

Conclusions

This evaluation will add to the evidence base in this area. The evaluation will be accessible via this Briefing and in other ways, and it will be used to enable FAS to grow and develop. But a 12-month evaluation of a pilot project is too brief. Information needs to be collected beyond the boundaries of such a limited time scale. There is a need for something sustainable, which can become increasingly the FAS method of working.

FAS has made a significant contribution to both alcohol and family services, and has started to bridge the gap between them. Initial generous funding from the Camelot Foundation enabled FAS to start. A limitation for this innovative service however is that, to enable it to reveal its full potential, it requires both a development phase and a maintenance phase. The funding for this latter phase is not yet secure and hence whether or not FAS will survive for long enough to fulfil its potential is still unclear.

“I just feel confident talking to them ... you only have to talk to them if you feel like it ... its not the building, like the comfy room, it's like you can go there any time you have a problem” (girl, aged 13).

Further Information

The full Evaluation Report on the pilot year of FAS is available for £5 (incl p&p) from

Family Alcohol Service
88-91 Troutbeck
off Robert Street
London NW1 4EJ
Tel: 020 7383 3817

The report can also be downloaded via the following websites:

<http://www.bath.ac.uk/mhrdu>
www.nspcc.org.uk/inform/downloads/familyalcoholsevice.pdf
www.arp-uk.org

Further information about the Mental Health Research & Development Unit and details of research programme leads in the various programme areas (substance misuse, children and families, adult mental health, older adult mental health, alcohol, drugs & the family) is available from the Administrator;

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RESEARCH BRIEFING



The Family Alcohol Service: Evaluation of a Pilot

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Alcohol problems affect families negatively, and in many diverse ways. These effects include deteriorations in physical & psychological health, employment, education, ability to parent, relationships, family finances, and a range of family dynamics & functioning. Certain families may be at even higher risk: those living in poverty for example, or dealing with unemployment or lacking in social support. Children in these families can have a particularly hard time, often suffering from a wide range of behavioural difficulties, problems within the school environment, emotional and psychological difficulties, and (in younger children) developmental delay. Yet despite this huge range of problems, most services are focused on problem drinkers, not on their family members.

Many researchers and commentators have called for a more integrated approach, a more family focused approach to working both with affected children and parents and with problem drinkers, which concentrates on parenting and family functioning, instead of purely on simple child protection or drinking outcomes. There has also been a considerable national policy drive towards such a family focused approach, and it is likely that this impetus will continue with the imminent publication of the NHS National Service Framework for Children. In the Alcohol field there is also growing interest in the family dimension, and the Cabinet Office Strategy Unit has stated that the new National Alcohol Strategy will have a focus on 'vulnerable' and 'at risk' groups, such as children.

The lack of services to help families has been increasingly recognised over the past few years. In 2002, the National Society for the Prevention of Cruelty to Children (NSPCC) and the Alcohol Recovery Project (ARP), funded by the Camelot Foundation, launched a pilot Family Alcohol Service (FAS) to see if this might start to meet this need. FAS has at its core a model of an integrated service. The service is integrated in two ways: as a multi-disciplinary service, utilising a range of professions and integrating both alcohol-focused and child and family focused professionals and ways of working; and integrated in that it seeks to work with the whole family: the non-problem drinking parent, the children, other family members, and the drinker him or herself.



The Study

The evaluation of the Family Alcohol Service's first pilot year covers the period April 2002-March 2003, was funded by the Camelot Foundation and the NSPCC, and was undertaken by the Mental Health Research & Development Unit, a joint Research Unit of the Avon & Wiltshire Mental Health NHS Partnership Trust (AWP) and the University of Bath.

The evaluation was commissioned in order to examine the extent to which the pilot service achieved its aims. This involved identifying the range of people who used the service, the effect or outcomes of this service and the barriers and gateways encountered in providing this new service. The evaluation employed a mixed methodology utilising quantitative and qualitative data sources, including standardised questionnaires, interviews, focus groups, diaries and case notes. Detailed information was collected from both adults in the families and children, and from staff and referrers.

The Family Alcohol Service

A solution-focused therapeutic service is provided to all family members who decide to engage, and to significant others who have an influence over the welfare of the child/children. The focus is on the child and working with family members to reduce the impact of parental drinking upon them. The intervention has two stages. A first stage intervention with each family normally consists of 5 sessions, usually with two workers co-working and seeing some family members individually. In these sessions information is gathered from the whole family about all aspects of their life, with the emphasis on positive reframing, on what the family feel that they do well, rather than focusing on the presenting problem. Following the first stage intervention, the work involves any or a combination of: family sessions, individual sessions or couple work. There is an underlying family systems view of the work: that a positive change in one family member will engender change in others. Hence the service intervenes with family members separately and together to assist them to work towards their stated goals.

The pilot service has seven WTE posts (8 individuals). It is multi-disciplinary and multi-agency (some having a background in child and family services, others in alcohol services),

with the manager coming from NSPCC. An ongoing challenge for FAS in its first year has been the recruitment of staff into some of the posts.

- *“I think that this service and this model will take two or three years to develop, and with constant changes being needed to be made”* (FAS staff member).

Key Findings

Overall, in the first 12 months of operation there has been contact with 74 families, with over 30 of these families (over 40% of the total number of contacts) engaging with FAS for at least 1 session, 8 of them engaging beyond the first session but then dropping out, and 17 of them sustaining their engagement with FAS for a significant time without dropping out.

Source of referral

- There have been 30 referrals from Social Services Departments, 5 from statutory or non-statutory alcohol services, and 14 self-referrals, some following advice from other sources (alcohol agency, GP, college tutor and social services). The rate of self-referrals has increased over time.

The children

- The families contain around 120 children aged 18 years and under. At least half of these children are aged 10 years and under. The children are fairly evenly split between boys and girls. In about fifteen families there are 3 or more children aged 17 years and under. In 4 of the families there is a child with a disability.

- At the time of referral, many children in these families were on the Child Protection Register (CPR) or were the subject of Care Proceedings. Many children were living with other family members or were in care. Many had experienced stressful childhoods, had problems at school and were fulfilling caring responsibilities towards siblings and parents. Some children were suffering a lack of basic necessities such as regular, healthy meals, or sufficient supervision (being on the street late at night). Many children had difficulties with respect to peer problems, conduct problems and emotional symptoms.

The families

- At the time of referral, many families were experiencing a multiplicity of problems, including domestic violence, mental health problems (usually depression), difficulties with housing or employment, relationship difficulties, other substance use and bereavement. In some cases the problem drinker or non-problem drinker came from a background of alcohol misuse and violence. In many cases the parents are separated and the distant parent has little or no contact with the children. In cases where there are several children, these are often fathered by more than one man.

- In 8 families at least one family member is from a minority ethnic background,

- Initially it tended to be the problem drinker who engaged with FAS, but the numbers of children and other family members who have engaged has increased throughout the year. Unusually compared with findings from other evaluations, the service has been able to engage with single mothers who have alcohol problems. In 41 cases it is the mother who is known to be the problem drinker, though in a few cases both parents are believed to have problems. The father was identified as the drinker in at least 16 cases. Many of the drinkers also have mental health problems and some of the other problems outlined above.

- Problematic illegal substance use is known to be a factor in only 4 families. The vast majority of the cases engaging with FAS have alcohol problems alone, not jointly with illicit drug problems.

Outcomes

- *“There are nice kind people ... they listen to my worries”* (girl aged 8)
- *“It helps me to think about myself and things that I am good at, it shows you what type of a person you are”* (boy, aged 8).
- *“I came in here feeling full, now I feel empty, emptied out the problems I had, the worries I had”* (boy, aged 10).

Key work that has been undertaken with these families has involved focusing on parenting and family functioning, improving parent-child communication, and on keeping children safe.

- Family members (children, parents and others) have been enthusiastic in their praise for the service, and both referrers and FAS staff have reported significant success in engaging difficult-to-treat families in the change process.
- Children have become less anxious, and some have been able to express and resolve long standing negative feelings about their situations. Coping responses have also improved, as has school attendance, achievement and relationships in some cases. Children have started to show an increase in resilience characteristics. Changes have been made with respect to Care and Supervision orders and CPR registration.

- Parents have reported many major improvements in their functioning attributable to the service: being more able to cope, more aware of the impact that their drinking has had in the past on their children, and an enhanced commitment to ensuring that any such impact is reduced in the future. The appearance of many parents improved over time, attributable to increasing self esteem.

- Family functioning has improved in many cases: better communication, meals eaten together, joint parent-child activities: many children have been able to regain a sense of 'childhood'.

- 2/3 of the problem-drinking parents who engaged for 2+ sessions sustained abstinence or reverted to abstinence if they had a short relapse. Parents who were not able to acknowledge the impact of their drinking on their children were less likely to engage.

- The evaluation team have attempted to follow up families who did not remain engaged with FAS. In many cases families have experienced a variety of problems, often of a long standing nature, many of which (especially in combination) undermine parenting capacity and adversely affect child development, whilst making engagement very problematic for all parties. Some valid work was achieved by FAS with this group of families despite the limitations, but parent/carer non-engagement remained a key issue and precluded face to face work with the children.

Referrers viewed FAS very positively, although some felt that there was a need for greater clarity over the service's role. There is a need for further work on the issues of child protection, confidentiality, and information sharing.

- *“the way they guided us ... looking at our strengths, which made a big impression on me, looking at your own strengths and the kids looking at their own strengths and realising that they have got strengths ...it's such a positive thing ... it's easy to feel worthless”* (a father).

- *“... I got upset talking about my Mum and started crying and I went out of the room and got a bit of paper, and started writing down how I felt about everything ... it helped me to find a way to talk to my Dad and tell him how I was feeling”* (girl, aged 13).

Good Practice points

- There are significant benefits from the varied backgrounds (both alcohol and child care agencies) and utilisation of a multi-disciplinary team, with staff reporting major positives as being co-working, peer support, de-briefing, and supervision and support from the Manager, including over complex/child protection cases. Such high quality supervision is vital.

- Both staff and parents have reported that the orientation to obtain an holistic view of what is going on in a family has been very helpful: seeing the issues as more than something to do with alcohol and problematic drinking, and being inclusive of children as integral to family life and the part that drinking may play in it.

- Having a model that is flexible has proved to be very important: this has enabled FAS to alter their procedures to involve children far earlier in the process of engagement, when it became clear that too few children were being engaged. If children can be engaged, it is more likely that other family members will also engage.

Working with children

- Children identified a number of things about the approach that they found particularly helpful, including: feeling safe enough to be able to express some difficult thoughts and emotions without feeling they are being disloyal, reassured that information given will be contained

and not get back to the adult in question or make matters worse, working at the child's pace, and the importance of being "listened to" and "taken seriously".

- It is vital when working with children to be aware of the child's development and coping mechanisms and the way parental drinking may have affected their particular anxieties and related behaviours. It is also important to have different ways of working with children of different ages.

- Work with children and families to allow children to take a central role in their families is very important, enabling children to understand and feel part of what is going on, and part of decisions being made in the family.

Inter-Agency working

- Referrals from social services proved more difficult to engage than did self-referrals, but once the family has engaged, there are no strong differences in outcomes or the length of time a family continues to attend FAS.

- In families where engagement has proved most problematic, it has been suggested that more joint work, earlier and more detailed consultation about disengagement, and increased use of FAS in a consultancy role even when clients have dropped out, might improve engagement rates.

- Referrers could do more at the referral stage to stress FAS's willingness to meet the parent's needs, and to dispel parents' assumptions that they are predominantly providing an additional child protection role. FAS could consider further the impact of approaches to working with families experiencing high levels of violence, and clarify whether other services could offer support to family members at times when crises or mental health issues or concern about involvement with statutory services, affect attendance.