopier, an e-mail address [if available], going through the paperwork for seeing clients [referral forms, assessment forms etc.]), when team meetings will take place, when supervision will be available, information on other local services, etc. Try to make sure that there is money in the budget for induction-period training, given that some staff members may be new to the alcohol field while others will be new to children and families work.

Management

Good management ensures that the service is well structured, organised and managed, so that staff know when they can ask for advice and support, both in terms of their clinical work, but also in terms of practical issues, such as where paperwork is kept and how to contact other local services, and in terms of policy development, and external relationships. Well-managed staff know what they are meant to be doing, and understand their responsibilities, as well as the limits on those responsibilities.

Supervision

The work that your staff will do with children and families will sometimes be upsetting and challenging, leading to the potential for a whole raft of negative emotions amongst your staff. Supervision is essential, particularly for staff who are dealing with emotional fallout from children and families living with alcohol misuse, and to monitor the work that is being done with children and families. Supervision should be regular and protected in terms of time allowed for it and where it takes place. It provides an excellent opportunity for everyone to share their experiences, ideas and to learn from other facilitator's approaches. Supervision also acts as a forum for discussion around good practice and new methods, and as such offers a regular opportunity to identify and meet training needs.

"It is important to have good supervision and support for facilitators to ensure quality and development of skills and ideas across all groups. This is an important element in continually adapting the model to ensure family members' needs continue to be met."

Nick Barton, Clouds.

Organisation

Steering Group / Management Structure

As has already been stated, whilst setting up a service might seem to be an individual and isolated venture, it is definitely the case that it should be about support and good working relationships with others. What this means for your service is that a clear management structure, alongside good networks with partner organisations, other local agencies, service users, trustees, financial advisors and others, all provide you with a supportive and protected context within which you can deliver your service.

Partnership working

You may find yourself working with more than one agency to set-up and run your service. Whilst such partnerships can be incredibly empowering and inspirational, they can bring their own challenges and tensions. For example, partnership organisations will have different fundraising methods, along with varying structures and procedures. You may find that each partnership organisation wants to take responsibility for the employment of different members of the staff team, but that different organisations have different terms and conditions that lead to unequal practices across staff. If your service bridges two key areas of service provision, then there will be a challenge in appointing a manager who has the required skills and expertise to bridge those gaps. Guidelines to help you include:

- Ensure that there is clear ownership of responsibilities within the partnership, and that named individuals have specific roles and responsibilities.
- Ensure that there is a strategic plan that includes how changes will be implemented and lessons learn from the pilot or initial period.
- Ensure there is a long-term financial strategic plan.
- Ensure there is money in any budget that covers evaluation and good quality external supervision.
- Draw up job descriptions and internal structures that reflect the needs of the service, not the originating or managing partner agencies.
- Ensure that there is one set of agreed policies and procedures covering terms & conditions (such as holiday entitlement, sick pay, pension arrangements, etc).
- Have a clear idea of the therapeutic model the service will use, research this well, have clear goals and outcomes not only for the service as a whole but for each individual client/family. Evaluate its effectiveness, making the changes that are necessary so that the clients get the full benefit from the intervention, and the staff, are helped to stay motivated because they can see that what they are doing is really working.

Policies, procedures and documents

Organisational documents to have in place (with those in purple felt to be essential to have in place before you open your service) include:

Organisational structures
Accountability structures
Equal opportunities
Meetings
Processes – referral, assessment, recording, service delivery completion / exit
Organisational diagrams

Human Resources
Recruitment and selection, Job descriptions
Appointments and Contracts
Orientation and training
Supervision
Health and safety (include a lone working policy)
Grievance, disputes and dismissals

Board / Management Committee
Roles
Processes
Executive
Delegations

Administration
Financial planning
Insurance
Budgets
Paperwork – files, recording data etc.

Examples of some of these documents are given in the Appendix to this section of the Toolkit. In addition the Stars project, based in Nottingham, has recently launched a website (see resources section for web address) which lists a number of policies and job descriptions the organisation has developed. Both these, and examples in the Appendix may be useful as a starting point when thinking about policies for your own service.

Service

"Have a clear idea of the therapeutic model the service will use, research this well, have clear goals and outcomes not only for the service as a whole but for each individual client/family. Evaluate its effectiveness along the way; making the changes that are necessary so that the clients get the full benefit from the intervention and staff and helped to stay motivated because they can see what they are doing is really working."

Wendy Robinson, Wendy Robinson consultancy.

As already pointed out in the introduction, it is not within the remit of this Toolkit to provide detail on how to work with children and families affected by substance misuse, nor to provide detail on therapeutic interventions. What is given here is an overview of ways of working (Orientation, below) and some therapeutic tools that have been used, with ideas in the Resources section and the Appendix to this section of the Toolkit of where to search for further information in this area.

However, a key resource, launched in Autumn 2005 by the Department of Health, Alcohol Concern and the University of Bath, is a series of individual Toolkits, which will offer support to specific professional groups to enable and assist them to work with children affected by parental alcohol misuse. Such individual toolkits have been or are being developed for Health Visitors, Children and Family Social Workers, Teachers, School Nurses, Practice Nurses and GPs, and Alcohol Workers.

Orientation

"This type of work or service is challenging to the system and requires a culture shift – people need to shift perceptions away from thinking there is 'no hope' for these families. We need to look away from the problems and focus on the solutions."

Rhoda Emlyn-Jones, Option 2.

There are three sorts of things that can be done to help families:

- Work with family members to promote the entry and engagement of misusers into treatment. Examples are the Pressures to Change model developed in Australia, CRAFT (Community Reinforcement and Family Training) developed in the USA, the ARISE programme, Network Therapy and Yates' co-operative' counselling service.
- Develop joint involvement of family members and misusing relatives in the treatment of the misuser. Examples are unilateral family therapy, behavioural couples therapy, network therapy, SBNT (Social Behaviour & Network Therapy) and CRAFT.
- Respond to the needs of the family members in their own right. Examples are Al-Anon, NACOA, CRAFT and the stress-strain-coping-support brief intervention.

All three have been tried, and all three work! Other references in the Resources section give further detail. It will be up to you to broadly review the evidence base and to decide what kind of service and model you want to operate, taking into account the local evidence of need, any other services which already exist, the views of those who you have talked to and networked with (including children and families themselves), your own ideas as to what you want to deliver, and any funding available to you and what that funding is for. Examples of how other services have gone about developing the therapeutic basis for their service are given in the Appendix to this section of the Toolkit.

There is a noticeable shift for services in adopting approaches that focus on protective / resilience factors and processes in their work with families This is the basis of the Family Alcohol Service and of Option 2, and the basis of the training alcohol professionals will be receiving as part of the Alcohol Concern/Parenting Fund project. The 'Strengthening Families' approach, which also focuses on building resilience in families, has proved popular in the USA, where it was developed, and has now been adapted for use in the UK, by a team in Barnsley. (For literature on resilience and more information about the Strengthening Families programme, including the Strengthening Families website, see the Resources section of the toolkit).

Therapeutic Tools

There are many that have been used: again, what is listed below is a small selection, with suggestions as to where to find out more.

- Values, Strengths and Goal Cards (see Appendix). These can be incredibly helpful, and are regularly used within a range of services (for example, Option 2 and the Family Alcohol Service). They are an excellent tool for prompting discussion, perhaps getting clients to open up, and finding out what is important to a family and the individuals within it, and they help plan the work that you will do. They can be used regardless of the level of engagement of the alcohol misuser. The cards can be bought (a Google search will provide plenty of ideas) or you can make your own. This could be a good team exercise and you can be as straightforward or as complex as you like. It is a good idea to always allow your clients to think of their own additional values and strengths and get them to make a new card to add to the pack. Chapter 7 in Mark Hamer's book (Resources section) gives an excellent overview of the use of these cards. His website, http://www.another-way.co.uk allows you to print off a set of cards that you can use yourself.

> "I must say as a practitioner I love working with cards. It allows me to remember and to ask all sorts of questions. It allows clients to choose to answer or not answer. Cards help clients to feel very relaxed, to interpret things in their own way, to challenge assumptions, to acknowledge the strengths and beliefs that they hold and those of other family members. Clients often find the cards very interesting and enlightening and have sometimes asked that I leave the cards with them so that they can use them on their friends. **Handing a pack of cards to a client is itself empowering.** "
>
> Mark Hamer, 'Preventing breakdown: A manual for those working with families and the individuals within them" (2005, p56)

- There are many questionnaires that could be used with children and families that may help you to assess certain aspects of your clients' lives and to assess change over time. This can be useful for ongoing monitoring and evaluation of your work (see the next section of the Toolkit for more detail). Many of these measures were designed for use in research projects but could easily be applied to every day clinical work. They can be used routinely or on a more ad-hoc basis to introduce a new approach to the work.
    - The measures could include: Symptom Rating Test, Coping Questionnaire, Family Environment Scale, Strengths and Difficulties questionnaire (adult and child versions), Adolescent wellbeing / Adult wellbeing, Alcohol use, Family Activity Questionnaire, Parenting Daily Hassles questionnaire, Recent Life Events, Beck Depression Inventory. References to these measures can be found in the Appendix to this section of the Toolkit.
    - If you use any of these measures then consider how they could be part of a more rigorous evaluation of your work, perhaps involving a research collaboration.

- Other tools might be the use of a spider 'network' diagram to consider issues of support to children and families, and how more good quality support could be obtained, anger management, parallel use of self-help tools including diary methods, parenting skills, relaxation techniques and play or art therapy.

- For more general ideas on working with children and young people, you could try the 'Evaluator's cookbook', developed as part of the National Evaluation of the Children's Fund, or you could look at some tools developed as part of a Joseph Rowntree funded research project (undertaken by Researchers at South Bank University) which spoke to children about their experiences of having brothers or sisters (their tools could be usefully developed for your work) (see the Resources section of the Toolkit).

- If you want your service to work with children, then there will be particular issues to consider (see box below). It is important to remember there are a number of ways to help children, and not all follow traditional 'therapy' lines, for example group support, fun and creativity sessions. It may be useful to make links with other services locally that provide direct services to children both for guidance, and to ensure you are not going to be providing the same thing.

- It is important to be flexible when engaging with families - be prepared to let families take time to settle in and begin to use the services on offer, and don't be put off if you offer a family service but parents are initially unsure about bringing their children along. You may also need to give some thought to helping parents prepare their children for attendance.

Confidentiality is a big issue that comes up in work of this nature. Talk to and learn from others, and be clear in the confidentiality and disclosure forms that you develop for your work. It is important not to hide behind confidentiality but to have clear boundaries in place so that you and your clients feel safe. You also need to be honest and upfront about how your service operates, and how confidentiality issues will be dealt with within that. The relationship between confidentiality to clients and information sharing between agencies will need to be clarified. However you choose to deal with these issues, transparency is vital so your clients know what to expect from you. Option 2 places a great deal of emphasis on transparency, and has developed a system whereby each family seen by the service is offered and entitled to their own service folder. This records all the work the family do with the service and is a record of all the information the service keeps about the family (see the Appendix).

If you are looking to work with families as part of an existing alcohol or substance misuse service, then try not to treat families any differently to how you would any other client, integrate them into your work and try to undertake your work with them in the same ways that the agency undertakes its 'core' work, rather than seeing work with families as an 'add on' service. There will be clinical and managerial decisions to make, however, around client files, note keeping, where notes are stored, how supervision works, and whether (and in what circumstances) workers might work over the same time period with both someone who is misusing alcohol, and someone who is their family member. Some organisations take a position that it would be inappropriate for the same worker to see different members of the same family; others that it is beneficial for the same worker to see all family members. There is no clear evidence that either of these positions is 'right'.

You will probably already have an agency child protection policy, but if you are starting to see children and families together for the first time, this policy will need to be more detailed that previously, in terms of what may be disclosed by child clients, or behaviour you may witness yourself.

Getting ready to open

Many new services are hesitant about advertising their service, as they fear that they will be inundated before they are ready to deal with a large influx. In reality, this is extremely unlikely, and most services only gradually build up their clientele. It takes a long time for people to know about a new service, and even once they do, it often takes a long time for professionals to refer people to the service or for individuals to approach it.

So promoting your service is a high priority and an ongoing task. For example, consider placement of flyers at the police station, shopping centres, through social services, GP surgeries etc. Try to attend meetings at local services to make a presentation and discuss your work, and perhaps even how you could work in partnership. For example, local Community Mental Health Teams, GP practices, Health Visitors, Domestic Violence Forums, user groups (such as through Families Anonymous and Adfam), libraries, dental surgeries and pharmacies. Consider also use of local media and the Internet. Do not under-estimate the power of word of mouth!

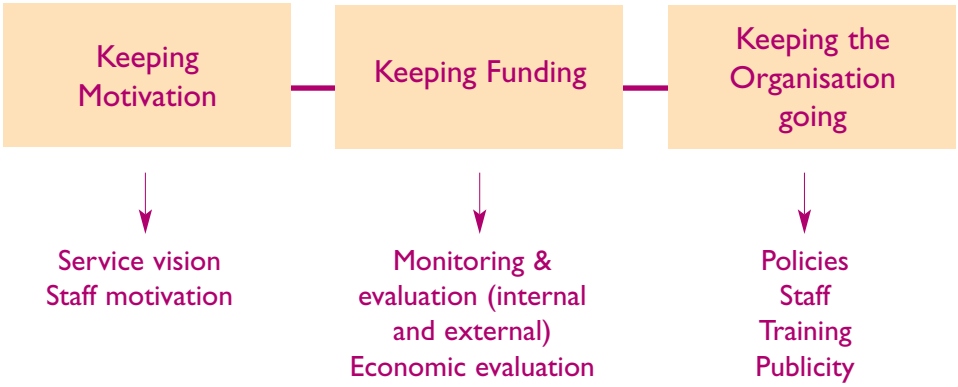
"Publicising services takes time and effort and is an issue to consider when looking into costing work."

Nick Barton, Clouds.

Section Three

Maintaining the Service

There is still lots to do once your service is up and running! After all the momentum, motivation and excitement in planning and setting up the service, it can seem an even greater challenge to keep the service going. Clear leadership and commitment are important from all those involved, as is close attention to the original vision for the service in the context of practice and policy change that may require creativity and flexibility. This section summarises the key things to consider at this stage to ensure longevity and effectiveness of your service.



"[You need] to be completely honest about problems you face – particularly with the funders. There is a tendency, because the project is 'your baby' and you are so passionate about it – not to want to admit when there are problems or things aren't working. But it is vital that you step out of that box in order to ensure you are doing the best you can for the family members. The funders appreciate this also."

Tessa Barrett, Families Plus.

Keeping Motivation

This can operate on two levels – maintaining the overall vision of your service, whilst attending to individual (including your own!) and team motivation.

Service vision

"A challenge is to fully understand what you want the service to achieve. To identify what the family members' needs are and how they can be met. The work must be grounded in this understanding."

Tessa Barrett, Families Plus.

It is likely that your original ideas for your service have evolved over time, and that they will continue to do so. Therefore, it is vital that you regularly (with your team, colleagues and peers) review the service vision, check that it is still appropriate, realistic and achievable, and use the review to identify things that need to be done to ensure that the vision is achieved. Team meetings, feedback from service users and team away days are useful ideas that you could adopt for this process. The Family Alcohol Service in London circulated a SWOT tool (Strengths, Weaknesses, Opportunities, Threats; see Appendix for this section of the Toolkit) for all staff to complete that gave all staff the opportunity to identify things that had gone well with the service and issues that needed addressing or developing.

Staff motivation

To a large extent, staff motivation is inextricably linked to team motivation. Ways of maintaining and developing team motivation include having good communication systems in place (such as having regular team meetings, ensuring that staff hear things directly as opposed to hearing first 'on the grapevine'), organising team away days, introducing new ideas or therapies or therapeutic tools, developing a website which actively promotes and disseminates the work of your service, and having social events. There will also be additional things which can be done to maintain and develop individual staff motivation: consider how supervision is run, how staff training needs are clarified and then met, how issues of pay, promotion and career pathway are addressed, consider the development of a website that individual staff could be involved in creating or adding sections to.

Keeping Funding

There are two main issues to discuss here. First, the extent to which your service is working, and the best way (for your area and within your resources) to deliver such a service. Internal outcome monitoring will be important here. Second, your plan to ensure continued resources for your service; this includes funding, staff, premises etc. In addition to routine, internal outcome monitoring, collaboration with an individual or a team who could offer an external service evaluation could be of benefit (external funders often prefer external to internal evaluations). Where possible, factor in at least some level of evaluation and monitoring from the outset, even including the financing of this in your applications for funding.

"Seeking funding year on year is difficult – there is a need to convince people over and over again about the value of your work. A real challenge is how to get the problem properly acknowledged and on a national scale."

Christine Greer, Drinksense.

Monitoring and evaluation

"The only way to ensure you are meeting the needs of your clients is to keep evaluating the services you provide – either internally or externally – the more objective the better. It is essential to keep learning and keep evolving to meet changing needs."

Nick Barton, Clouds.

"You need to be high profile in demonstrating effectiveness – be very robust in your scrutiny of the service and how you demonstrate outcomes."

Rhoda Emlyn-Jones, Option 2.

Monitoring and evaluation can provide the corroborative evidence to ensure initiation or continuation of funding, and it generates the necessary evidence base that allows demonstration at a national, regional and local level to policy makers and commissioners of the importance of effective services to this population group. Involvement of all staff, including Managers / Directors, paid staff, group facilitators, volunteers, reception / admin staff and services users, in monitoring and evaluation is important so that it doesn't feel like an imposition and is owned by all.

Monitoring and Evaluation is vital, but does not have to be comprehensive; do what you can within the resources and skills that are available to you, but if you cannot do much in the early days then do give thought to how this area can be developed in the future.

Evaluation can be very simple. It can be as basic as having a brief outcome / follow-up monitoring tool to provide some information on attendance, change, maintenance of change, etc. Remember that you may be required to have an external audit of your service; if so, think what minimal extra data could be included as part of this process, to add to the evidence of the impact that your service is having. If you are part of an existing service, then a process for monitoring and/or evaluation might already be in place; find out how you could get involved with this and include questions that will allow specific evaluation of your part of the service. Where possible, funding can be obtained for a larger scale, more

in-depth, process and / or outcome evaluation (involving collaboration with others, such as a research department). Several services (Family Alcohol Service in London, Families Plus in Wiltshire, STARS in Nottingham, and the Chrysallis Project in Sussex) have done just this. The results of monitoring and evaluation can be a useful resource to draw upon when writing annual reports, funding applications, giving presentations, going to meetings, writing service literature, etc.

Evaluation can also assist the organisation to develop. Families Plus told us how valuable an internal evaluation was to the initial development of their work. Their association with an established organisation (Clouds) of national repute was also very valuable and made the process of developing services for families easier in many respects. An evaluation of the first year of the Family Alcohol Service in London was useful in securing further funding, but it also allowed the staff time to reflect on their practice.

Examples of monitoring and evaluation tools, and references to evaluation reports and questionnaires that can be used, are in the Appendix to this section of the Toolkit.

Economic Evaluation

In recent years the demand for economic evaluation of programmes and services that impact on the health of the public has risen. Presenting figures and data, that relate to the economics of your service, in the language of the policy debate, can aid you in the quest to maintain existing and secure additional resources for your service. The Appendix to planning the service gives a broad overview of some of the key principles of economic evaluation, along with an example of how such an evaluation might be tackled. The approach is based on the key principles and structures of the Family Alcohol Service in London, but could easily be applied to other ways of working with children and families.

This might all seem very daunting!! We suggest that developing good relationships with your accountants or auditors (or those at the service to which you are linked or with whom you have good links) will greatly help with this part of running and maintaining your service. Additionally, collaboration with a local University or college department to undertake evaluation work is likely to be of benefit.

Keeping the Organisation going

There will be numerous practical, organisational and procedural things that you will need to attend to, in order to ensure the smooth and ongoing running and development of your service.

Policies, procedures and documents

All policies, procedures and documents will need to be reviewed on a regular basis, to ensure that they are still up-to-date (i.e. in line with national guidelines and policies) and relevant to the nature of the service that you are delivering. Part of this review process might trigger the need for new policies and procedures. It is useful to involve staff and users of the service in this review process.

Staff

Once your service has been operating for a while, there will be a need to check how your staff are getting on. Annual appraisals of staff are important to introduce and utilise, where training needs and new skill developments for each individual are examined, their progress against career goals can be monitored, and satisfaction with their job can be discussed (with possible changes of hours from full- to part-time or vice versa).

It may also be useful to undertake a more collaborative staff review, where the staff group contribute to a review of the way the service is developing, leading to clarification of what new or developing skills would augment the service, or whether additional paid or volunteer staff need to be recruited,

Also, staff (paid or voluntary, full- or part-time) will leave and replacements will need to recruited and inducted, and team relationships with new staff joining an established team will need to be carefully maintained and developed.

Training

Training is essential to maintain and develop the skills of yourself and all of your staff team. A large part of training involves training courses, though it can often be hard to fund them. If possible, try to make sure that the service has a training budget, and (if you are part of a larger service) that you can access that budget. Having good local links might also be helpful for accessing training (sometimes at no cost to your organisation), or holding reciprocal or joint training with other teams. It may be that you can only afford for one person at a time to attend a training course, but consider how information they bring back can be cascaded throughout the rest of your team (they could lead a training session for the team, or give photocopies of training materials obtained on a course to others, etc).

However, it is important to highlight that training can be much more than attending training courses. Buying, or having access to, a few key books, manuals, DVDs and journal articles will be a valuable resource for your stuff. Having at least one PC on your premises that has an Internet connection will also allow your staff to use the Internet to find information. Identifying the skills of your staff members and whether you could run internal meetings or seminars to learn from each other might also be a helpful idea, bringing additional opportunities to develop and maintain a positive team spirit.

Publicity

"There is a real need to keep promoting your service to referring agencies, as these are the people you rely on to help put family members in touch with your service. It is important to constantly keep awareness about what your service is, who it is for and how people can access it. You need to keep it in the forefront of referrers' minds."

Tessa Barrett, Families Plus.

The final issue to consider in terms of keeping your service going is about ongoing publicity of your service. This involves promotion of your service to referring agencies, commissioners and other stakeholders, service user & carer groups, primary care, social services, education, police, probation, schools etc. This can be achieved by: attending meetings, holding open days, giving presentations, writing newsletters, talking to the local media, or developing a website. Part of the publicity could include collated information from any outcome monitoring or evaluation that you have undertaken.

Finally

Keeping Going is fundamentally about the service that you offer, and ensuring that you do the best that you can within your capacity, to provide an accessible and beneficial service, whatever that may be, to children and families. It will be important, therefore, to keep an eye on the needs of your clients (children and families) and how these needs might change. Internal or external evaluation could be useful here. Be prepared to constantly reassess your work – be open-minded and willing to admit when things aren't working and to ask for help to make changes. Staff, clients and funders will appreciate this.

"I think the biggest challenge is keeping that going once the service is up and running, and making sure there is clear leadership and commitment to the original ideas, as well as flexibility from the partners to learn from the pilot period and implement the changes that practice has shown to be necessary."

Wendy Robinson, Wendy Robinson Consultancy.

"Don't give up, keep at it, it is hard work and there are challenges, but the challenges are all manageable."

Christine Greer, Drinksense.

Section Four

Resources

Index

1. Toolkit Contributors

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2. Case Studies

In the following three case studies, Wendy Robinson, Joan Anderson and Paddy Rafferty share with us their journeys to establishing a service for family members.

Case Study 1

Wendy Robinson is former Specialist Advisor at the NSPCC, and was instrumental in establishing the Family Alcohol Service, launched in 2002. Wendy now runs Wendy Robinson Consultancy.

Wendy had worked in the alcohol field, mainly with women and children, for about four years She had been gradually persuaded, by the clients themselves, and then research and literature she went on to read, that a family focused intervention to alcohol problems was worth pursuing. At the time she was working mainly with women who had young, dependent children and saw how services for them were hugely lacking in providing support on issues relating to childcare and parenting, and how the lack of focus on this did the women themselves no favours, for it was often the stresses of the parenting role that contributed to the way these women were misusing alcohol.

In conversation with the children themselves, Wendy was told many, many times that despite all the problems they still wanted to be at home with mum and dad, yet Wendy could not see how the interventions currently on offer supported this. She began to feel that there must be a middle way between leaving parents with alcohol problems to cope alone and serious child protection interventions from social services. She also wanted to think about how to build on families strengths, because although the alcohol use in these families may have got out of control, it did not automatically follow that parenting was all negative. Wendy had previously worked to develop services specifically for children because there was a huge lack of these, but the simple yet profound acceptance that children live mainly in families led her to further explore the development of services that were holistic and systemic.

Wendy's background and training is in therapeutic services, so she was drawn towards that kind of approach when thinking about the type of service she wanted to develop. However, she also realised that families need practical support as well, and wanted to see how the two things could be brought together. She had also observed how chaotic and stressed these families could be, and how expecting them to attend a number of different appointments at different places and with different services was setting them up to fail, so wanted to see how something could be provided under one roof. It also seemed essential that the service brought together expertise from both the childcare and alcohol fields because that was what was lacking: a service to bridge the gap between the two. From here, after much discussion with the NSPCC for whom Wendy worked, she was given the time to carry out a feasibility study with a colleague from an alcohol agency with whom the NSPCC were discussing the possibility of partnership. This study contained a detailed literature review and from this Wendy was able to collect evidence of effective interventions. The study also contained a national mapping study that showed hardly any services of this kind were available, and a local needs assessment further highlighted the real needs for the service in the locality.

From here on it was a case of doing things step by step, with a lot of personal focus and determination from Wendy herself, and the backing of the NSPCC, which has a central ethos of providing innovative services to support families and protect children. It took a lot of talking with managers, at operational and policy level. Once the feasibility study was published this opened a lot of doors because it was clear to see that the service was needed and possible to achieve. The two partner agencies then committed to working together to make the service happen, and used the feasibility study as the basis of a number of funding bids.

Wendy developed a therapeutic model that brought together her own experience of working in the field, the effective interventions that she had come across while doing the feasibility study, and solution focused and strength based therapeutic models and tools. The result was a unique model that has at its heart a clear initial structure to assist in successful engagement, followed by a less structured and more individualistic and openly creative method from there on.

Practical decisions were informed by and made with the help of a steering group and management group set up to oversee the setting up of the service. The steering group involved key people from both sides as well as members of the evaluation team that had been selected to be involved from the outset. Both organisations used their own usual methods for fundraising to try and secure the money needed (including for a built-in evaluation of the first year of the new service). It was not an impossible task as both agencies have a solid reputation, and the feasibility study provided much needed clarity and evidence.

There were many potential funders who could not be approached because of the large size and national nature of one of the partner agencies. Also some funders since the beginning have been interested to fund but have been unable to do so for this very reason. Many funders,

especially charitable trusts, are looking for smaller more independent agencies. However, those that were approachable were ones who were looking for innovative services rather than interested only in funding an alcohol service. The initial funders, the Camelot Foundation, were happy with the funding application and made no suggestions for changes. Securing funding beyond this proved more difficult, however. As a result, the larger of the partners has been funding the service from its own central pot while trying consistently to develop a service level agreement with the local authority whose clients are the main group using the service. It is likely that if this agreement and funding goes ahead then certain modifications will be required.

Wendy was able to continue using the premises she had been situated in whilst working on a small project for the NSPCC. In terms of staffing, agreements were made between the partner agencies on usual methods for recruiting staff, and for following the model for staff type and numbers as was recommended in the feasibility study. Staffing numbers had to be pared down slightly, however, as the funding that was secured did not allow for the numbers that had been recommended in the study. When organising policies and procedures, Wendy carried forward those already in existence – general policies and procedures - from the two partner organisations. In the months leading up to recruiting staff and opening the service, however, Wendy worked up the specialist internal policies, procedures, protocols, guidelines etc that the service would use.

Initial teething problems did crop up, particularly relating to staff recruitment. Another issue was that the generic structures and procedures that belonged to the larger partner were imposed on the service, and there was a clash here sometimes due to the fact that the new service was a specialist service and needed some structures and procedures that reflected this. Some tension existed therefore as a consequence of the nature of the partnership between the two organisations, one of whom is very large and national, the other that is small, specialist and regional. The generic structures of the larger partner did not always fit the specialist nature of the new service and there was not much flexibility, which made letting the service evolve naturally and grow organically quite difficult. For example, if Wendy and others had discovered through the running of the service that a new member of staff with particular skills was needed, this would not have been possible because the managing agency had strict structures about who could be employed within their services. Introducing complementary therapies was also difficult because this was not something that the managing organisation was in the habit of providing. Another challenge was getting good quality service managers who had the skills that bridged the gap between alcohol and childcare, therapeutic work and social work/family support. When the original manager left the post was advertised several times without success.

There were also issues relating to the division of roles and responsibilities between new staff and those who had been involved from the beginning. There was a consistent management group, steering group and advisory group who looked at these issues regularly. However, many were never resolved as such, just worked around and accommodated, not always to the benefit of the service.

The Mental Health R&D Unit at the University of Bath conducted an evaluation of the first year of the new Family Alcohol Service. It was hard to maintain once the external evaluators left, and the management did not have an immediate decision of how to incorporate the evaluation methods into general practice.
From Wendy's perspective, the challenges involved in developing the Family Alcohol Service were less about setting up the service – "there is a kind of momentum and excitement and high level of motivation at that stage, from all involved, especially in our case perhaps because we were doing something almost entirely new and across the board responses and support were positive" – but more about keeping going once the service is up and running. There is a need to make sure there is clear leadership and commitment to the original ideas, as well as flexibility from the partners to learn from the pilot period and implement the changes that practice has shown to be necessary.

Wendy feels the key lessons learned from the experience are to do with partnership working. Where a service is developed as a result of a partnership, it is vital to ensure partners are compatible, flexible and meet regularly. There should be clear ownership of responsibilities within the partnership – it is important to ensure that named individuals have specific roles and responsibilities. A strategic plan should be developed that includes how changes will be implemented and lessons learn from the pilot or initial period. There also needs to be a long-term financial strategic plan. It is important to ensure there is money in any budget that covers evaluation and good quality external supervision. Job descriptions and internal structures should be drawn up to reflect the needs of the service, not the originating or managing partner agencies.

Finally, Wendy feels it is important to have a clear idea of the therapeutic model the service will use – this should be well researched. Clear goals and outcomes must be developed not only for the service as a whole but also for each individual client/family. The therapeutic model should evolve, primarily through the evaluation of effectiveness along the way; making the changes that are necessary so that the clients get the full benefit from the intervention and staff and helped to stay motivated because they can see what they are doing is really working.

Case Study 2

Joan Anderson is a general health and mental health nurse, working at the Bristol Area Specialist Alcohol Service (part of the Avon and Wiltshire Mental Health Partnership NHS Trust Specialist Drug & Alcohol Service). Joan has worked hard to develop a specific service for family members of those with alcohol problems. She shares her journey here:

I have long realised that the family members of those with drinking problems can suffer greatly and that there is little or nothing available to help and support these people. Addiction services within the NHS have tended to concentrate on the drinker and his/her needs. The other concerned people caught up in the chaos tend to be shut out under the guise of confidentiality. In mid 2003 I sat down with my Manager to explore whether I could provide a service for the carers.

Planning stage:

There were a number of things that I did to try and give me the framework for planning what we could offer family members:

1. I informed the team about what I was hoping to do, to get as many ideas, pieces of advice, and suggestions from them as I could. Collectively they have a vast amount of experience and it was important that they believed I was putting my energy into something worthwhile.
2. I arranged visits or made telephone contact with organisations that had this type of support already in place or worked with carers in some way. This involved going outside the NHS to places in and around Bristol, and included Al-Anon.
3. I attended a meeting of our Service User Support Group for their collective support, ideas and advice. They were very interested and have closely followed my progress over the months.
4. I made contact with partners of former clients who have had support from us in the past for their suggestions and advice.
5. I drafted a leaflet to advertise the service. I involved my colleagues, our User Support Group and partners of former clients with proof reading and suggesting ideas for improvements. Good contact times to give out the information were at assessment, pre detox. appointments, and 1:1 appointments as well as via telephone contact.
6. I set up an information folder that contained details of the service alongside additional information on useful websites, general information and suggested reading lists.
7. I decided on the format of the service. This was to be a group that would meet on a Wednesday evening, between 6-7pm. I decided to try a group setting because I feel very comfortable with, and have a lot of experience with, group work. Additionally, it has the benefit of enabling me to deal with more than one person at a time and for carers to learn from one another's experience. I made plans around how to structure the hour.
8. I drew up a list of people who were prepared to be a 'guest speaker' in the group from my colleagues, Al-Anon and partners of former clients.
9. I discussed and made decisions about boundaries that would need to be in place, both for those attending the group, but also for myself. This caused me a lot of headache and worry. Would it be disruptive to someone receiving treatment? Would I get caught in the middle of the carer and the drinker? Most advice I received was that offering help can be very helpful to the carer and can also encourage the drinker to seek help. I decided that boundaries of confidentiality would be explained at the very beginning, adhered to and carers reminded often of these.
10. I thought about what documents I might need. I checked with our Trust the regulations around recording contacts with carers. I was told that I was under no obligation to keep records of any kind. I chose to monitor the service so I could assess its uptake and usefulness in the future by doing an audit. I kept a log of every person that telephoned, a snapshot of their particular problem and the outcome of the telephone call and if they attended group and how many times.

My overall aims and objectives:

- **To provide a safe service with clear boundaries that was of use to carers.**
- **To help carers understand their role in the alcohol dynamics.**
- **To help carers gain some insight into the drinking alcoholic behaviour.**
- **Empower carers to pick up the threads of their life and live their life.**
- **Begin to demystify and untangle the web of addictive behaviour and those trapped in it.**
- **To ensure that the carers feel supported. For no blame to be felt by the carers.**

I felt I needed further advice on how to engage the carers, what to avoid doing and saying and what their needs were. I contacted Al-Anon and they fed back to me that the most important things were to: acknowledge their pain; help them know somebody else has their pain; help them break their isolation; avoid lecturing them; remember that carers usually have to feel desperate to ask help; it can be a very delicate balance to engage them; and keep the message simple. Finally, I added to this list that a key component of work with family members - **to listen to them.**

The group was launched in February 2004. Word slowly spread, telephone contact increased and carers began to attend after a month.

Reality of running the service

- It has been a huge learning curve for me. Each new carer told me a story of a living situation that could feel overwhelming. My coping mechanism was to stay calm, still and not to panic; to give the carer time and the flow will gradually slow down; and, above all, listen, support and don't judge.
- One of the most amazing moments was having accompanied several carers through the early stage of their recovery journey, helping them gain some understanding of themselves, and then to watch their faces and hear them respond to a new member starting from scratch. They were able to say, "I've been there" and, "That was me a few weeks back". They were able to understand and help the new group member but also seemed aware that the new carer was too raw with pain to give them too much information.
- I knew before I started that the boundaries were vital for the safety and success of the group and experience reinforced this time and time again. I therefore make it clear to the carer:
  - That I will not discuss the patient's care with them but will talk generally about alcohol to answer any questions they might have.
  - Whatever the carer says to me will not be divulged to the patient.
  - Whatever the patient says in treatment will not be discussed with the carer.
  - If they want to discuss things between themselves at home, that is very different but I won't take information from one to the other.
  - I make all these points clear to the patient so there is no misunderstanding about this information.
- I find the best way to get these points across is at the beginning of contact with the service and to tell both parties at the same time. This minimises their worries and can lead to a lot more discussion at home.
- I had to remember that I cannot tell people what to do, only give information and make suggestions for them to consider.
- I had to consider the safety of the carers and myself. I ensured that all carers spoke to me personally (by 'phone) before they started attending the group; this 'phone call allowed me to conduct a risk assessment and to explore problems to make sure the group was appropriate for the carer.
- **After a while I decided to take out the word 'group' from the leaflet and call it a service**. I altered the leaflet to explain that sometimes there would be other people attending in the evening and sometimes it would be just them. This was to try and make the service more flexible and because some people are anxious of group settings.

The service now consists of the following: Telephone contact, a one off, pre-arranged, 1:1 appointment and a Wednesday evening group.

- I opened up the service to carers who did not have anyone attending our service. I noticed that a lot of the telephone calls to the unit were from people worried about someone who was not engaged in our service. These carers did not have any other form of support. It seemed to make sense to open up the support service to these people. As a result of this, I have seen evidence of contact with carers through the support service leading to the drinker entering into treatment at a later stage and doing very well.
- The guest speakers were brilliant. These have been from Al-Anon and partners of past users of the service. I would make a phone call and have never been refused. I arrange with the guest just how much of the hour they are able to remain so everybody knows just what they are doing. The face-to-face contact is by far the most powerful help for the carers.
- I realised that I had to accept that attendance would fluctuate and that this is the nature of the illness I am working with and not my fault.
- A problem was identified in that a carer could gain access to the service but their problem drinker could not. This was because a carer can just telephone and speak to me and no formal records are kept and I don't ask them their postcode before I speak to them. The person with the alcohol problem has to be referred and there are necessary and strict geographical boundaries around this.
- It is possible that the leaflet we give out is all the help that some people want or need at that stage.
- Carers can be as reluctant as the drinkers to seek help. They are possibly as hard to get into a situation of support as the drinker. Their recovery is a journey and this can only happen at their pace. This can be very slow.

Where are we now, and where are we going?

It took me eight months to plan and set up the service. It has been running for eleven months now.

- 27 carers have telephoned me, with 13 just wanting to talk on the telephone and requested nothing more, 4 wanting longer telephone conversations and asking for some information to be posted to them, 1 attending an individual 1:1 appointment.
- Of these 27 carers, some have just called once and others have called many times. This is quite a time commitment but you gradually build up a 'telephone, supportive relationship' with them.
- Many carers have met me in the unit building and have not needed to telephone. These are so numerous I have not kept a record of them.
- 13 carers have attended the group.

I plan to have the carers leaflet included on our Trust website, along with the other leaflets of our Alcohol service. This allows GP's and other professionals greater access to the information. I would also like to set up a pilot with a Community Mental Health Team in Bristol when I can assess how helpful it is to offer the service to carers of their clients who have alcohol problems.

It has been a rewarding and worthwhile journey of planning, implementing and discovery for me. I hope to maintain the service and continue to grow and evolve as and when it feels necessary to provide a useful and needed service.

Case Study 3

Paddy Rafferty is a former Senior Alcohol Worker (Team Leader) with Trafford Alcohol Service. Paddy also works with the Psychological therapies Team in Trafford as a counsellor and with Relate as a couple's counsellor. Over recent years he and his colleagues, and a group of family members, have worked to develop the Trafford Alcohol Family Group. This is a synopsis of their story.

The 'Family Group' has been developed within Trafford by family members to become an independent organisation with two goals – the first to provide support for adult family members of problem drinkers, and the second to highlight the issues family members face and to advocate on behalf of family members, in other words to put family members on the political agenda. The family members have now developed a greater level of autonomy by forming their own independent group with their own constitution. They have given their group the name of MISSION imPOSSIBLE, conveying the idea that there is hope even when things seem hopeless. The group is now able to draw on funding to help them maintain the group (premises, refreshments, literature, speakers and training). At the same time, the group still rely on Paddy to facilitate their group therapy sessions. Because of their autonomy, and because the group has now gone to meeting once a week, it does feel as if the group has now entered a new stage in their development.

Paddy became aware that, whilst their service only worked with drinkers, family members often came along too – they were often the people to make contact on behalf of the drinker, and they clearly had a lot of involvement in the process. Colleagues also had an awareness of these issues, and a concern that nothing could be offered to the family members. Paddy went along to his manager with his initial thoughts. She suggested it would be good to do some research around the needs of families (this role was added to his job description). From the very beginning they had the benefit of family member involvement – three family members in particular were very keen to help develop something and became strongly involved. A key characteristic of the work developed was the partnership between the family members and the workers.

The next step was to write to and meet with agencies that would have contact with family members and ask them what they knew about the families with substance misuse issues, what their needs are and what an alcohol service could do to address their needs. Alongside this consultation with other agencies, they held two focus groups with family members (12 family members attended). These meetings consisted of a question and answer session, followed by a brainstorming about what family members would want from a service dedicated to their needs. The result revealed that family members of problem-drinking relatives faced very specific issues – particularly shame – that they needed help with. They are often kept out of their relative's treatment and faced a 'veil of professional secrecy' even though they are the primary carer. The family members were very clear that they could play a very positive role in the treatment and support of the drinker and were advocating, where possible, the need for professionals to include them more and work with them in partnership. The

needs identified from a service were: support, outreach and training. It Is important to keep stressing the need for family members to have a group of their own and to educate families and substance-misusers about the necessity for the family members to receive support in their own right.

At this stage it was decided to respond to the needs of family members, given the limited time and financial resources, by setting up and running a family support group. The aim was to put something in place in the first instance to address the need as far as possible in this way, but for this to act mainly as a pilot with a view to developing something more substantial and integrated within the service in the future. Paddy and others felt that action would be more powerful than theory as far as commissioners are concerned. Setting up the group would demonstrate the need, and the effectiveness of working with families. They hoped that having something already running would eliminate any questions of how such a service would work.

The group had three main functions:

1. To provide support to family members – a safe environment for them to share their experiences and feelings
2. To provide education to the members by bringing in guest speakers (drinkers and family members) / experts. For many this has provided the first opportunity to ask questions and learn more. One of the regular speakers at the Family Group is Dr. Chris Daly, Consultant Psychiatrist in Substance Use, who has been a strong supporter of and adviser to the group.
3. To educate professionals in Trafford about the experiences of family members. The group organised two forums for professionals in the area in consecutive years looking at the impact of alcohol on families. A family member chaired the last Forum.

While the group has tried different formats it is now currently meeting one evening in the week for three hours. This has only been within the last month or so. Meeting once a week gives the group some continuity and it also makes it easier for people to know when the next meeting is. Trafford Alcohol Service has given Paddy the time to facilitate this group. The first hour provides time for informal chat, tea, and the presence of an alternative therapist to work on relaxation techniques and provide head massage. The next hour and a half is the main support group time with additional group discussions and business matters. The final half hour provides time for guided meditation and relaxation exercises.

The model that the group adopted was developed in an ad-hoc manner, through discussion with the group. Both facilitators had previous experience of group work and had worked together previously. They used this knowledge and understanding of the importance of creating a safe environment in which people can communicate and share. They set up some boundaries, including the importance of not talking about the drinker – the facilitators were aware that they didn't want to become drawn into a three way cycle where the fact they had knowledge of both the drinker and the family member could interfere in their work with either party. It has been difficult for family members not to talk about their relative but this 'rule' has been useful in terms of helping the family members to focus more on themselves, and to learn to talk about themselves and their own needs. The model has also drawn on an evidence base about what helps family members – drawing largely on work that suggests the benefits to focusing on coping strategies and a focus on the family member, not the drinker. One issue that does tend to come up about the drinkers, however, is the fact that family members feel very much left in the dark about their relative's care even though they are the main carers. Facilitators need to be down to earth in order to remove barriers and need to demonstrate a genuine investment in the group in order for it to work to it's full potential.

One challenge has been how to integrate new members. These family members need more time to share and to get support from others, whereas the focus for older members is generally on the education and political aspects of the group. It was decided to have more groups – in order to be able to continue with the remit of providing support (particularly useful for newer members) whilst also continuing with the education and business side of the group's activities. Meeting once a week should make it easier to integrate new members.

Whilst Trafford Alcohol Service has at all times been supportive of the group, the restrictions on the service has often meant that the facilitators of the group have sometimes had to draw on their own time and energy to support the group. A real issue has been the fact that it has been difficult to secure permanent premises – this and other resource issues have made it difficult for the group to move forward and progress. They have been unable to advertise the group too widely as there have been no fixed premises available to run the group from but also for fear of it becoming unmanageable within the constraints. This has been a difficult balance to achieve between keeping the group going, and using it to its potential whilst at the same time keeping it manageable. There was a thought at one stage that members may contribute financially, however, those who set up the group were against this and felt the service should pay to rent premises once a month. As time has went on, there was less money made available for the group. However, now that the group are able to draw on funding in their own right, they are able to rent a room from Trafford CVS for their meetings.

One important lesson that the group learned is to seek advice when trying to get funding. Until recently no funding for running the group was sought. However, the group ran two forums on consecutive years to educate and train professionals in the area about the needs of family members. The group applied for funding for these

events - they did not approach this strategically and just wrote to people they knew of – and got funding mainly because of the personal contacts they used. However it is very useful to seek advice from people who have experience of getting funding for similar projects. The group is currently getting advice from the Trafford Council for Voluntary Service, which offers guidance on seeking funding amongst many other aspects of running a voluntary group. Funding for the most recent Family Forum came from the Children's Fund and Health Action Zone (HAZ) in Trafford.

It is important to make sure that family members understand that the support group is not a miracle group – the group aims for 'progress not perfection'. The best times are when progress is visible – the members need to see that the group is 'going somewhere', and has a sense of direction. Stability is a key issue for running the group – problems with premises, funding and staff consistency have been difficult. Some family members have found non-attendance an issue, feeling disheartened by the struggle to keep the group going. People do move on so over the last number of years there have been changes within the membership of the group. However, there has been a small core group of people who have regularly attended the group and there has been a consistently high attendance (probably an average of ten family members) over the last number of years.

Paddy feels his involvement with family members has enriched his work as an alcohol counsellor. Working with this group has given him some access to the distress and pain associated with living and coping with the drinking of a family member. It has also allowed him to witness the spirit and courage of people who, in the face of what may often seem a hopeless task, still believe in the possibility of change and a better life. Finally, family members have challenged and informed Paddy's practice as an alcohol counsellor in terms of both the way he works with the drinker and the way he thinks about issues such as confidentiality.

3. Special issues

Introduction

There will be three issues that will be covered in this section of the Toolkit: domestic violence, child protection, and working with children from black and minority ethnic groups.

It is rare for alcohol misuse to occur in isolation; often it is combined with other complex issues, such as domestic violence, drug misuse, mental health problems, financial problems, unemployment, bereavement and ill health. Children and other family members can be at increased risk of problems if there are other issues present in addition to the alcohol misuse (accumulation of risk). Domestic violence (where there is also alcohol misuse) can be a particular problem for children and families. Cutting across all the problems that such families might face is the real risk that the child or children will be at risk of harm or neglect, necessitating social services involvement and thus notification of child protection issues. Whilst it is not the remit of this Toolkit to provide much detail on these issues, given the severity of the situation when these issues co-exist, and the particular impact that this might have on service provision, there is scope for exploring these two issues in a bit more depth. Further reading and details of other helpful resources is given in the Resources Appendix to this Toolkit. Examples of child protection policies and information sharing documents are also given in the Appendix to this section of the Toolkit.

It is important to highlight that it may not always be necessary or appropriate for services to try and work with children and families where these additional complex issues are present, with onward referral to other services needed. However, good relationships with domestic violence services and/or social services, for example, can mean that the training and support is there for your service to work with these complex issues, or to establish and maintain appropriate and beneficial shared care arrangements where appropriate.

The third issue to be explored in a bit more depth in this section is that of working with children from black and minority ethnic groups. It is particularly hard to estimate the numbers of children and family members who may be affected. What is known is that they will often have particular and additional needs related to culture, language, distance from country of origin alongside some of the consequences that often befall those from other cultures living in this country, such as poverty, unemployment, social exclusion and stigma. Accessing services can be a particular challenge for those wanting a service to be accessible to these populations. Women's groups, family support groups and partnerships with other (generic) agencies that work with black and minority ethnic groups are service models identified as potentially useful.

It must be noted that people from black and minority ethnic groups are just one diverse population group whose needs need to be particularly considered when setting up a service. Others include travellers, those living in rural communities, those with disabilities, the lesbian, gay, bisexual and transgender community, men/fathers, sub-populations of family members such as grandparents, and family members who are also dealing with a substance misusing relative who is in prison or who has died.

Domestic Violence

There is not much literature on the combined occurrence of alcohol misuse and domestic violence, and the experiences of children who live in such families, nor is there much help for families where there problems co-exist. What is clear is that where the two problems co-exist, they can bring severe problems for children, in both the short- and long-term. These problems include the children being at increased risk of themselves being the victims of abuse and violence, even if the domestic violence is not initially aimed at the children; and of them developing other problems, both in childhood and as they grow up.

Services need to understand that serious barriers exist which block people's access to help. Where problems of domestic violence in the family are severe, the parent (usually the mother, who will herself be a victim of violence) will often be also be very reluctant to seek help: this is because of a (realistic) fear that her parenting and the family environment will come under scrutiny, which could lead to social services becoming involved and, potentially, her children being removed. Thus, working with domestic violence coupled with alcohol misuse, particularly where there are children involved, can create real challenges for clinical staff.

This does not mean that such challenges should be shied away from! There is limited guidance on working with these issues, but training, information, support, and collaboration with other agencies are important. There needs to be agreement of clear referral criteria and assessment questions. It may be useful to use a Domestic Violence Screening Tool with all families that come into contact with your service. Good supervision for staff is vital. Cleaver et al. (1999) and Gorin (2004) are both useful references. Mullender et al. (2002) and Calder (2004) are useful books that look at children's experiences of domestic violence.

The Stella Project in London is one service that works to meet the needs of those who are affected by both alcohol misuse and domestic violence. A Toolkit has been produced, which is available from the Stella Project (details in the Resources appendix).

Recent policy initiatives with respect to children within the UK should start to move these issues, individually and collectively, higher up the agenda. These policy documents include: Every Child Matters: Change for Children; amendments to s.31 of the Children Act 1989; the Domestic Violence, Crime and Victims Bill 2003; and the National Service Framework for Children, Young People and Maternity Services (2004).

Child protection

This section will give some ideas, in addition to those elsewhere in this Toolkit described for generic professionals, as to how professionals can work with children, and each other, to help and support children and families.

If you are working directly with children, then there are certain things that should trigger immediate seeking of help and support from your Line Manager, and if they agree, then speedy contact with social services. If as a result of something the child tells you, you decide to do this, **it is vital to discuss your course of action with the child, and to offer basic pastoral support to the child in the meantime.** Such triggers to immediate action include:

- If a child discloses actual, current, sexual or physical abuse, or if it is clear that there is current serious parental neglect.

- A combination of factors, which in isolation would not require a referral, but together indicate that a referral is the best course of action (for example, combined domestic violence and serious parental mental health problems and major alcohol consumption by one or both parents).

However, it is very important to recognise that a referral to social services is not always necessary, though it is often the preferred course of action for many professionals who do not feel able to respond to children affected by parental alcohol misuse. Many generic professionals (teachers, nurses, etc) feel that somehow the presence of parental alcohol misuse means that they are unskilled to help the affected child, so they refer on to social services. The counter argument, demonstrated by recent policy initiatives such as Every Child Matters, is that professionals should respond to the child and their distress, as they would to any other problems that children might have: i.e. they should respond to the child's needs, rather than have the alcohol (or drug) misuse of the parents as the primary focus.

Following the Victoria Climbie inquiry, substance misuse services are now required to ask all adult clients about any children that they might have, and to record certain factual information about all families and their children. Thus, it makes sense for all services to fully consider how well they are able to respond to their younger clients, and to have a clear understanding as to their responsibilities, to what can be done without involving social services, and when such a referral is necessary.

All local authorities will have child protection guidelines: your agency should have copies, plus they will usually also be available on-line. These will be generic, covering all scenarios and not just parental substance misuse, but there will be lots there that will be relevant.

A number of local child protection committees have also produced guidelines to support professionals working specifically with children and families where parental substance misuse (including alcohol) is known to be a key factor. Examples include London, Bristol and Nottingham, and it is worth checking to see if your local area has child protection guidelines specific to substance-misusing parents. There are also national guidelines: the best is actually related to drugs not alcohol (the SCODA guidelines) but there is a great deal that is in common across these groups of parental problems.

The headings within the general assessment framework for assessing children's needs can also be extremely useful if you are attempting to decide whether or not the risks to children are such that you need to refer the family for a specific child protection assessment. Your assessment should examine: provision of basic necessities; the child's general health needs and whether they are being met; accommodation and home environment; the child's perception of the situation; the carer's perception of the situation; the family's social network and support systems; health and safety risks; the pattern of the carer's alcohol misuse.

A key barrier to working successfully with children, or to working successfully in collaboration with other agencies, particularly social services, can be confidentiality and information sharing. Some agencies have developed particular guidelines and policies to respond to this challenge; examples are given in the Appendix to this section of the Toolkit. Certainly, Every Child Matters, and other documents and guidelines to emerge as a result of this ground-breaking child care initiative, should further support the need for clarification of how, and a willingness to find a way, to work in collaboration and share appropriate information.

Examples of child protection policies, and an information sharing policy with social services, can be found in the Appendix to this section of the Toolkit.

Children from black and minority ethnic groups

Like children generally, children from black and minority ethnic groups can be at risk of developing problems as a result of living with one or more parent(s) or other adults with a substance misuse problem, including themselves developing problems with alcohol or drugs and of being subject to care proceedings (CPR registration, adoption etc.). However there is a real lack of research and practice in this area. It is important that these problems are highlighted and acknowledged and that intervention is delivered in a context that is sensitive to the particular needs that these children have and cultural and ethnicity issues that might arise.

The Children's Society STARS Project (Support, Therapeutic, Advocacy and Research Studies), based in Nottingham, has given particular consideration to children from black and minority ethnic groups in the course of its work; about a quarter of the children attending the project since its launch are from minority ethnic groups.

Issues identified as important include:

1. Children having unclear ethnic origins.
2. Different ethnic identities within sibling groups.
3. Racial stereotypes: the attribution to one racial group within a family of the role of 'perpetrator'.
4. Issues of racial identity.

"Practitioners making decisions about, or working therapeutically with, this group should avoid any temptation to view issues of "race" and the impact of parental substance use as separate phenomena. For this group of children, the two may be inextricably linked and must be assessed, addressed therapeutically and planned for as such".

(Sara Mayer (2004) The needs of black and dual heritage children affected by parental substance misuse. In Phillips R (2004) Children exposed to parental substance misuse: Implications for fostering and placement. London; British Association for Adoption and Fostering (BAAF) (Chapter 9; 145-162).

4. Useful References

Websites

Addaction	http://www.addaction.org.uk/
AdFam	http://www.adfam.org.uk/html/index.cfm
Al-Anon	http://www.al-anonuk.org.uk/
Alcohol Concern	http://www.alcoholconcern.org.uk
Parenting & Alcohol Project (Alcohol Concern)	parenting@alcoholconcern.org.uk.
Area Child Protection Committees (via Department for Further Education & Skills)	http://www.dfes.gov.uk/acpc/
Association for Chief Executives	http://www.acevo.org.uk
Association for Directors of Social Services	http://www.adss.org.uk/
BACP (British Association for Counselling and Psychotherapy)	http://www.bacp.co.uk/
Barnardos	http://www.barnardos.org.uk/
CAFADS	http://www.cafads.org.uk/
Charities Commission	http://www.charity-commission.gov.uk/
Childline	http://www.childline.org.uk/
CoreKids	http://www.corekids.org
Drug Misuse Information Scotland	http://www.drugmisuse.isdscotland.org/eiu/eiu.htm
ENCARE	http://www.encare.info http://www.encare.co.uk
Every Child Matters	http://www.everychildmatters.gov.uk
Families Anonymous	http://www.famanon.org.uk/
Families Plus	http://www.clouds.org.uk/family.htm
Federation of Drug and Alcohol Professionals (FDAP)	http://www.fdap.org.uk
Hidden Harm (Advisory Council on the Misuse of Drugs)	http://www.drugs.gov.uk/
NACOA (National Association for the Children of Alcoholics)	http://www.nacoa.org.uk/
NCH (National Children's Homes)	http://www.nch.org.uk/
National Council for Voluntary Organisations (NCVO)	http://www.ncvo-vol.org.uk
NFPI (National Family and Parenting Institute)	http://www.nfpi.org/
NIMHE (National Institute for Mental Health in England)	http://www.nimhe.org.uk/home
NSPCC (National Society of the Prevention of Cruelty to Children)	http://www.nspcc.org.uk
NTA (National Treatment Agency)	http://www.nta.nhs.uk/
Option 2	http://www.allwalesunit.gov.uk/index.cfm?articleid=313 http://www.another-way.co.uk/
Prime Minster's Strategy Unit	http://www.pm.gov.uk/output/Page1.asp
STARS Project	http://www.parentsusingdrugs.org.uk
Stella Project	http://www.womeninlondon.org.uk/archive/gldvpstl.htm
Strengthening Families	http://www.strengtheningfamiliesprogram.org
Women's Aid	http://www.womensaid.org.uk http://www.thehideout.org.uk (for children)

Leaflets

- Adfam produce numerous resources for children and family members. See the Adfam website or e-mail publications@adfam.org.uk

Policies, Guidelines, Tools and Standards

- Department of Health, Department for Education and Employment, Home Office (2000). Framework for the Assessment of Children in Need and their Families. The Stationery Office, London.
- Every Child Matters: Change for Children is the UK government's cross-cutting approach to support all children, http://www.everychildmatters.gov.uk
- NAHRSE is the National Alcohol Harm Reduction Strategy for England, http://www.strategy.gov.uk/work_areas/alcohol_misuse/index.asp
- MoCAM – Models of Care for Alcohol Misuse was in consultation form only when the Toolkit was completed. Keep an eye on the Alcohol Concern and NTA websites for more news.
- We Count Too, published by three family support charities, Adfam, Famfed and Pada, is good practice and quality standards for work with family members affected by someone else's drug use" [available online at http://www.drugs.gov.uk].
- Getting our Priorities Right, published by the Scottish Executive, is good practice guidance for working with children and families affected by substance misuse. http://www.scotland.gov.uk/library5/education/gopr-00.asp
- Kearney P, Levin E, Rosen G & Sainsbury M (2003). Families that have alcohol and mental health problems: A template for partnership working. Social Care Institute for Excellence. SCIE Resource Guides No. 1. Downloadable from: http://www.scie.org.uk/publications/resourceguides/rg01.pdf
- Kearney P, Levin E & Rosen G (2003). Alcohol, Drug and Mental Health Problems: working with families. Social Care Institute for Excellence. SCIE Reports No. 2. Downloadable from: http://www.scie.org.uk/publications/reports/report02.pdf
- There are quality and training standards that substance misuse services have to consider. QuADS (Quality in Alcohol & Drug Services) are Organisational Standards for services (Downloadable from: http://www.alcoholconcern.org.uk/servlets/doc/824). DANOS are the National Occupational Standards that describe the key standards of performance required of individual workers in the substance misuse field. The 90 units are grouped into 3 key areas (service delivery, management of services and commissioning of services), each divided further into a number of key roles. Downloadable from: http://www.skillsforhealth.org.uk/danos/standards.php
- A website produced by the ENCARE (European network for children affected by risky environments within the family) network (http://www.encare.info) includes its own Toolkit for helping those who want to set-up a website particularly for children.
- STARS in the UK has developed a website for children, http://www/parentsusingdrugs.org.uk
- The Evaluators Cookbook, published as part of the National Evaluation of the Children's Fund, contains 25 'recipies' for participatory evaluation exercises for use with children and young people. It is a resource for anyone working with children, http://www/ne-cf.org

Building resilience

- Bostock L (2004). Promoting resilience in fostered children and young people. Social Care Institute for Excellence. SCIE Resource Guide No. 4. Downloadable from: http://www.scie.org.uk/publications/resourceguides/rg04.pdf
- Gilligan R (2003). Promoting Resilience: A resource guide on working with children in the care system. London: BAAF. (See: http://www.baaf.org.uk/res/pubs/books/book_promres.shtml)
- Newman T (2004). What works in building resilience? Barnardos Policy and Research Unit. See http://www.barnardos.org.uk/resources
- Newman T (2002). Promoting Resilience: A review of effective strategies for child care services. Centre for Evidence-based Social Services, Exeter, England & Barnados. Downloadable from: http://www.barnardos.org.uk/resources/researchpublications/documents/RESILSUM.PDF
- Velleman R & Templeton (2005). Reaching Out – Promoting Resilience in the children substance misusers. In Evans D, Harbin F & Murphy M (2005) (Eds) Secret Lives: Understanding and working with children who live with substance misuse. Russell House Publishers.

Workbooks & resources for direct work with children affected by parental substance misuse

- Gorin S (2004). Understanding What Children Say. National Children's Bureau.
- Hastings J & Typpo M. (1994). An Elephant in the Living Room – The Children's Book.
- Heegaard M. (1993). When a Family is in Trouble – Coping with grief from drug and alcohol addiction.
- Hobday A. & Ollier K. (2005). Creative Therapy with Children and Adolescents. Impact Publishers.
- Kroll B & Taylor A (2003). Parental Substance Misuse and Child Welfare. London: Jessica Kingsley,
- Moe J (1993). Finding the Buried Treasure. Sierra Tucson Press (USA).

- NSPCC (1997). Turning Points.
- Oaklander V (1988). Windows to our Children. Gestalt Journal Press.
- Plummer D (1999). Using Interactive Imagework with Children – Walking on the Magic Mountain. Jessica Kingsley Publishers Ltd.
- Shapiro L (1993). The Building Blocks of Self Esteem – Activity Book. Childswork/Childsplay USA.
- Shapiro L (1994). Tricks of the Trade – Techniques to help children grow and change. The Centre for Applied Psychology, USA.
- Stallard P (2004). Think Good – Feel Good. Wiley & Sons.
- Sutherland M & Engleheart P (1993). Draw on Your Emotions. Winslow Press

Monitoring and Evaluation

- Some services have had their work independently evaluated. Evaluation reports of the Family Alcohol Service in London and Families Plus in Wiltshire are available from the authors of this Toolkit, or from http://www.bath.ac.uk/mhrdu. STARS in Nottingham and the Chrysallis project in Sussex can be contacted individually for copies of their evaluation reports. .
- The Scottish Executive has produced a guide on conducting evaluations of services and groups for families and carers of drug users. There is a lot here that is equally relevant to alcohol misuse, and that could be useful. See http://www.scotland.gsi.gov.uk or http://www.drugmisuse.isdscotland.org/eiu/eiu.htm
- Alcohol Concern has developed the Alcohol Outcomes Spider, an "outcomes tool for alcohol agencies to measure the key outcomes of their work with alcohol service users". Whilst targeted at those services working with alcohol misusing clients, the principles could just as easily be applied to work with children and families. Each of the eight 'legs' of the spider corresponds to progress in a particular outcome area – internal journey, social, physical health, emotional health, occupation, crime and community safety, relationships and alcohol. See http://www.alcoholconcern.org.uk/servlets/doc/909 for more details.

Measures

- Beck Depression Inventory. Beck AT, Ward CH, Mendelson M, Mock J & Erbaugh J (1961). An inventory for measuring depression. Archives of General Psychiatry 4, 561-571.
- Symptom Rating Test. Kellner R & Sheffield B (1973). A self-rating scale of distress. Psychological Medicine, 3, 88-100.
- Family Environment Scale. Moos RH & Moos R (1981). Family Environment Scale Manual. Palto Alto, CA: Consulting Psychologist Press.
- Coping Questionnaire. Orford J, Guthrie S, Nicholls P, Oppenheimer E, Egert S & Hensman C (1975). Self-Reported Coping Behaviour of Wives of Alcoholics and its Associations with Drinking Outcome. Journal of Studies on Alcohol, 36:1254-67.
- The Family Pack of Questionnaires and Scales. Cox A & Bentovim A (2001). National Assembly for Wales. London: The Stationery Office. Includes: the Strengths & Difficulties Questionnaire, Parenting Daily Hassles Scale, Home Conditions Scale, Adult / Adolescent Wellbeing Scale, Recent Lift Events Questionnaire, Family Acitivity Scale and the Alcohol Scale. Available to download from: http://www.wales.gov.uk/subichildren/pdf/facnf/facnf-questscales-2001-e.pdf

Special Issues

- Calder MC with Harold GT & Howarth EL (2004). Children living with domestic violence. Lyme Regis; Russell House Publishing.
- Mullender A et al. (2002). Children's perspectives on domestic violence. London; Sage.
- Galvani S (2004). Grasping the nettle: alcohol and domestic violence. London; Alcohol Concern Acquire magazine, Winter 2004.
- The Home Office has published a report on 'Tackling Domestic Violence: providing support for children who have witnessed domestic violence'. Home Office report no. 33 available via http://www.homeoffice.gov.uk.rds/pdfs04/dpr33.pdf
- Women's Aid has launched The Hideout, the first national domestic violence website for children and young people, at http://www.thehideout.org.uk
- Stella Project (2004) Domestic violence, drugs and alcohol: good practice guidelines. London: The Stella Project.
- Baird K (2005). Bristol Pregnancy and Domestic Violence Programme Training Pack. Bristol; University of the West of England. Kathleen has done quite a bit of work in this area; more details can be found via the UWE website; http://www.uwe.ac.uk
- Mayer S (2004). The needs of black and dual heritage children affected by parental substance misuse. In Phillips R (2004). Children exposed to parental substance misuse: Implications for fostering and placement. London; British Association for Adoption and Fostering (BAAF) (Chapter 9; 145-162).

General Reading on Addiction and the Family (not a comprehensive list)

1. Barber JG & Crisp BR (1995). The "pressures to change" approach to working with the partners of heavy drinkers. Addiction, 90, 269-276.
2. Barber JG & Gilberston R (1996). An experimental study of brief unilateral intervention for the partners of heavy drinkers. Research Social Work Practice, 6, 325-336.
3. Barnard M & McKeganey N (2004). The impact of parental problem drug use on children: what is the problem and what can be done to help. Addiction, 99(5), 552-559.
4. Brisby T, Baker S & Hedderwick T (1997). Under the Influence: coping with parents who drink too much. Alcohol Concern.
5. Cleaver H & Walker S (2004). From policy to practice: the implementation of a new framework for social work assessments of children and families. Child and Family Social Work 9;81-90.

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12. Evans D, Harbin F & Murphy M (2005) (Eds). Secret Lives: Living with substance: a Guide for Practitioners /Managers who work directly with children who live in substance misusing families. Lyme Regis: Russell House.
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14. Forrester D & Harwin J (2006). Parents who Misuse Drugs and Alcohol: Effective interventions in social work and child protection. Chichester; John Wiley & Sons.
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22. Miller W, Meyers R & Tonigan J (1999). Engaging the unmotivated in treatment for alcohol problems: a comparison of three strategies for intervention through family members. Journal of Consulting and Clinical Psychology, 67, 688-697.
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29. Rafferty P & Hartley P (2005, forthcoming). Shame about the children. A legacy of distress for adults who have grown up with parental problem drinking and family disharmony. Journal of Substance Use.
30. Rafferty P (2001). Shame, alcoholism and implications for treatment. Journal of Critical Psychology, Counselling and Psychotherapy, 1(3), 161-175.
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45. Velleman R, Copello A, & Maslin J (Eds) (1998). Living with Drink: Women who Live with Problem Drinkers. London: Longman.

5. Checklist

The following checklist (covering all the important steps and issues raised in the toolkit) has been designed for use as a practical aid when setting up a service.

✓ Checklist

Things to do / think about:

Planning the Service

- Get local evidence ☐
- Decide what kind of service to set up ☐
- Get funding ☐
- Get support ☐
- Consider service user involvement ☐
- Develop policies, procedures & documentation ☐

Getting up and running

Premises		Staffing		Organisation		Service	
Needs	☐	Recruitment	☐	Steering Group	☐	Orientation	☐
Location	☐	Induction	☐	Partnerships	☐	Policies	☐
Cost	☐	Management	☐	Policies	☐	Tools	☐
Legal Issues	☐	Supervision	☐			Opening Day	☐
Health & Safety	☐	Training	☐				

Maintaining the Service

Keeping Motivation		Keeping Funding		Keeping the Organisation going	
Service Vision	☐	Monitoring & Evaluation	☐	Policies	☐
Staff motivation	☐	Economic Evaluation	☐	Staff	☐
				Training	☐
				Publicity	☐