A BETTER FUTURE FOR FAMILIES:
The importance of family-based interventions in tackling substance misuse.
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ABBREVIATIONS

BtC                Breaking the Cycle
BCS                British Crime Survey
CSJ                Centre for Social Justice
DAAT               Drug and Alcohol Action Team
DfE                Department for Education
DIP                Drug Interventions Programme
FDAC               Family Drug and Alcohol Court
FIP                Family Intervention Project
NDTMS              National Drug Treatment Monitoring System
NTA                National Treatment Agency
TOP                Treatment Outcome Profile
ZCT                Zurich Community Trust

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The completion of this report would not have been possible without the help, support and advice of many people and organisations.

Firstly, we would like to thank all members of the Commission for their guidance, ideas and words of wisdom that were given so generously throughout the compilation of this report.

We would also like to acknowledge the ongoing support of Zurich Community Trust, in particular Pam Webb and Jane Boulton. Without their help Breaking the Cycle and this report would not have been possible.

We are also grateful to the local authorities that took the time to reply to our questionnaire; their contribution has been invaluable.

Finally, we must extend our utmost gratitude to Bianca Horn, Frank Birtwistle, Sue Hannah, Emma Cox and Cinzia Altobelli, Tim Vanstone, Claire Winship, Emma Bond, Thomas Cornwallis and Nick Crichton who all took time from their busy schedules to participate in our in-depth interviews. Together, their contributions have shaped much of the content of this report.

Thank you.
CHAIR’S FOREWORD

I am pleased to have been a part of this important commission of experts in the fields of addiction, families and young people and would like to warmly thank fellow members of the commission for their learned guidance, penetrating insight and careful analysis of the report’s findings and recommendations. I commend and congratulate the Addaction team not only for their preparation of this report but also for their considerable success in supporting families in recovery, and on behalf of all those involved I would like to extend my gratitude to Zurich Community Trust for their generosity in supporting the ‘Better Future for Families’ Commission.

My involvement in drugs and alcohol issues was not initially as a politician but as a criminal defence solicitor representing mostly addicted clients. My case files provided details of lives and families across generations damaged by addictive substances and I was witness to the terrible impact on children that substance abuse and the associated problems cause. It is these experiences that have given me the resolve to see where we can do better to improve the situation and so prepare future generations to live healthy and hopeful lives in stronger, safer communities.

Traditionally, Government at all levels has looked at the issue of addiction in terms of simply providing treatment for individuals. We have often failed to take account of how the troubles an addicted person face can have a severe and lasting impact on those closest to them, especially those in their care. Failing to address the resulting problems in shared family experience has not only impeded our efforts to effectively address the underlying and exacerbating factors encouraging substance abuse in an individual’s life; it has also led to a tragic growth in the number of people addicted as children. Those children whose adult relatives are struggling with addiction too often become a part of the destructive inter-generational cycle of drug and alcohol problems within families and communities.

It is my hope that this report will serve as more than an addition to the national commentary on the current situation, but will fire up and provide a spur and inspiration for those with responsibility for the improvement of local practice. The recommendations of this report, and especially the experience of the Breaking the Cycle project, should stand as a challenge and an encouragement to commissioners of services as they seek to confront the reality of inter-generational drug and alcohol abuse and work to empower and support families facing its consequences.

David Burrowes MP
COMMISSION MEMBERSHIP

We are proud to introduce the members of the ‘Better Future for Families’ Commission, all of whom bring unique insights and experience of ways to tackle substance misuse and who join us from Government, charity, education and business sectors.

David Burrowes MP: Chair

Before entering Parliament in 2005, David worked as a solicitor for Enfield firm Shepherd Harris and Co, specialising in criminal law and was an advocate in police stations and Courts in Enfield, Haringey and Hertfordshire.

In 2005-07 David helped lead the Conservative Party's policy work on drugs and alcohol with the Centre for Social Justice (CSJ). In 2007 David became Shadow Justice Minister.

In May 2010, David was made Parliamentary Private Secretary (PPS) to Oliver Letwin MP, Minister of State for Government Policy. Through his role, David is able to work at the heart of Government to help shape policy in a number of areas, including drugs and alcohol, the voluntary sector, and family.

Simon Antrobus:

Simon Antrobus is Chief Executive of Addaction and has been working in the voluntary and community sector for over 20 years. He has held senior positions in a number of national voluntary organisations and prior to joining Addaction Simon was Chief Executive of Clubs for Young People.

Simon also spent five years as a part-time detached youth worker in communities in Northamptonshire. He has served as acting Chair of the National Council of Voluntary Youth Services. He also chaired a national inquiry for the Centre for Social Justice chairing a commission team which produced Dying to Belong: An in-depth review of street gangs in Britain (2009). Simon has also chaired the ACEVO sponsored Public Health Commission and is a non-executive director of the Community Alcohol Partnership programme.

Tim Culling:

Tim Culling has worked in the financial services industry for 30 years and is currently the Head of Operations for Zurich's UK Life Insurance business. Also, effective from early 2012, Tim will take up the additional role of Chair of the Zurich Community Trust. The Zurich Community Trust in the UK is a registered charity and works to support a range of local, national and overseas charities - many selected by Zurich employees - with a mission to help disadvantaged people move from a state of dependence to independence.

The Zurich Community Trust has been proud to work with Addaction in piloting and developing the Breaking the Cycle (BtC) programme and remains involved in helping to develop and embed this important initiative. The Trust has committed £1.8 million to BtC over a five year period. In his role as Trustee, Tim has been personally engaged with and involved in advocating the work and success of the BtC pilots.
Michael Daniel:

Michael started on Addaction's Breaking the Cycle programme towards the end of 2007. Michael became a heroin and crack user after moving to east London in the mid nineties. He had a son in 2001 whilst still using, but decided he wanted to stop. It didn't work out and things started to go downhill. In November 2008 Social Services started court proceedings to have his son taken into care. Addaction's Breaking the Cycle was then brought in to mediate the relationship between Michael and Social Services. This summer, Michael went to court to show his parenting assessment certificate and in August got a care order to say he could have his son back.

Vivienne Evans:

Vivienne Evans has worked in health promotion and substance misuse prevention policy for 40 years. Before taking up her role as Chief Executive of Adfam, she was Head of Programme Development at DrugScope, leading on education and prevention work in a partnership project with Alcohol Concern.

She is a former member of the Advisory Council on the Misuse of Drugs (ACMD) and chaired its working group on the implementation of Hidden Harm. She is currently the chair of the advisory committee for the Family Drug and Alcohol Court project, the Substance Misuse Skills Consortium and a member of the NICE Quality Standards Drug Use Disorder Topic Expert Group.

Vivienne was awarded the OBE in 2008 for her contribution to substance misuse prevention and families work.

Christian Guy:

Christian is Director of Policy at the CSJ. He has led work on a number of CSJ publications, on topics including drug and alcohol addiction, prison reform, poverty in older age and the Coalition Government. He led the pre-general election implementation planning for the CSJ's criminal justice and addiction policy work, and was speechwriter to former CSJ Chairman Iain Duncan Smith MP. Christian is Assistant Director of Jonathan Aitken's Westminster Forum. Before joining the CSJ he worked as a Community Organiser for a partnership of local authorities, police, schools and voluntary sector organisations in Surrey.

Lisa Harker:

Lisa Harker is Head of the Strategy Unit at NSPCC. She was previously Co-Director of the Institute for Public Policy Research, one of Britain's leading think tanks. Lisa has worked as a policy adviser for several charities and government departments, including a stint as the government's Child Poverty Tsar. She lives in Oxford with her husband and two recently adopted children.
Bianca Horn:

Bianca Horn is a Systemic Family Therapist who has worked for Addaction as a Breaking the Cycle worker for more than three years in Tower Hamlets. With ten years’ experience, Bianca engages families - particularly parents - and their children in the service to reduce the harms associated with problematic substance use. Although Bianca is currently interested in clinical and social care coordination in the voluntary and community sector, she is a formally trained Social Worker and is also working in statutory settings such as the National Health Service as Honorary Group Family Therapist. She is an enthusiastic advocate for family - based services and champions approaches that aim to reduce risk and promote resilience in children's development and within families in general.

Joanna Manning:

Joanna Manning is Programme Manager at The Children's Society and leads on parental substance misuse and the impact upon children and families. She managed one of the first services in the country set up to support children affected and currently manages the Stars National Initiative, a hub of information and guidance on parental drug and alcohol misuse which provides resources and support to a wide range of practitioners, and works alongside local and national government to influence policy and practice. Joanna works hard to ensure that the voices of children affected are heard and that we have a workforce that is better equipped and skilled to respond to their needs. Joanna has 20 years' experience in the voluntary sector working with and for some of the most marginalised children and families.

Gracia McGrath OBE:

Gracia McGrath OBE is Chief Executive of Chance UK, an innovative early intervention mentoring programme for primary school children with behavioural difficulties. In October 2010 Chance UK won the Bank of America/Merrill Lynch Neighbourhood Excellence Award. In 2011 Chance UK won Most Innovative Charity at Britain's Most Admired Charities Awards.

Chance UK has grown under Gracia's leadership and runs a pioneering franchise scheme that sees the Chance UK programme run in partnership with other organisations across the UK.

Gracia is in her 10th year as Chief Executive of Chance UK and it was for this work that she was awarded an OBE in the Queen's Birthday Honours list in June 2009.

Gracia McGrath has worked in the voluntary sector for more than 20 years. She is a member of the Queen's Award for Voluntary Service (QAVS) Committee and Chance UK is a former winner of this award. Gracia was a member of the Working Group for the Centre for Social Justice (CSJ) report Dying to Belong: An in-depth review of street gangs in Britain (2009), an advisor on No Excuses – a review of educational exclusion (CSJ 2011) and the soon-to-be published report on youth justice.
Annie Steele:

Annie Steele is the Regional Development Manager for Swanswell. Swanswell is a national charity which helps people to remove the things that stand in their way - whether physical, emotional or practical - to overcome drug, alcohol and other problem behaviour. Annie worked in Accident and Emergency as an Registered General Nurse before moving into the substance misuse field and has worked for Swanswell for 15 years, initially as a GP liaison worker responsible for developing working with GPs with drug and alcohol users. She has held a number of posts including Service Manager in Coventry and Warwickshire and Assistant Director of Services. During 2005-06 Annie was seconded to Birmingham Drug and Alcohol Action Team for a year to further develop the shared care scheme and to increase the engagement of GPs working with all the relevant Primary Care Trusts to promote and encourage the treatment of drug users in primary care. In her role as Regional Development Manager, Annie is part of the team responsible for helping more people to benefit from Swanswell's new and innovative approaches.

Tim Vanstone:

Tim has 13 years experience of working within drug and alcohol treatment for Addaction holding many operational roles from Administrator through to Assistant Director of Operations and now Head of Breaking the Cycle - a post he has held since January 2011. This has enabled him to gain extensive experience of the impact substance misuse has on individuals, families and communities.

As Head of BtC his role is to oversee the operational development of the service and to ensure an effective roll-out of services across the organisation by 2015. Tim works closely with Addaction management and commissioners to ensure effective implementation of the service with regard to consistency of approach, quality standards and robust outcome monitoring.
METHODOLOGY

In 2011, Addaction set up a commission of experts, chaired by David Burrowes MP, to study the impact of family-based interventions and to highlight the wealth of benefits that can be experienced by trying to tackle inter-generational substance misuse head-on.

The report’s findings are supported by in-depth, qualitative interviews with a group of key stakeholders from various sectors in the UK. This group includes Addaction’s own Breaking the Cycle workers, other agencies and representatives from other drug and alcohol charities. The Commission also interviewed local authorities across England about their own current and prospective approaches to the problem of intergenerational substance misuse.

This evidence has been used to highlight both the strengths and weaknesses of existing family-based interventions, and will serve as a resource from which to improve the models of care available.

The report looks purely at family-based interventions that are specifically targeted towards families with drug and alcohol misuse problems. Family-based interventions include those that work with the whole family, the parent and the child and the examples referred to and the recommendations made should be considered only in relation to drugs and alcohol.

This report will be disseminated to all MPs and local commissioners in the UK with the aim of focusing their attention on targeted interventions for families with drug and alcohol problems. Addaction will also share the report with all relevant stakeholders, including charitable organisations working with the family.
EXECUTIVE SUMMARY

It’s time to act

This report exposes the huge challenges faced by this country to provide a better future for families whose lives are blighted by drug and alcohol problems. Despite a planned annual spend of almost £5 billion on children and families by the Department for Education (DfE) across the UK, and £466 million allocated in the pooled treatment budget from central government, millions of children are growing up in families blighted by substance misuse. The financial equation is very simple. It costs up to £4,000 to provide an effective single family intervention against an estimated yearly cost to society of over £75,000. The continuing waste of this country’s human capital if we do not urgently and more effectively address this issue is beyond calculation. The UK’s Coalition Government has recently pledged almost half a billion pounds to try to tackle troubled families in our communities by providing trouble-shooters to work with them. At present it is unknown how many of these families have significant drug and alcohol problems, but this could be seen as an opportunity to encourage any parents with substance misuse problems into treatment and take action to break the cycle of inter-generational substance misuse.

Figure 1: The cost of Breaking the Cycle

Estimated cost to society for one troubled family

£75,000

Cost of Breaking the Cycle intervention for up to one family

£4,000

The World Health Organisation (WHO) identifies parental substance misuse as a serious public health concern; there’s no doubting the impact of its conclusion that ‘the negative effects of excessive drinking…particularly on children, remain a concern and have to be considered a pertinent public health issue…children are the most severely affected, since they can do little to protect themselves from the direct consequences of parental drinking.’ (WHO, cited in Delargy et al, 2010).
The stark reality of parental substance abuse:


- Up to 350,000 children live with a parent who has a drug misuse problem (ACMD, 2003).

- Between 2009 and 2010, 68,207 adults who received drug treatment had a child living with them (see Appendix 4).

- The children of problematic drug users are seven times more likely to grow up with drug and alcohol problems themselves (Mckeganey, 2004).

- According to Rt Hon Eric Pickles MP, Secretary of State for Communities and Local Government and Conservative MP for Brentwood and Ongar, the costs incurred by 120,000 ‘problem families’ add up to £9billion a year. The children of these problem families are affected by many different problems, including drug and alcohol issues (DCLG, 2011b).

- 57% of serious case reviews (of serious or fatal child abuse) reveal evidence of parental substance misuse (Brandon et al, 2008).

- During 2008 and 2009, 4,028 children were counselled by ChildLine for their parents' alcohol misuse and 2,284 for drug misuse (Mariathasan et al, 2010).

- There is no universal provision of family-based drug and alcohol services. Levels of provision are currently patchy and variable.

- More than 20 agencies can be involved in supporting families with problematic drink and drug addiction, from the police service to Social Services and health agencies, sometimes ineffectively.

- ‘Parental problem drug use can and does cause serious harm to children at every stage from conception to adulthood...Effective treatment of the parent can have major benefits for the child’ (ACMD, 2003,3).

- The latest NDTMS figures show that 43% of adults exiting treatment in 2010-11 completed treatment having overcome their dependency (Roxburgh, 2011). Latest BtC family-based intervention delivered 53% achieving their treatment goals and in total 76% showed significant progress towards recovery.
**The Societal Impact**

The children of problematic drug and alcohol users are seven times more likely to develop a substance misuse problem themselves, to stop the vicious cycle of inter-generational substance misuse the support offered to the families facing these issues simply has to improve. Addaction has discovered that by providing intensive family support to help parents suffering from substance misuse, success can be achieved in rebuilding their lives, and their children can be offered the chance of a better future.

**It is clear that local and national Government must continue to put the right tools in place to address this issue. And Fast**

Addaction’s own programme, Breaking the Cycle is an example of an intensive family-based intervention programme that takes a whole family approach. Based in specialist drug and alcohol services, the programme provides interventions for parents, which allows them to best prioritise the needs of any children or young people in their care, therefore also involving the children in their parents’ recovery journey.

There are many different models of intervention when working with families with substance misuse problems, and Addaction’s own BtC project represents just one way of doing this. There is no one universal way of structuring family-based interventions for substance-using parents but it is certain that many (examples have been identified in Chapter 5) have demonstrated significant success in helping families overcome their problems resulting from a family member’s drug or alcohol addiction.

We have to do things differently if this destructive and costly cycle of inter-generational drug and alcohol dependency is to be broken. The Commission makes the following seven key recommendations:

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**The Commission’s recommendations**

1. If this cruel cycle of inter-generational substance misuse is to be successfully broken, local planning must exploit the benefits provided by family-based interventions. The needs of the family must be taken into account at every step and the voices of the children must be heard.

2. A standard framework for the collection of data about these families using a common, cross-service approach should be developed to quantify the true scale of inter-generational substance misuse accurately.

3. Public Health England and local health and wellbeing boards must develop strong, effective inter-agency networks to support the provision of family-based interventions.
The Commission concludes

The ‘Better Future for Families’ Commission concludes that family-based substance misuse interventions are of clear social and financial benefit, and although not a new concept (most local authorities have some form of family support) this may not be primarily focused on specialist support for parental substance misuse. Although there are good examples of quality intensive provision across the UK, there is still a long way to go in terms of improving family-based interventions where substance misuse is a problem and to creating a wider net of more accessible provision of these services across the UK.

A number of improvements to this intervention strategy are essential; of paramount importance is ensuring the availability of and access to services, which can meet the incredibly high levels of demand. This commission believes that family-based interventions are critical and can be extremely successful. It is therefore important that services move forward from a concentration on drug/alcohol users as individuals and towards a consideration of the service user’s family, with reference to safeguarding children. Substance misuse problems can have a profound effect on families, in particular children.

Only once these improvements are made, can a consistent level of long-term, effective support for the families be created and delivered to those who are so badly affected by their own or someone else’s substance misuse.

4. Drug and alcohol training should be developed and delivered for all frontline workers, regardless of their sector. In addition, drug and alcohol services need to work more closely with children’s services, GP surgeries, teachers, Sure Start and other children’s support centres.

5. Longer-term engagement is required with families where there is parental drug and alcohol abuse. Longer-term commitment is needed for continuing care for affected families so their future development can be adequately supported.

6. Communication and support for service users should be enhanced, utilising the opportunities that social networks and the internet provides, to deliver more effective contact channels and family-based, peer-led support.

7. The use of new charity and social impact bond funding models should be supported, encouraged and embraced to ensure greater coverage of addiction-focused family support programmes.
Table 1: Table of Recommendations

To illustrate how the recommendations were gathered, the table below shows how each recommendation relates to the challenges faced, outlined in Chapter Three.

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<tr>
<td>Lack of Provision (see 3.1, p.25): Family-based drug and alcohol services are not widely available, with current provision across the UK being patchy. Local authorities need to be aware of the social and economic benefits of family-based services.</td>
<td>Current local planning needs to be used to address benefits provided by family-based interventions. See Recommendation 1, p.54</td>
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<td>Data Issues (see 3.2, p.28): There is a lack of accurate data collected and available to quantify the scale of the problem. Family-focused questions would help with this.</td>
<td>A standard framework for data collection and questions about family and children must be entrenched as part of a more comprehensive assessment. Questions about family and children must form part of the assessment, with a common framework for the collection of this data. See Recommendation 2, p.54-55</td>
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<td>Lack of Partnership Working and Effective Protocols (see 3.3, p.29): Local, multi-agency partnership working is vital to the effectiveness of family-based interventions.</td>
<td>Effective networks must be established with a consistent framework for the commissioning of family-based interventions. See Recommendation 3, p55</td>
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<td>Lack of Child-Focused Family Interventions (see 3.4, p.32): Models of family-based interventions focusing on children and young people are extremely fragmented, but it is critical that children are helped due to the profound influence parental substance misuse can have on their future development.</td>
<td>Children's opinions and concerns must be taken into account. There is a need for more family interventions services for drugs and alcohol that are focused on children. See Recommendation 1, p.54</td>
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<td>Stigmatisation (see 3.5, p.33): The stigma placed on drug and alcohol users can have a profound effect on their access to services and treatment. Many frontline workers have a lack of training in how to deal with those with drug and alcohol issues.</td>
<td>Training on drugs and alcohol for all frontline family workers would raise an awareness of the stigma attached to drug/alcohol users and help to encourage them to access treatment. See Recommendation 4, p.55</td>
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<td>Importance of Continued Contact with Families (see 3.6, p.36): Longer-term commitment is needed for continuing care for affected families so their future development can be adequately supported.</td>
<td>Longer-term engagement with families where the parental drug and alcohol problems is critical. See Recommendation 5, p.56</td>
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<td>Current Economic Climate (see 3.7, p.37): The challenges faced in relation to family-based interventions are further accentuated by today's tough economic climate and harsh public spending cuts.</td>
<td>New charity and social impact bond funding models could be explored as a potential way of developing greater coverage of addiction-focused family support programmes. See Recommendation 7, p.56</td>
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<td>Communication Support Services (see 5.4, p.50): A new and innovative way for substance misusers to combat and understand their problems through online communication in the form of blogs and forums with others experiencing the same problems.</td>
<td>Communication and support for service users should be enhanced, utilising the opportunities that social networks and the internet provides, to deliver more effective contact channels and family-based, peer-led support. See Recommendation 6, p.56</td>
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CHAPTER ONE: INTRODUCTION

Too often, individuals with a substance misuse problem develop behaviours that have a negative impact on the family members around them (Copello et al. 2005). The ramifications of these behaviours can be catastrophic.

Drug and alcohol misuse is a problem which affects many people in the UK. Often these individuals go on to have children whilst still suffering from substance misuse or developing problems after they have had children. In either case it is important to recognise that parental substance misuse is an important issue which needs tackling for the health of the parent as well as for the health and future of their children.

Traditionally, the treatment of the individual alone has been the focus of the majority of treatment services. Other than cases where there are child protection issues to consider, with no remit for services to explore further, the wider impact of parental substance misuse on children and young people in particular has been all too easily disregarded. However, positive steps have been taken and the 2008 and 2010 drug strategies do include this important issue.

Today, the current Government is re-evaluating the impact of drug and alcohol misuse on the family. ‘The Government is now identifying and starting to realise the importance of family-based interventions...previously the way services were commissioned focused on individuals’ (Tim Vanstone, Head of BtC).

The latest 2010 drug strategy set out a new framework in which to tackle the problems arising from drug and alcohol dependency which affects individuals and society and has a renewed recovery focus. This Government will work with people who want to take the necessary steps to tackle their dependency on drugs and alcohol, and will offer a route out of dependence by putting the goal of recovery at the heart of all that we do’ (HM Government, 2010, 4).

The Labour Government introduced the ‘Think Family’ agenda, family intervention projects and Sure Start, and since the Coalition Government took office in May 2010, there has been a continued focus on the importance of early interventions, a move supported by Graham Allen’s report, ‘Early Interventions: The Next Steps’ and a report written by the Centre for Social Justice (CSJ) on ‘Making Sense of Early Intervention’. Early intervention is ‘intervening in the life of a child or young person when the problem presents itself regardless of their age at the time. Early intervention also advocates positive interventions for those children who are vulnerable as a result of their circumstance even if their vulnerability has not yet resulted in behaviours such as criminality or substance misuse in order to prevent that possibility’ (Gracia McGrath, OBE, Chief Executive Chance UK).

The CSJ report argues that intervening early can generate huge savings to reduce issues such as alcohol misuse. Notably, the Government’s latest drug strategy highlights an encouraging commitment to early intervention for problem families: ‘Prevention must start early...families, particularly those with the most complex needs, will be supported to give their children the best possible start in life’ (HM Government, 2010, 9).

The current Coalition Government has adapted the structure of local authorities, made changes to the way they work and created a raft of new initiatives all of which are part of the overall move towards localism. Public Health England and the health and wellbeing Boards will hopefully provide new opportunities for even more enhancements to local commissioning plans.

7Quotes from Tim Vanstone are reconstructed from handwritten notes as a telephone interview was conducted.
The Government has also recently announced that it will be dedicating £448 million to a new ‘Troubled Families Unit’ with the aim of turning around the lives of the estimated 120,000 problem families in the UK over the next three years (DCLG, 2011b).

Central to this report is the problem of parental drug and alcohol misuse which is likely to affect many of these problem families. Children and young people can be negatively influenced by their parents' substance misuse and the future social and economic consequences of such a cycle of misuse are colossal. Failure to break the cycle is not an option and ‘the number of affected children is only likely to decrease when the number of problem drug users decreases.’ (ACMD, 2003, 3).

**Failure to break the cycle of misuse is not an option**

‘Inter-generational substance misuse’ is the cycle that follows a parent’s drug or alcohol misuse and which can be passed on to their children; it is a cycle of substance abuse that can be incredibly hard to break without any form of intervention.

It is within the power of politicians, policy makers, commissioners and local authorities to help to change the lives of families affected by substance misuse and to give them the opportunity to move towards a substance-free life. By implementing family-based interventions where it is needed, real change can happen today and through the generations ahead.

The Commission has an inspirational message: if more services are established to support parents with substance misuse problems and their children and families, there is less likelihood of the potential cycle of addiction being stopped. This can only be beneficial to the wider society.

There is clearly an argument that treatment is at its most effective when the service user is considered as part of a family unit and has access and support from a wider network of resources. ‘Family intervention demonstrates that the lives of young children and young people can be turned around when their families – who often have many complex problems - are targeted intensively. This is also a more efficient way for local authorities to work, as evidence shows that fewer children are taken into care or excluded from school’ (Tim Loughton MP, Children’s Minister, cited in Cabinet Office, 2011). This shift towards a more holistic approach to alcohol and drug policy shows that including family members in treatment can produce real, positive outcomes with a better likelihood of sustainable change for substance misusers and their families.

Addaction is a leading drug and alcohol service with an involvement in early intervention programmes and has run a highly successful, family-based project called Breaking the Cycle (BtC). In 2005, with the support of Zurich Community Trust, Addaction launched a pilot project aimed at breaking the cycle of inter-generational drug and alcohol addiction. The pilot has been a remarkable success in suppressing parental drug and alcohol use and work has continued in the three pilot sites, with plans to expand to a further 20 locations by the end of 2012.

Addaction is convinced of the efficacy of this family-based intervention model and is dedicated to growing it nationwide. This dedication is borne from experience and success was evidenced in the *Breaking the Cycle Final Report* (Novak et al, 2009), which revealed that 83% of clients achieved some level of progress while working towards their treatment goals and 81% of parents stabilised, reduced or stopped the highly problematic substance use that impacts so negatively on them and their family’s lives.
The remarkable benefits of family-based projects

Thanks to a combination of the proven success of this project and a Government that is committed to supporting recovery from drug and alcohol dependence, a commission of leading experts was formed by Addaction. The aim was to study the impact of family-based interventions and to highlight the encouraging benefits.

The Commission's resulting report:

• outlines how important family-based interventions are if we are to break the cycle of inter-generational substance misuse;
• describes some evaluated family-based interventions;
• explains why families should be the focus of substance misuse treatment;
• gives a unique insight into different models of family based interventions.

The report concludes with specific recommendations for implementing strategy at local commissioning level alongside the future development of family intervention programs. These recommendations are central to this report and aim to put family intervention work firmly on the agenda with an objective of BtC and similar projects being rolled out nationally.

The Rt Hon Eric Pickles MP, Secretary of State for Communities and Local Government, said:

“The moment some children are born their life chances are simply written off. From day one their lives are defined by the problems that surround them - drugs, alcohol, crime, mental illness and unemployment - they grow up in chaos and their own lives are chaotic.

“During the summer riots the whole country got a sudden, unwelcome insight into our problem families - the ones that make misery in their communities and cause misery to themselves.

“It’s a story of futility and waste. Waste of money. Waste of people. And it has simply got to stop. We are going to stop it. We can no longer afford the luxury of fruitless, uncoordinated investment. The damaged lives and communities.

“We need action and results - not endless restating the problem - like getting kids back to schools, adults into employment, stopping criminal behaviour.”

(DCLG, 2011)
CHAPTER TWO: THE REALITY TODAY

‘I lost days and weeks to alcohol. I became homeless. I was violent and ended up with a criminal record because of the things I did when I was drinking. I couldn’t look after him (my son) anymore...my children saw me drunk and out of control, banging my head on the police car.’

(Sarah, BtC service user)

The beginning of this report has laid bare many of the issues society is faced with in relation to parental drug and alcohol misuse. It is also clear there are major costs to society. This chapter goes onto further develop the social and financial costs of parental substance misuse and the lack of family-based interventions to tackle this. ‘Drug misuse can place an enormous strain on the families of drug misusers including the children of drug-using parents, and can have a serious negative impact on the long-term health and wellbeing of family members’ (NTA, 2007). It is essential local and national Government remain aware of this fact; not only for the financial savings it can achieve, but also for the social benefits our communities can enjoy now and into the future. ‘Services tend to focus on a single problem of a single person. This can increase the risk of relapse and creates a costly cycle of deprivation. Breaking this cycle will mean fewer lives wasted, less damage to communities and better value for tax payers’ (Cabinet Office, 2011).

2.1 The Financial Reality

The financial cost of dealing with families with at least one parent who has a significant drink or drug problem is considerable. The Right Honourable Eric Pickles MP, Secretary of State for Communities and Local Government, has calculated the most troubled families can cost £9billion every year (DCLG, 2011b), many of whom may have drug and alcohol problems.

It has also been estimated that the cost of family members and carers of problem drug users in England is £1.477billion (Copello et al, 2009) and that the cost of alcohol harm to the NHS in England is estimated at a staggering £2.7billion (IAS, 2007). Due to these figures being so high, the financial implications to society cannot go ignored.

‘People ask why I run back to my mum, well she’s my mum. You only get one mum. No matter what she does to me, I’m still going to be there aren’t I? Still going to be there to help her and the rest of it.’

(Jodie, daughter of substance misusing parent in, Ask Me About Me, an awareness-raising and training DVD produced by The Children’s Society)

‘I had my children removed after having an alcohol problem for 22 years.’

(Nikita, BtC service user)
2.2 The Social Reality

Substance misuse within a family means family members are susceptible to problems ranging from domestic violence, child abuse and drink driving, to criminal behaviour and disappearances for days on end (Copello, 2005). Fifty-seven percent of serious case reviews (of serious or fatal child abuse) reveal evidence of parental substance misuse (Brandon et al, 2008). By their nature, these problems potentially have a negative impact on the lives of family members, particularly those of the children who are more likely to have poor adult outcomes as a direct result. It is estimated that 60% of children taken into care have at least one parent with a substance misuse problem (Travis, 2008).

These are the facts that simply cannot be ignored when treating individuals who have drug or alcohol problems.

There is evidence that parents pass their addictions on to their children. Studies show parental alcohol and drug use is a known risk factor for child substance misuse and it is known that many young people drink and take drugs.

- The number of 11-15 year olds taking drugs is on the decline at 22% (UK Data Archive, 2009), but is still unacceptably high.
- 51% of 11-15 year olds (UK Data Archive, 2009) have had at least one alcoholic drink.

A report by Demos revealed that ‘parenting style is one of the most important and statistically reliable influences on whether a child will drink responsibly’ in later life (Bartlett et al, 2011, 13). If an intervention can stop parents abusing drugs or alcohol, it can help them understand and see the damage that substance misuse has on those around them and possibly lead to changes in their behaviour and parenting style, and consequently their child’s attitude to substances.

And this vicious cycle can be broken.

Factors such as parental acceptance of drug use, socio-economic instability, physical or sexual abuse and poor family organisation all increase the risk of a child going on to misuse substances in the future (Ball et al, 2002, Hawkins et al, 1992). According to the findings from the UK Data Archive Study on Smoking, Drinking and Drug Use among Young People in 2009, those who thought their families would intervene to stop them taking drugs were less likely to take drugs in the first place. In contrast, those who thought their parents would take a more lenient approach felt the opposite was true (UK Data Archive, 2009). Parental influence is, without doubt, a crucial determinant, and effective treatment of the parent can have major benefits for the children.

Conversely, research reveals the factors that reduce and protect children from inter-generational substance misuse include strong family attachments, supervision, boundaries, affection and emotional warmth (Bartlett et al, 2011) while ‘A combination of discipline and affection’ (Bartlett et al, 2011, 9) leads to effective parenting. It is also known that effective treatment of substance misuse in parents can significantly decrease the negative impact on the child (ACMD, 2003).
A far from normal family life for some children

While young people may become aware of their parents’ substance misuse, this knowledge doesn’t necessarily translate into an understanding of what it actually means, either for themselves or their parents. Data suggests many young people can adapt, over time, to their parents’ substance misuse and family life; not until later do they then come to understand the seriousness of the issue of misuse or recognise that their family life was far from ‘normal’ (Houmøller et al, 2011).

*Hidden Harm* (ACMD, 2003) recommends developing ways to help the children of problem drug users to express their thoughts and feelings about their circumstances. It is vital to allow children to understand the situation, especially when so many children take over caring roles for siblings as well as themselves (Mariathasan et al, 2010).

‘It was quite bad really she (Mum) couldn’t really help us with anything. We had to do lots of things on our own. Nothing was really getting done. I had to get up on my own and help my little sister get ready for school.’

(Emily, daughter of substance misusing parent, in Ask Me About Me, an awareness-raising and training DVD produced by The Children’s Society)

Children in these environments face a multitude of problems; fear, for themselves and their siblings, and fear of their parent’s substance misuse. An insight into these problems can only be truly gained when children are included in the parent’s recovery process; as they recover, so too will the child. The Munro Report 2011, set up by the Government, examined the changes and improvements that should be made to child protection services and how they will happen will be a vital component in dealing with childhood fears and recovery.

The ‘voices of children should be heard’

‘The reason I’m never happy is because I’ve always got something to put up with...I’m always worrying, every second...I was worrying about my mum and my sister and what could happen to them...they could die or something.’

(Emily, daughter of substance misusing parent, in Ask Me About Me, an awareness-raising and training DVD produced by The Children’s Society)

Sadly, research to date has lacked specific focus on children as part of the family unit (Barnard, 2007) and has also neglected to look at the powerful enabling influences of the family as well as the constraints. However, a key recommendation of the *Hidden Harm* report and subsequent policy reviews have taken steps towards addressing this by recommending that the ‘*voices of children should be heard and listened to*’ (ACMD, 2007, 104 Houmøller et al, 2011).
It is also important there are systems available to help children reflect their needs, as the Munro Review 2011 has revealed many children and young people find the system overly confusing, and their opinions are not listened to (Munro, 2011). If this is the case then what is currently available at present will not be able to effectively help children access support. The Munro Review 2011 represents an extremely positive step towards reforming a system and putting children at the heart of this.

The majority of problem drug users have a history of multiple disadvantages before the onset of a substance misuse problem. These problems (as listed below) can also affect children's lives as a result of their parent's drug or alcohol abuse problems:

- Being in care as children, having an unstable background.
- ‘Ill-treatment’ or impairment of health and development; for example sexual, emotion and physical abuse.
- Having few or no qualifications.
- Emotional, behavioural and other psychological problems.
- Having a record of criminal activity and/or anti-social behaviour.
- Poor family support.
- Patterns of chronic unemployment (Buchanan et al, 2005).

Drug-taking for these disadvantaged individuals can be viewed as a symptomatic response to long-standing social inequalities and personal difficulties, with many problem drug users ending up in prison (Buchanan et al, 2005). Interventions designed to prevent substance misuse within schools can be seen as a one-dimensional approach that has limited success for those who have complex needs. This method fails to take adequate account of other risk factors (mentioned above), which could impact on inter-generational substance misuse.

**Intervening before problems escalate out of control**

‘Intervening early... can help avoid problems escalating to crisis level and reduce the number of families and individuals who need intensive support in the future.’

(DCSF, 2008, 13)
The early and teenage years are seen as particular periods of vulnerability and represent key stages of development and transition (Bartlett et al, 2011). According to the NSPCC (2011) there are at least 113,000 babies with a parent with a drug or alcohol problem, emphasising that support for these babies needs to be early (Manning, 2011 cited in Cuthbert et al, 2011). Although the Government has focused on early interventions for infants to three-year olds, it is important to acknowledge the benefits of intervening before birth and for those aged from three to 24 years-old; in fact, intervention in the early stages of any problem is crucial, regardless of the age of the individual. The concept ‘earlier is better and earliest is best’ (Hosking et al, 2010, 60) should govern policy. ‘Drug and alcohol use in pregnancy is a real problem. The children often start their lives on a life support machine as they are born premature. The first 8 weeks of life is crucial...they never catch-up’ (Nick Crichton, District Judge). Recent research has also highlighted this demonstrating more clearly how important and critical interventions can be during pregnancy and the early years of a baby’s life, ‘providing the essential foundations for all future learning, behaviour and health...if we don’t act early we risk storing up problems for the future’ (Cuthbert et al, 2011).

Early interventions at any age provide an opportunity to reduce the long-term damage individuals may be doing to themselves or those around them by intervening before the problem escalates as early as possible. In these circumstances, by working with the family to overcome their problems, the risk of the individual passing their addiction on to their children is minimised.

‘Many families are not coming to the attention of services until their situation reaches a crisis point...we need to intervene early to stop that escalation’ (Emma Bond, Hidden Harm Coordinator). This further demonstrates the need for early intervention. The earlier the intervention the better the chance the family has of being able to cope and deal with the issues that drugs and alcohol are causing them, and stop it from escalating out of control into a situation that will more adversely impact on the children and young people affected by it.

The Government has come to recognise this encouraging local authorities to invest in early intervention, just as the scientific evidence of its importance and long-term benefits has become widely accepted and well-documented (Hosking et al, 2010).

The current drug strategy (HM Government, 2010) observes that there must be a sharper focus on effective prevention and early intervention before problems become entrenched. This new approach will emphasise earlier intervention for families at risk, such as those in which children might experience harm as a result of parental substance misuse. It will also provide targeted youth support for vulnerable young people in all areas.

These social and economical impacts cannot be ignored. The benefits of addressing the problem by implementing programmes of family-based interventions include an attempt to address all the problems covered above. The harm done to children can be reduced, family functioning can be improved as well as achieving a reduction or complete stop to an individual’s substance misuse. By working with the whole family to tackle substance misuse, the effects on children and other family members can be more closely controlled and monitored and can, ultimately, ensure these negative effects are minimised.

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* Calculated from 19,500 babies under 1 year old are living with a parent who has used Class A drugs in the last year and 93,500 babies under 1 year old live with a parent who is a problem drinker (Manning, 2011, cited in Cuthbert et al, 2011).
CHAPTER THREE:  
THE CHALLENGES FACED  

‘There is no standardised approach and therefore a lack of confidence and understanding in knowing what would work best in family-based interventions. We need a framework to allow this and a document setting out good practice.’

(Source asked for anonymity)

This chapter examines the challenges that we are presented with when trying to improve the provision of family-based interventions for those with drug and alcohol misuse problems. Each challenge set out corresponds to the recommendations made in the conclusion. (see Table 1, page 16).

To help inform this report, a survey was conducted (see Appendix 5) to determine local authority strategies for implementing family-based interventions where substance misuse is a problem. The responses were invaluable and helped to identify the challenges faced and evidence this report.

In-depth interviews were also conducted with key stakeholders who are involved in family-based interventions, including workers from Addaction’s own Breaking the Cycle, other agencies and representatives from other charities. Some of the local authorities quoted requested that their quotes remain anonymous.

3.1 Lack of Provision

The lack of statutory requirement to provide family-based drug and alcohol services inevitably means they are not widely available. ‘There is so much unmet need in this area which must be responded to by Government as a specific issue’ (Turning Point, 2006, 29). This is despite initiatives such as Think Family and the NICE Clinical Guidelines 2007 that advocate reducing the impact of substance misuse on the family unit and protecting children from harm. (It is important to mention that NICE guidelines in relation to alcohol have changed recently. Now, in all cases where a service user is presenting for alcohol support and a parent, carer or family member is involved, they should receive an assessment in their own right.) ‘The scale of the problem is a lot bigger than we think; we are only really hitting the tip of the iceberg in helping families with substance misuse problems. Unless you are working in it, you don’t really get an idea of the scale of the problem as it is not routinely reported’ (Emma Bond, Hidden Harm Coordinator).

A map developed by the DfE (see Appendix 1) shows the numbers of families that have been offered and accepted help from a family intervention project. Even though this map does not refer exclusively to drugs and alcohol it illustrates that around 22 local authorities have had only 10–30 families who have been offered and accepted onto a family intervention programme. Given that there is an estimated figure of 120,000 problem families in the UK (with some regarding this as a severe underestimate) many local authorities are helping too few families to really see a significant reduction in this figure. Local authorities are working to

* Quotes are reconstructed from handwritten notes as a phone interview was conducted
identify families within their locality, and many local authorities have the capacity to help a great number of troubled families. However the data available regarding these families is still inefficient therefore making it difficult for local authorities to quantify the scale of the problem they are faced with.

It follows that only some local authorities are able to take the issue on board. RBWM\textsuperscript{10} DAAT commented: ‘As a small borough, we are not in our services able to carry out whole family interventions via our substance misuse services and therefore have to be creative with our referrals to ensure everyone in the family receives the support they need. There is a small FIP in the borough...however it has a youth crime focus and is therefore only suitable for a small number of cases.’

**Innovation is clearly needed to target and help the whole family**

Although there is evidence of the cost-effectiveness of intensive family intervention programmes, as long as family-based interventions are not a statutory requirement local authorities will not want to deviate from current practice, particularly during a time of intensive spending cuts. In addition many local authorities do not possess the skills to effectively deliver family-focused services. ‘There is no good practice and a lack of understanding’ (Source asked for anonymity).

**Embedding family models into service delivery**

Evidence shows family-based interventions are successful in ensuring that substance misuse is not passed on to children and future generations. ‘There is a good body of evidence that interventions aimed at the family and social networks can also lead to positive therapeutic change’ (Velleman et al, 2007, 84). It has been demonstrated how family interventions lessen the likelihood that children of substance misusers will repeat the cycle of behaviour. Improving the parent-child relationship through family interventions can increase levels of resilience and decrease the risk that children will go on to repeat harmful behaviours (Kendall et al, 2010, Bry et al, 1998).

From our interviews, it is clear there are many family services available: ‘most areas have some kind of family service...but it is varied’ (Tim Vanstone, Head of BtC.) However, the provision available is very diverse and patchy and does not present a consistent picture nationwide with ‘no uniform approach to working with families’ (ibid). This can then get in the way of providing effective services and makes it even more important ‘to have a whole systems approach so we can cater to the needs of all the stakeholders involved’ (ibid).

The response of drug and alcohol commissioners to family-based interventions was mixed and demonstrates the lack of consistent family interventions projects in England: ‘we do not have any family-based interventions specifically for those where substance misuse has been identified’ (Anonymous DAAT). However, a few local authorities were in the midst of organising new strategies for implementing family-based interventions and remained positive about the progress being made: ‘We have recently commissioned a Holding Families Project that should work with 45 families in the next year’ (Rochdale Council).

\textsuperscript{10} Royal Borough of Windsor and Maidenhead
The importance of local authorities in family interventions

Although many local authorities recognise the importance of family interventions and acknowledge the many gaps in current provision, a local authority that wished to remain anonymous said: ‘We are developing in this area. Whilst Children Services offer a range of activities and support for families the pathways and coordination between substance misuse and children’s services is not as robust as they should be.’

Despite the lack of provision, the majority of responses contained some optimism regarding the launch of family-based interventions for drug and alcohol users. The response from Bradford NHS was particularly positive, describing their ‘bespoke family training which is currently being ratified by the Bradford Safeguarding Children’s Board…over the next 4 months we will deliver family training to a further 160 staff across the district’ (Liz Barry, Joint Commissioning Manager for Substance Misuse & DIP, Bradford NHS).

South Gloucestershire DAAT also said: ‘We commission a ‘Families Also Matter’ service that provides group programmes, 1:1 support, couples counselling, family member meetings, grandparents’ support groups and offers training to professionals in the field’ (Sarah Telford, South Gloucestershire DAAT).

A further eight respondents gave answers in a similar vein, with programmes such as ‘Think Family’, which is designed to cross the divide between children’s and adult’s services and to compliment, rather than replace, the safeguarding guidelines and procedures that are already in place, appearing in a few responses. ‘As commissioners for adult services we have included in all our contracts the requirement for services to have a ‘Think Family’ approach’ (Sally Woffenden, Barnsley DAAT Strategy Coordinator). They also referred to hidden harms, ‘into which we have put funding’ (ibid).

A DAAT that wished to remain anonymous mentioned the Family Intervention Project, which ‘is well established... As part of this team there is a specific worker funded by the DAAT who works with substance-misusing parents in need of intensive interventions.’

There is still a long way to go

‘It is only recently that people are starting to become clued into family-based interventions’

(Frank Birtwistle, BtC worker, Cumbria)

These responses demonstrate that despite there being some effective family intervention programmes to help drug and alcohol users already in place and efforts made to set up programmes, there is still a long way to go before they are rolled out nationally. Local authorities must be aware of the beneficial social and economic impacts of family-based interventions so they can encourage such programmes to be set up to help the families of drug and alcohol misusers.

11 Quotes from Frank Birtwistle reconstructed from handwritten notes as a telephone interview was conducted
3.2 Data Issues

Today, one of the major barriers faced when looking at the families who are blighted by substance misuse is the lack of accurate data available to quantify the scale of the problem. ‘We need to collect more data to give evidence of what is working and then publicise it’ (Bianca Horn, BtC, Tower Hamlets). Data is available on an individual’s substance misuse problems, but there is a lack of accurate data to quantify the precise scale of inter-generational substance misuse.

‘There is data about parental substance misuse, but not about inter-generational substance misuse... NDTMS parental status is recorded in drug treatment, but people are not initially asked if they have a drug or alcohol problem.’

(Source asked for anonymity)

It is vital that the data we have is accurate so that it can create a proper picture of the reality of the situation. ‘National figures tend to be used which I think are under-reported and a huge underestimate and don’t always reflect what’s happening locally’ (Emma Bond, Hidden Harm Coordinator). More efforts therefore must be made to ensure that the right data is collected so that we can put the services in place to help the high number of families suffering from drug and alcohol misuse problems.

The Home Office admits that it does not routinely collect information on children affected by their parents’ substance abuse (see Appendix 4). ‘There is no requirement in the UK for Safeguarding/Child Protection Units or Services to routinely record and monitor the extent of parental substance misuse as a significant contributory factor in referrals for case conferences and child protection registrations’ (ACMD 2007, 33). On submitting a Freedom of Information request, the response was confirmation of the need for more data to be collected in this area. The Home Office stated that ‘statistics on numbers of children living with drug or alcohol abusing parents are not routinely collected’ (See Appendix 4).

This response was also echoed in comments from local councils. ‘A final solution to collecting robust data has still to be decided upon’ (anonymous DAAT). Another DAAT also conceded ‘there is currently no formal data collection by commissioners’ (anonymous DAAT).

It is clear that data collection must be improved so all councils and service providers have the accurate information they need to ensure they are providing an effective service.

Despite these issues of data collection, NDTMS data and TOP data is frequently referred to as ‘the primary source of data collection’ (Rotherham NHS), ‘however NDTMS data is fairly basic’ (DAAT Policy Officer).

Up-to-date data is vital ‘to inform needs assessment and identification of partnership priorities’ (Debbie Stovin, Adult Treatment System Manager, NHS Rotherham); data collection is also key to effectively evaluating and demonstrating the impact of family-based intervention programmes.

Getting a better idea of the scale of the problems faced

12 Quotes from Bianca Horn are reconstructed from handwritten notes as a telephone interview was conducted.
For a clearer indication of the scale of the current problem of families affected by substance misuse, family-focused questions should always be included when an individual with a substance misuse problem is being assessed. Tools are currently in place to try and ensure that clients are questioned about their family situation, but there appears to be a scale of under-reporting. ‘Yes there needs to be more questions about the family but also more questions about drugs’ (Emma Bond, Hidden Harm Coordinator). To ensure that we get a full idea of the extent of the problem of inter-generational substance misuse it is vital that services such as social care and Sure Start are asking questions not only about the family but also about the drug and alcohol use of the individual presenting to the service.

Questions about a service user’s family should routinely form part of the data collection process and recorded in such a way so that local trends can be identified, measured and catered for by an appropriate commissioning of services. ‘Questions about families need to be included in assessments so we can get a better idea of the scale of the problem’ (Bianca Horn, BtC worker, Tower Hamlets). If family-focused questions are entrenched into the assessment process, then data can be collected, quantified and the scale of the problem faced can start to be better understood.

There is still much work to be done to tackle the problem of inter-generational substance misuse particularly when it comes to gathering evidence. We need to continue to gather evidence of the effectiveness of family intervention programmes so they can become commonplace throughout the UK. ‘We need to keep doing research to demonstrate that it is important and that it is working. It is clear that there is a need for it...we need to work on raising awareness’ (Bianca Horn, BtC worker, Tower Hamlets). In addition, the scale of inter-generational substance misuse must be measured, enabling data to track individual family members’ success and also that of the whole family unit.

‘Everyone agrees that something must be done to tackle inter-generational substance misuse. What can be done for the children who grow up in households where they may come a poor second to adult relationships with substances? One or two excellent initiatives have sprung up around the country but they are somewhat isolated and unconnected. Something a good deal more systematic seems to be required.’

(Emma Cox, Project Manager M-PACT and Cinzia Altobelli, Leader of Therapeutic Services)

3.3 Lack of Partnership Working and Effective Protocols

In order to develop a safety net for the whole family, a local, multi-agency partnership approach is critical: ‘Partnerships and networking are vital. There is always willingness to work together but people have different approaches’ (Emma Bond, Hidden Harm Coordinator). Families will suffer from other problems as a result of their drug and alcohol misuse, therefore it is key to their full recovery to be interacting with a multitude of other available services. ‘There are so many more things that affect families other than substance abuse...agencies that work in isolation are an example of what’s not working...information exchange between agencies needs to be improved’ (Tim Vanstone, Head of BtC). Without close partnerships the families cannot get the effective help that they require.
Strong links need to be built within the local area. Specialist drug services including clinics for pregnant women, family support services, alcohol services, detox and aftercare services as well as other relevant services for families, children and young people such as employment and housing services (including dual diagnosis and mental health services) must collaborate. Joint working is recognised as one of the biggest changes needed to improve the outcomes of children who are affected by drug and alcohol issues (Delargy et al, 2010). When building successful family intervention programmes ‘we should involve families in setting up services, with families consulted at every step of the way’ (Tim Vanstone, Head BtC).

Effective, joined-up working and close partnerships can help family-based intervention projects to be more effective: ‘We need greater awareness and need to look at improving pathways between agencies...We need a more collaborative approach’ (Source asked for anonymity). ‘It’s about coordinating all services, having partnerships in place and conducting outreach work’ (Tom Cornwallis, Hidden Harm Co-ordinator).

‘By working together, services can make practical steps to protect and improve the health and wellbeing of affected children’ (ACMD, 2003, 3). Local safeguarding boards are already in place to ensure people working in all sectors with adults and children with substance misuse problems comply with their responsibility to safeguard children. ‘An increasing number of substance misuse and children and family services have accessed training to help them better identify safeguarding concerns and respond to the needs of the whole family’ (HM Government, 2010, 22). Health and wellbeing boards are also being setup, but unless these boards and networks available are used intelligently, they will not achieve their full potential.

A more coordinated and collaborative approach is essential when it comes to tackling families with substance misuse problems; the current approach is seen as ‘expensive, ineffective and a bad deal all round’ (DCLG, 2011a). A new partnership-focused approach will undoubtedly prove more cost-effective and efficient in helping drug and alcohol misusing families to recover.

All families are different; there is no uniform approach

Partnerships and networking are also important for referrals and for ensuring clients are signposted and referred to the right service that will adequately suit and cater for their own specific needs. All families are different; there can be no uniform approach to dealing with families. Since each project and every agency can offer their clients’ families something different, it is even more important to appoint the right partnerships and have a real understanding of the way they work. This is also key when it comes to getting people into services that are under the radar and which are not known to other agencies, hence the importance of Hidden Harm projects. ‘Those who don’t meet the threshold are the most vulnerable and therefore those that need extra support’ (Source asked for anonymity).

The role of a drug or alcohol family worker is to gather the right parenting information at the start of the treatment journey, which ensures the potential risks to children are identified at the outset and the client is supported as they develop their parenting skills. Using this
information, the worker can provide harm-reduction interventions and signpost the client to the right services that will really support their path to recovery. Every client-facing practitioner should be aware of all available pathways that are open to families and clients’ children so the appropriate support can be tailored, early intervention encouraged and good working relationships with colleagues in children’s services developed. It is also essential for every relevant service that can meet the needs of individuals and families to be listed in a directory, which can be promoted within local areas for workers to access easily.

It is a positive step to observe that many local authorities were encouraging collaboration and they emphasised the strong networks they have with other agencies:

‘We ensure that we work to raise awareness within the local community...in addition, we work in strong partnership with other internal departments and external agencies in order to recognise substance misuse issues and make appropriate referrals at an early stage’ (RBWM DAAT).

‘We are joining up children’s centres with substance misuse services, ensuring substance misuse services are doing parenting assessments...’ (Vickie Crompton, Cambridgeshire DAAT Coordinator)

Some local authorities, however, were less positive about their networks and links with Social Services, admitting social care services had ‘not engaged’ with the model for joint working protocols, citing ‘political tensions’ around local authority reorganisation of resources as a concern. Many local authorities were either in the process of trying to set up Family Intervention Services and joint working protocols or are simply too small to be able to run family interventions.

‘Without Breaking the Cycle there is nothing. We have to make sure there are enough agencies with that family so that they get the support that they need.’

(Sue Hannah, BtC worker, Cumbria)

‘Despite a number of multi-agency workshop meetings around implementation we are a long way off this model. Children and young people social care services have not engaged with this agenda and there are a number of political tensions to contend with around local authority reorganisation, thresholds and resources...’

(Juliet Grainger, Wolverhampton City Council Commissioning)

13 Quotes from Sue Hannah are reconstructed from handwritten notes as a phone interview was conducted.
3.4 Lack of Child-Focused Family Interventions

‘In order to break the cycle of inter-generational substance misuse we must offer positive support to children of substance-misusing parents, showing them an alternative vision of their own future. Response to stress, sadness and anger are learned behaviour, we need to help these children find healthy responses to the difficulties that they will face in their lives. It is also important for children and young people to have non-substance-misusing role models to follow’ (Gracia McGrath OBE, Chief Executive Chance UK).

Services for children and young people who are suffering the consequences of parental substance misuse across the UK have been limited, fragmented or, in places, completely non-existent. It is critical these children get exactly what they need from family intervention programmes. ‘There are activities for the children, for example we run family activity days which are based around improving parenting skills. It would be beneficial for a young person’s worker, in particular where there is a young substance misuser and it is the parents asking for support’ (Frank Birtwistle, BtC worker, Cumbria). This lack of provision is surprising as local authorities have a statutory responsibility ‘under the Children Act 1989 to safeguard and promote the welfare of children within their area who are in need’ (Munro, 2010, 7). However, it can be seen that services for children suffering the effects of parental substance misuse are severely lacking.

It should be obvious that children be considered when the harmful effects of parental substance misuse are being analysed but, in truth, the impact of parental substance misuse on children is rarely examined, since it can all too often be hidden from view (Delargy et al, 2010). Any parental behaviour has a profound influence on the future of children; it is clear those children’s voices must be heard to help them deal with and recover from the numerous mental health problems parental substance misuse can place on them.

‘It hasn’t been recognised that children have voices...in school, children are educated to the understanding that drugs are bad for them and they don’t want to speak up about their problems...there is not enough out there for children whose parents suffer from parental substance misuse. Children are not always seen as the most important. If we are only thinking of the parents there will be effects...this is the next generation and we must recognise that there is a problem.’

(Claire Winship, Specialist Children Worker, Compass)

‘We try to get an idea of what children want and need...so they know it’s okay to talk about it, it’s okay to be angry...’

(Claire Winship, Specialist Children Worker, Compass)
3.5 Stigmatisation

Substance misusers are a highly stigmatised group

As Lloyd suggests: ‘stigmatisation matters’ (Lloyd, 2010, 11). In this case, it is vital to consider the concept of stigma and the effect it has on substance misusers’ access to treatment and their ongoing recovery process. ‘There is a stigma that exists. We don’t want drug and alcohol users to be afraid of entering into treatment’ (Source asked for anonymity). Perhaps unsurprisingly, it is the very nature of the stigma that’s placed on problem drug and alcohol users that leaves so many too scared to enter treatment; they worry about the reaction they’ll receive and the fear their children will be taken away from them because of their problems.

‘There are lots of issues with stigma. They have a huge fear that their children will be taken away from them if they bring their substance abuse problems into the open in family centres. People try and hide it as much as they can. It rarely happens that their children are taken into care, but it’s one of the key barriers for parents seeking help’

(Bianca Horn, BtC worker, Tower Hamlets).

There are many barriers that face an individual when entering drug or alcohol treatment; stigma is certainly one of the most dominant. ‘There is lots of distrust but you build up that trust through continual engagement and contact with clients’ (Tom Cornwallis, Hidden Harm Coordinator).

And so another vicious cycle is met; many individuals may want to attend treatment and start their road to recovery but are worried that, by entering treatment this may stigmatisate them even further as by entering treatment they are cementing their identity as that of an ‘addict’ or ‘junkie’ (Lloyd, 2010).

Where parental substance misuse exists, there’s a risk that substance misuse practitioners will not work effectively with parents and families for a number of reasons, including:

- a lack of understanding of the effects of substance misuse;
- a lack of understanding of how children’s services operate and how to work with them;
- a fear of getting things wrong and not knowing what to do with the information they are presented with;
- silo working;
- a fear that questions about children will discourage the client from accessing treatment;
- the confidence and competence of the worker.

‘It is not, though, only about offering new initiatives, but ensuring that frontline workers, any worker in fact, within the field, has adequate and sufficient training to offer the required support to these children and families as routine practice’ (Emma Cox, Project Manager M-PACT and Cinzia Altobelli, Leader of Therapeutic Services).
Sure Start and family centres are also available to help these families. Unfortunately, they are not specialist drug and alcohol services and, due to the ‘stigma and fear associated with drug and alcohol abuse and the prejudices that individuals have’ (Tim Vanstone, Head of BtC), they simply cannot cater for the specific needs of drug and alcohol users. ‘Many social workers and children’s centres are not specifically trained to ask the right questions about drug and alcohol use. Workers need to understand that there is no right answer, it’s complex. A strong partnership with substance misuse services helps’ (Emma Bond, Hidden Harm Coordinator). ‘Also many social workers have big caseloads, with drugs and alcohol cases left down the bottom of the agenda (Tim Vanstone, Head of BtC). It is important that frontline workers know that there is no uniform approach to working with families affected by drug and alcohol use, and as is demonstrated in the rest of this report, there are multiple different models of family-based interventions, many of which are successful.

Regrettably, it is entirely possible that workers within these non-drug and alcohol-specific services are not trained to deal with the problem of substance misuse and can even be ‘distrustful and judgemental’ (Lloyd, 2010, 8). Forrester et al (2008) demonstrates this in a survey of 248 recently qualified social workers, which revealed one third had received no training on substance misuse on their training course.

Starting the journey to recovery

‘There needs to be a care module in how to deal with drug and alcohol users’ (Source asked for anonymity). The NTA plays a valuable role here by raising awareness of training activities that are taking place and encouraging more people to sign up: ‘There is little funding for training but we can help raise awareness for it’ (ibid). With this in mind, more confidence can be had that workers dealing with drug and alcohol users will have the right training to help them start their journey to recovery in the most effective way possible.

The DfE does support the need for more training in this area and currently funds a programme called First Steps. Addaction has formed a collaborative sector partnership with Adfam and Alcohol Concern to deliver First Steps to develop the skills of a broad range of professionals, all working to support children and families affected by parental substance misuse. This project works with staff in children’s centres, helping them to better identify and help families in need.

This training is just a drop in the ocean for the workforce as a whole. However it is not mandatory so relies on willingness and recognition that this is an issue they need to respond to.

At present many social workers are not adequately trained to deal with the problems drugs and alcohol users present. ‘Training on substance misuse is not part of the compulsory university curriculum, leaving individual courses to choose how and if students study this topic’ (Miskelly, 2010). This is also reinforced by a study which the University of Bedfordshire carried out for the Home Office in 2009, which reported that more than half of newly-qualified social workers felt that they could not adequately deal with problems arising from drug and alcohol misuse (Miskelly, 2010). Despite this, there is recognition amongst professionals that this should and must change: ‘a recent poll carried out by the General Social Care Council (GSSC) shows that an overwhelming 89% of social workers surveyed want the social work degree to include training on drug, alcohol and substance misuse’ (GSSC, 2010). In order to achieve this, steps are being taken by the Social Work Reform Board in reviewing the content of the social work curriculum (GSSC, 2010). It is important for the need for change to be recognised, without this change we cannot adequately help those with substance misuse problems. Social workers are often best placed to respond to and
help those with drug and alcohol problems in their specific locality, making further training in drugs and alcohol for social workers a positive step in the right direction.

‘We need to make sure staff are properly trained in a different way, they must be trained to deal with the problem and identify it in the first place so that they can refer them on to the right places.’

(Bianca Horn, BtC worker, Tower Hamlets)

Through this, frontline workers can be helped to understand addiction, and its effects on families and children. Frontline workers can support a parent to access treatment during recovery. One way to help combat the stigma surrounding drug and alcohol substance misuse is to train all practitioners, from whatever sector, to equip them with the skills they need to deal with and support substances misusers appropriately.

‘Many children have attendance problems and lateness – but we have good links with all professionals involved... but some teachers are not fully aware of parental substance misuse, more is known now, but more training is definitely needed.’

(Claire Winship, Specialist Children's Worker, Compass)

People who suffer from substance misuse face a myriad of problems; the key to the success of their treatment is a real understanding of these often very complex needs.

‘It is all very complex, there is a multitude of issues...there is always something else there...it's about finding out what is behind the drug and alcohol problem.’

(Tom Cornwallis, Hidden Harm Coordinator)

A DAAT in London did comment, however, that 'substance misuse would not stop families taking in other family interventions that the borough provides'.

Where there are parental substance issues, it is the responsibility of our professionals to consider how to build trusting relationships with families and be conscious that our attitudes and practice may act as barriers to engagement with families. One must remember that substance misusers are a highly stigmatised group and this can, and does, have profound effects on their lives, particularly in their ability to combat their addiction and move towards recovery (Lloyd, 2010).
'There needs to be more awareness about how to deal with the situations that arise, it's about unravelling the situation and taking the layers off. It is also about staff having the confidence; there is no one right way of dealing with the problems that children present with.'

(Claire Winship, Specialist Children's Worker, Compass)

Professionals in all agencies must recognise, above all else, that their primary duty is to safeguard and promote the welfare of the child; adult drug and alcohol providers are required by law to fulfil their role in safeguarding children. However, these professionals, too, need support when it comes to understanding and appreciating the effects of parental substance misuse.

3.6 The Importance of Continued Contact with Families

Important to understanding this challenge is what is meant by inter-generational substance misuse. Inter-generational substance misuse is the cycle that follows a parent's drug or alcohol misuse and which is then passed on to their children and other family members. This is a cycle of abuse that is extremely hard to break.

‘There needs to be a start, middle and end to interventions. If we work too long with them they can become too reliant on us so it can be difficult to separate at the end. We can see an element that the cycle is broken when they finish and we encourage them to access group sessions if they want to. It is about giving them the resilience to cope with their situations... they can be referred back in at any time.’

(Claire Winship, Specialist Children's Worker).

Without continued contact and longitudinal study, family services cannot know if they have truly broken the cycle of inter-generational substance misuse. Through continued contact with families that have been involved with services we can monitor the progress of the families to see if the children go onto develop problems with substance misuse. ‘We monitor the outcomes and change that has happened since their initial engagement with the service. We try to prepare our clients for reality and establish a support network for them once they leave us by signposting them onto other relevant services’ (Emma Bond, Hidden harm Coordinator). However, this continued contact need not be referral back into the intensive support system. It is important that the clients learn to cope by themselves but at the same time knowing that if they do feel they might relapse or want someone to talk to, that there is some form of continued support available to them.

‘They can always come back once they have been discharged; it’s just a phone call. I always say to my clients, ‘you know where we are if you need anything’. Sometimes people ring just to let me know how they are. Yes, there definitely should be longer contact, you can never assume that because clients haven’t come back that everything is okay. Volunteers can be used on the phone’

(Sue Hannah, BtC worker, Cumbria).

It is also important that the resources are in place to allow for and facilitate this longer-term contact with clients, to give them the onward support that despite being discharged they still are in need of. ‘Longer term contact can be problematic as we don’t have the capacity or man hours to do it, but it is important. We always refer clients on to appropriate services and are there for relapse prevention’ (Frank Birtwistle, BtC worker, Cumbria).
Through continued contact with clients who engage with family services we can start to properly measure and quantify the scale of inter-generational substance misuse. This must go hand-in-hand with improved data collection and would need to be done over a long period of time.

### 3.7 Current Economic Climate

The challenges outlined in this chapter have been even further accentuated by the harsh economic environment which the UK is currently facing. It has resulted in significant changes to the way public services are delivered and financed and is presenting a period of unease and uncertainty about how services will be developed and commissioned in the future. The current economic climate has led to widespread spending cuts in public services and, with a serious lack of funding, many organisations are facing the closure of services and projects that are now unable to grow.

‘National and local guidance and strategies support this call (for strategies to tackle inter-generational substance misuse), but unfortunately, due to funding constraints one of the first areas where cuts are made is family support’ (Emma Cox, Project Manager M-PACT and Cinzia Altobelli, Leader of Therapeutic Services). ‘A challenge is we don’t have the resources available, we need to use what we have available in the most effective way’ (Tom Cornwallis, Hidden Harm Coordinator).

**Now is the time to invest in family based interventions**

Organisations now need to look at new and innovative ways to fund their services; one way this might be achieved is through new social finance initiatives, including Social Impact Bonds. ‘*Through a Social Impact Bond, private investment is used to pay for interventions, which are delivered by service providers with a proven track record*’ (Social Finance, Online). At present it is thought that £40million can be raised by the four Social Impact Bond pilot sites in Hammersmith and Fulham, Westminster, Birmingham and Leicestershire (Cabinet Office, 2011). Graham Allen’s report, *Early Interventions: The Next Steps* recommends the use of Social Impact Bonds to finance and deliver intensive early interventions to combat drug and alcohol issues.

The Payment by Results (PbR) model also presents an opportunity and a challenge to how services are delivered and commissioned. These services really have to deliver, with results measured to show they are delivering the positive outcomes. Now is the time for local authorities to invest in services that have a proven track record of demonstrating effective outcomes; the links to sustaining recovery in the long term and rebuilding peoples’ lives rather than just helping them in the short-term. The basic principles of PbR are hard to argue against as they are considered with improving performance and value for money but it is not without careful consideration as its outworking could undermine the Government’s social policy approach. Measuring and identifying these outcomes is one of the key challenges of PbR.
CHAPTER FOUR: ADDACTION’S BREAKING THE CYCLE

‘The project is innovative, creative and provides effective and imaginative support for families. The holistic approach, supporting all areas around the family, provides support for both parents and children and in some cases, extended family members. By working closely with other agencies, services and professionals across the city, BtC can signpost families for the best support.’

(Source asked for anonymity)

This chapter focuses on Addaction's Breaking the Cycle (BtC) project as an example of a scheme that has had positive results in tackling inter-generational alcohol and drug misuse.

Breaking the Cycle is an example of an intensive family-based interventions programme that takes a whole family approach through providing interventions mainly for parents (but also for the children) to allow them to best prioritise the needs of the children and young people in their care. The children are therefore also involved in their parents’ recovery process and helped to understand their parent’s issues. BtC also works with the children, for example in the form of organising activity days for them.

Other family-based interventions models for those with substance misuse problems will be examined in the following chapter. Interviews with BtC project workers are used here alongside service-user case studies.

The focus on cross-generational use and the health and social impact of substance misusers on families, including young carers and grandparent carers needs to be increased within family-focused interventions. Significant early years’ investment for young people can have a positive impact on both the health of emerging generations and on the cost to society of social care, criminal justice and health. Other risk factors such as mental health emerging from a parent’s drug and alcohol use can increase these costs to society. There has to be investment in these kinds of early and preventative interventions to make social and financial savings in the future.

‘I have seen the huge difference BtC makes for families. I think it is quite unique as it offers families the time to spend with an experienced worker. Due to the small case load, key workers have the time to pay attention to the family. It also works with families when there is still a fair amount of chaos whereas most services will only work with families once they are abstinent.’

Jane Brown, Drug and Alcohol Action Team

4.1 Breaking the Cycle

Addaction’s innovative BtC project was established in partnership with Zurich Community Trust (ZCT) and has been operational since 2005. It supports and empowers families with parents who have substance misuse issues and improves family function and family life, creating an environment where children can thrive. Our overall findings show BtC’s family-centred approach, which includes raising awareness of substance abuse and the familial impact, is contributing to the empowerment, changes and improved lives of the families who are engaged with BtC. BtC 2011 evaluation data shows 91% of parents now put the needs of their children first. There is evidence that including family members in treatment
can produce positive outcomes for all the family and increase the likelihood of sustainable change for that family (Novak et al, 2009). It is particularly aimed at children that have fallen into the ‘hidden harm’ category. As a result of intervention with these children's parents it is hoped that they will not be drawn into a life of substance misuse and the problems that come with it.

The Memorandum of Understanding drawn up between Addaction and Zurich Community Trust outlines the main aim of BtC as ‘aiming to transform the way drug services work with clients and their families by taking a holistic approach in the support and treatment of families with children’s needs being paramount’ (cited in Novak et al, 2009).

“We offer a full holistic approach to the client... we get them involved with partnership agencies.”

(Sue Hannah, BtC worker, Cumbria)

The project was inspired by the Every Child Matters Outcome Framework with the main objective that every child, no matter what their background or circumstances, has the support they need. It also aims to provide holistic treatment to families affected by substance misuse and seeks to tackle the issue of inter-generational substance misuse. One of its key strengths is the way the project is ‘involving families in the recovery process... We have the capacity to work with families when at a crisis point and can provide intensive support...It encourages families to come together and gather an understanding of what’s going on which in turn can break down prejudices. Family is a massive motivator for people... families are generally a support mechanism’ (Tim Vanstone, Head BtC).

Three pilot sites, in Tower Hamlets, Derby and West Cumbria, were selected to test the efficacy and feasibility of family interventions. It was envisaged that 150-200 families per year would benefit from an engagement with BtC - a service delivered mostly at the home of service users. Home visits are seen as one of the project’s main strengths as this is ‘an environment where family is most comfortable...making it easier to unmask hidden harms. This is not so easy when going to a treatment service and sitting in a room talking to a counsellor. In the home you can see first-hand what is going on’ (ibid). ‘The clients are immediately put in system of control and so are quite willing to be open with us’ (Sue Hannah, BtC worker, Cumbria).

‘Home visits are a very important part of BtC... it gives us more insight into what is going on within the family. We can meet more members of the family as many struggle to turn up to services.’

(Bianca Horn, BtC worker, Tower Hamlets)

This is tailored support that meets misusers’ complex needs

However, BtC offers far more than home visits; this is tailored support that meets the multiple and complex needs of drug and alcohol misusers. ‘If they don’t want us to come to their home, they can come to the office, but travelling is a huge problem in our area. We can meet them at school, GP practices or we can use facilities of partnership agencies. BtC is very much client-led’ (Sue Hannah, BtC worker, Cumbria).

Project coordinators at each site assessed client families, referred them to specialist services and developed care packages to help parents improve their parenting skills,

14 Quotes from Jane Brown are reconstructed from handwritten notes as a phone interview was conducted
improve communication with their children, enhance their financial situation by giving them access to the appropriate benefits and helping them enrol on training courses or find work.

This approach encourages parents to be more focused on the health, safety and achievements of their children, all the time with an overarching aim being to reduce families’ substance misuse. The coordinators also signposted families to other sources of support, acted as advocates on behalf of families and developed partnership working with other agencies. Many of the families working with BtC have experienced complex and unsatisfactory relationships with statutory services in the past and require intensive support.

The BtC approach offers children a better parenting role model that, in turn, should help to break the cycle of drug dependency.

‘Breaking the Cycle has been very successful in achieving positive outcomes for families referred to the service and has proved to be a valuable resource to service users and professionals. Feedback from professionals and service users evidences a marked reduction/cessation of drug and alcohol use, improved health and wellbeing for children within the family and much improved parenting.’

(Sukriti Sen, Service Manager, Tower Hamlets)

BtC provides a service that supports the client and family in a non-judgmental, non-authoritarian way, providing both good quality information and expertise in relation to addiction and its impact on the family and providing practical support when families were in need or in crisis. Family interventions are seen as ‘empowering for parents as they can see other people around them improving as they do’ (Tim Vanstone, Head of BtC).

‘Many people I speak to say how unique BtC is in what it does’ (Bianca Horn, BtC worker, Tower Hamlets). This demonstrates not only a clear requirement for BtC, but also highlights the lack of provision of family-based projects that tackle substance misuse.

4.2 Case Studies

Case studies from BtC service users give us a special insight into the reality of the problems that drug and alcohol misusers face. They demonstrate how these problems are multi-dimensional and do not just affect the misuser, but have serious ramifications for those around them, notably their children. They also show the complex dynamic; clients have fears and preconceptions, many believe they will be stigmatised, fear their children will be taken away or treated differently and worry they will have no control over the decisions that are made.

‘Addaction and Zurich had the foresight to work on the edge of something, to be innovative. BtC was a bit different and ahead of its time….we can only really do family work if we can go and see the family and can see the environment they live in.’

(Frank Birtwistle, BtC worker, Cumbria)
**Sarah’s Story**

‘I first got help from Addaction eight years ago. After the birth of Christian 12 years ago, I developed postnatal depression and began to drink to cope with the huge changes. I started drinking at lunchtimes and the arguments with my husband began. I felt so low I started to self-harm.

‘Alcohol changed me; I was violent and ended up with a criminal record because of the things I did when I was drinking.

‘But, with the help of my doctor, I was given drugs to help me stop drinking; they would have made me sick if I had a drink and I was dry for nine months. I started having supervised visits with Christian at my parents’ house but this made abstinence hard, in fact seeing Christian became a trigger for me to drink again. Often I would be too drunk to make the next session and miss him for weeks in a row.

‘I then met my new husband and had got back on top of my drinking when I found out I was pregnant again. I had a specialist drug and alcohol midwife as well as my other midwife. I was sober for three and a half years and this time I knew I would get things right.

‘Then, fourteen months ago, my husband and I moved to Derby; we’d had a tough time and wanted a new start, but the rowing didn’t stop. We had a huge row one weekend when we had the children and he walked out. I had a drink and I knew immediately I’d done the wrong thing.

‘That was when I was introduced to Breaking the Cycle. Social Services and Sure Start were involved too and I felt overloaded, but their focus was the children not me. Sarah, my worker, has become one of the family since then. I can talk to her and know it won’t go any further. She’s always there for us, even when I text her at seven in the morning she comes straight back to me.

‘We’ve worked on the problems that my drinking has caused, not just for me but for the children too. She’s helped me be a better parent and to learn to say no to the children. The children are happier as well; thankfully I have both of them at the weekend again.

‘I feel like I’m moving on now. Sarah’s arranging for me to do some volunteering work and has helped me find new friends through the women’s centre. I know that if anything like this happens again, Imogen will be taken away from me and I won’t be able to have Christian to stay with me, so I need and want to stay dry.’

**Nikita’s Story**

Nikita said the approach of her BtC worker, especially the personal way the support was delivered, treated her as an individual and was not official or judgmental. However, she also noted that her worker was critical when necessary and helped her to achieve what was needed to get her son back.

‘Sarah at Addaction provided me with the support and help to beat alcoholism and get my child back at home with me. She helped me face past traumas and difficulties with my mental health problems – depression and post traumatic stress disorder. I’ve had acupressure and drama therapy which has helped with my anxiety and confidence problems.’

**Daniel’s Story**

‘Had a family day which was good because I was bonding with my little girl and meeting new people and they have got me back into the gym which is something I enjoy doing. Also I think the one-to-one helps a lot because they are there to talk about bad times and will help as much as they can to stop going back to how things were when I was drinking.’
4.3 How Breaking the Cycle Works

Treatment within BtC is tailored to meet individual needs and is based around a series of treatment sessions and home visits. The frequency of sessions varies according to the severity of problems, from daily contact during crisis episodes to monthly reviews when family life has been stabilised. Treatment includes a number of different methods, including Cognitive Behavioural Therapy (CBT), solution-focused therapy and drink diaries. All BtC workers are CCF (Care Competency Framework - Addaction’s standard baseline practitioner training) trained and FDAP (Federation of Drug and Alcohol Professionals) registered. One BtC worker is also trained in systemic family therapy; this sees people as embedded in relationships and dealing with group interactions and dynamics.

BtC not only caters to individual needs but also identifies the needs of the local community in which the service is based. This means that all BtC services are extremely flexible and able to effectively help those in the local area. For example, the BtC site in Tower Hamlets employs a Bengali-speaking project worker, so that it can meet the needs of the large Bengali population living in Tower Hamlets.

This flexibility is also seen in through the engagement time with clients: ‘it depends on what happens in the client’s life. We are not time-restricted against the clients progress, we don’t have to rush through, so the client doesn’t feel pressure, we take it one day at a time (Sue Hannah, BtC worker, Cumbria).

In line with recommendations of the 2003 Hidden Harm report (ACMD, 2003), BtC ensures that individuals and family members who engage with the service and who are not currently in treatment are fast-tracked into local treatment services. This is primarily achieved through networking and working effectively with other agencies to ensure that the very best help is provided.

At the core of the programme is a BtC coordinator. The work of the BtC coordinator is outlined in Figure 1 below.

Figure 2: The role of the Breaking the Cycle coordinator
BtC coordinators work to raise awareness of the Hidden Harm agenda with other professionals and organisations. In building these close relationships, the BtC coordinator also offers coaching and training to social services colleagues that enable them to feel better-equipped to work with substance misusing parents.

A coordinator is established in each site to assess the families and then from this develop a suitable care package to help parents improve their parenting skills, improve communication between the parents and their children and where appropriate refer them to specialist services. Coordinators will also signpost families to other forms of support such as toddler groups and homework clubs with the aim to helping the parents recognise their responsibilities to their children. They are particularly valued for the unique knowledge in which they possess in relation to substance misuse and the information and advice they can provide to families and other professionals (Novak et al, 2009).

*During the course of a single year, one BtC Coordinator alone will engage with 30 families in treatment.*

Families who engage with the programme meet the following criteria:

- the wellbeing of the child is directly influenced by parental substance misuse;
- exposure to substance misuse has resulted in one of more of the following:
  - a referral to social services;
  - a child is placed on the Child Protection Register;
  - care proceedings maybe or have been initiated;
  - the child is directly engaging in illegal activity as influenced by parental drug or alcohol use;
  - at risk of misusing substances themselves.

### 4.4 Evaluating Breaking the Cycle

BtC is grounded on independent evaluation, its approach includes the development of the first ‘family outcome measurement tool’ for substance misuse treatment services in the UK.

*‘The monitoring of BtC is rigorous, so we are therefore able to prove efficacy’* (Tim Vanstone, Head BtC). Accurate evaluation data is collected from all those families who engage in BtC; this transfers into a reliable and statistically-valid resource, which is designed to provide a broad indication of a client’s progress across 12 key areas (see Appendix 3). As part of this innovative approach, BtC developed a specialist-monitoring tool and rolled it out across all sites in October 2007, using evaluation data that had been collected from 68 families who had been engaged with and who had completed the pilot scheme.

Using a seven-point scoring system, the BtC coordinator works with the client to assess the extent to which a client has reached their treatment goals. It is a reliable and user-friendly method that can assess change over time and enables the level of progress or deterioration to be assessed. Evaluations are completed at the start and end of the client’s engagement, and every 30 days in between this period. This crucial evaluation service also interacts with existing data monitoring requirements and, where appropriate, feeds into relevant NDTMS and TOP data monitoring. Additional outcome measurement tools that provide metric data are also utilised and include tools recognised by the National Institute of Health and Clinical Excellence, including the Generalised Anxiety Tool and the Depression Inventory.
The rigorous collection of accurate longitudinal data is essential if we’re to combat the problem of substance misuse successfully. Until data is properly and effectively collected for a generation the impact cannot be properly measured or realised. This reinforces the need for longer term contact and evaluation of families.

The BtC model is incredibly flexible and provides the basis for a sound partnership venture between the service provider and local authority.

Practitioners are involved and actively participate in network and planning meetings within the local area. Experience shows us that just promoting a service at the occasional meeting simply will not be enough to build a strong working partnership. Networking is a continual process; it is the responsibility of project workers and managers to ensure partnerships work with all the relevant services and commissioners.

BtC has demonstrated success in proving that family-based interventions are extremely effective. This is demonstrated when looking at the latest NDTMS figures from an NTA report which shows 43% of adults achieving abstinence through treatment (Roxburgh, 2011). When this is compared with the latest BtC family-based intervention results which demonstrated 53% achieving their treatment goals and in total 76% showed significant progress towards recovery.

Across all sites, Breaking the Cycle has worked with 1002 families. Eight hundred and fifty-two families have been engaged and discharged and 150 families are currently still engaged with the service. By this quarter, the service will have expanded from three to twenty sites.

As the following table shows, the results from the BtC model have continued to demonstrate excellent progress in all areas that can affect an individual suffering from substance misuse; this progress benefits the whole family.

Table 2: Breaking the Cycle: End of Year 2011 Recovery Plan Outcome Findings

<table>
<thead>
<tr>
<th>Bar Chart: Percentage of Family Progression by Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image-url" alt="Bar Chart Illustration" /></td>
</tr>
<tr>
<td>Significant Progress Towards Recovery</td>
</tr>
<tr>
<td>No Progress</td>
</tr>
<tr>
<td>Deterioration</td>
</tr>
</tbody>
</table>
The table above outlines the results achieved by BtC in 2011. These results demonstrate the success of BtC and the important and positive changes that have occurred to the majority of families who have received help from BtC. The results above demonstrate that this family-centred approach promoted by BtC, helps to raise awareness of substance misuse and its impact on the family, promotes the practical skills to support the families needs and understanding of family life. This results in the changes and improvements to the lives of those engaged with BtC.

This data is derived from quantitative analysis of the outcome monitoring data from discharged clients. This outcomes monitoring is key in assessing whether clients are progressing and achieving their treatment goals, and to make sure that BtC is reaching its main aims and objectives.

### 4.5 The Costs of Breaking the Cycle

Since the deficit reduction plan was implemented in the UK, all public services now face a serious challenge to continue providing the same quality of services with fewer financial resources. In the current economic climate, it is more vital than ever for local authorities to deliver value for money in all areas.

*Family-based interventions are able to deliver extraordinary value for money.*

The total cost to a local authority is up to £4,000 per family, making Breaking the Cycle extremely cost effective. This figure is small in comparison to Rt Hon Eric Pickles MP’s estimate that 120,000 families are costing £9billion a year, or around £75,000 per family (DCLG, 2011b).

*It’s clear from our pilot programme that whole family interventions are clinically effective and that these early interventions represent real value for money in the long term.*
CHAPTER FIVE: 
OTHER WORKING MODELS

This chapter explores examples of other models and ways of working with families to help tackle the various issues that they may have due to a family member’s drug or alcohol misuse. This chapter demonstrates that there is no uniform way of structuring family-based interventions, whether it means working with the whole family, working solely with the parent or the children, intervening through the court, or setting up a virtual online community. All these models, despite all having very different and unique ways of intervening with families, have all demonstrated their success and the help they have been able to provide to numerous families affected by problems of drugs and alcohol.

5.1 The ‘Whole Family’ Approach: Action on Addiction’s M-PACT

The Moving Parents and Children Together programme (M-PACT) was devised by Families Plus to meet the needs of children living with parental substance misuse either historically or currently. It is a brief psychosocial, educational intervention that takes a ‘whole family’ approach working with parents and children from up to 8 families in a variety of group combinations. M-PACT recognises that parental substance misuse affects the whole family, and not just the individual substance user. The programme is made up of 10 sessions: an individual family assessment, eight consecutive weekly core sessions and a family review session.

The Walker Family

Karen had a history of problematic drinking for many years and had recently stopped.

Shirlee (11) and her younger brother (aged 5) were placed on the Child Protection Register because they had been neglected due to Karen’s drinking. The 5-year-old was believed to be suffering from foetal alcohol syndrome. Karen and Shirlee were referred to M-PACT by their key worker, in order to support the work being done as part of a parenting order.

Both acknowledged that they felt less anxious than previously and this led to better communication between mother and daughter.

Social Care agreed that these changes were significant enough for the children to be removed from the Child Protection Register.
Independent evaluation data has demonstrated the success of M-PACT. M-PACT promotes and enables:

- positive and honest communication;
- improved family environments;
- education and understanding of substance misuse;
- promotion of self esteem and resilience (in children and adults);
- greater understanding and appreciation of each other;
- the breaking of negative behaviour patterns;
- strategies for coping and enjoying quality time as a family.

The impact on children is clearly evidenced with 59.5% of children stating that M-PACT had helped them come to terms with and understand their parents’ problem and the effects that it has on those around them (Templeton, 2011). Engagement with the programme has been particularly high; approximately 80% of those who started a programme (125 individuals) completed a minimum of six M-PACT sessions. There is also evidence of improved school attendance, children coming off the ‘at risk register’ and parents seeking access to treatment.

Following successful pilot programmes in Wiltshire, all of which were independently evaluated, the organisation realised that M-PACT had helped and could continue to make a difference to families suffering the consequences of substance misuse. As a consequence of the successful pilot the M-PACT programme is now available to agencies across the UK as evidence shows.

M-PACT has a site in Tower Hamlets which is co-provided by Addaction. This demonstrates that projects do and should work alongside each other, to help those accessing the service access the best possible help to combat their addiction problems.

5.2 The Child Centred Approach: Compass Hidden Harm, Lambeth

The Hidden Harm project works with 5 to 19 year-olds who have parents or carers with previous or current problems with drugs or alcohol. These children have been affected by the consequences of misuse, either emotionally, behaviourally, mentally or socially; they need space to talk about their presenting issues and to build resilience, find inner strength and to work through their uncertainties.
‘We developed a project to work with young people whose parents have substance misuse problems...it affects the children’s behaviour...we wanted to get an idea of what children wanted and needed...we offer 12 sessions on a weekly basis...it is intensive arts-facilitated work about building their resilience, to give them space to explore their emotions, so they know that it’s okay to talk about it, and it’s okay to be angry.’

(Claire Winship, Specialist Children Worker, Compass)

‘It is about the children but it is dependent on their willingness to engage with the service’
(Claire Winship, Specialist Children Worker, Compass).

The project was developed in 2010 and began working with young people in May 2010; it has worked with over 50 young people in the borough of Lambeth since then. This alone demonstrates the project’s success to date and the need for the type of service that really listens to children’s voices and supports them through the issues they face when a parent with a substance misuse problem is involved.

‘Many of the children have to take on a caring role, caring for a sibling, because they don’t want their sibling to see their parent’s problem. They are mature beyond their years, and when they are immature it can be completely out of their nature...they can be immature to seek attention.’

(ibid.)

The project has a creative format and uses basic art therapy skills to explore the young person’s emotions and feelings through art and play. Parents must consent to their child engaging with the project and this is done through the common assessment framework process; parents are met when referral takes place to gain consent. The parent advisory model is followed to enable the parent to become the expert on their child’s needs and parents are referred to family therapy or a parenting course if they feel they can benefit from it, however ‘most of the parents have help already’ (ibid.).

‘I really enjoyed being able to talk to someone other than my family and the artwork we did was really helpful.’

(Service user)

The Hidden Harm project ensures families are aware of their child’s progress and know exactly how they’re engaging in the sessions held. The Think Family approach is used consistently and is truly beneficial when it comes to ensuring the child will work through the project, while parents gain strength from their child’s engagement. A person-centred approach that offers core conditions to children is used in every session to ensure a trusting and respectful relationship is developed in the process.
5.3 Intensive Court Based Intervention: Family Drug and Alcohol Court (FDAC)

‘FDAC has helped me be the sort of person I want to be. It’s helped me to remain focused and motivated and instilled in me a real sense of achievement and confidence.’

(Mother, cited in Harwin et al, 2011, 1)

At the time of publication the first pilot FDAC in England and Wales is still running and will continue to run until the end of March 2012. Commissioned by three local authorities in London (Camden, Islington and Westminster) in collaboration with The Tavistock & Portman NHS Foundation Trust and Coram, the scheme is based on the family treatment drug court model that is widely used in the USA and is showing promising results (Harwin et al, 2011). The idea for the court project originated from research that revealed two-thirds of care proceedings initiated by the three London boroughs were the result of parental substance misuse issues.

‘FDAC is a specialist problem-solving court operating within the framework of care proceedings...working with the court is a specialist, multi-disciplinary team of practitioners...the court reviews are the problem-solving, therapeutic aspect of the court process. They provide opportunity for regular monitoring of parents’ progress and for judges to engage and motivate parents, to speak directly to parents and social workers and to find ways of resolving problems that may have arisen’ (Harwin et al, 2011, 4).

Motivating parents to stay on the path to recovery

‘I am passionate about helping children, I get distressed at continually having to remove them from their families’ (Nick Crichton, District Judge). The main aim of FDAC is to keep the family together, as opposed to hastily breaking it apart. ‘This is what I was trained to do, to keep families together, not break them apart’ (Social worker, FDAC team).

FDAC is a distinctive form of family-based intervention, with a specialist court involved in intervening and helping the family towards recovery and supporting children to stay in the family, ultimately leading to a better family and home environment for the children. The overriding objective of the court is to change the lives of the children whose parents are suffering from serious substance misuse issues and whose care proceedings are under way to have them removed. The court helps parents get into the treatment and recovery services they so desperately need. The same specialist judge who oversees court proceedings remains in place throughout the process for each family and plays a pivotal role when it comes to encouraging and motivating parents to stay on the path towards recovery.

‘I’ve been to an ordinary care case before and normally you wouldn’t get any advice. This is what I think I need. In the other court no-one actually works with you.’

(Parent, cited in Harwin et al, 2011, 8)
An initial evaluation of the pilot FDAC demonstrates positive outcomes; 48% of FDAC mothers and 36% of fathers in contact with FDAC were no longer misusing substances and, at final order, the children of 39% of FDAC mothers were living at home. In general, parents were very positive about both the FDAC team and the judges, saying they were treated ‘like a human being’ (Harwin et al, 2011, 9).

FDAC represents an innovative approach to family-based interventions and it is clearly proving very successful; the Government has acknowledged this success in its Drug Strategy, 2010: ‘in London, the Family Drug and Alcohol Court provides specialist support to parents to help them overcome their drug and alcohol misuse and associated problems’ (HM Government, 2010, 22). Despite this, ‘it’s a battle, we want it rolled out, there are a number of areas interested and we are doing all we can to encourage them’ (Nick Crichton, District Judge).

Numerous award nominations, including one for the Guardian Public Service Award, are also testament to the innovative nature and success of FDAC.

‘Working in FDAC is both exhausting and exhilarating. Seeing parents take advantage of the very specialist help which is offered and really get to grips with serious drug and alcohol issues is immensely rewarding. The project is about outcomes for children, and we are managing to get more children home than in normal care proceedings. Of those who cannot go home we are getting them into an alternative permanence more quickly. Of course some parents struggle, but they have had the best chance and often develop a better understanding. I firmly believe that this kind of problem-solving approach offers a better way of addressing these very difficult issues – and the preliminary research bears it out!’

(Nick Crichton, District Judge)

5.4 The Online Approach - The Virtual Community: Wired In

‘I was amazed when I came across Wired In. This was the place I had been seeking for a long time. It’s great as I can put down what was happening, how life is now and how I want the future to be for my family. I am not judged or made to feel guilty…it is like pulling up a chair and having a cuppa with some friends. Yes, friends, that is how I see all other community members. We all have problems with either drink, drugs, rehabilitation – the list is endless. But as long as we band together, it means that you’re never alone.’

(Linda, recovering mother)

Wired In is a unique online communication programme that represents an innovative way for substance misusers and their families to communicate with each other, so they can better understand their problems and help find the recovery pathways that suit their individual needs most appropriately.

This pioneering initiative was launched 10 years ago to empower people and help tackle their substance misuse problems head-on. The principle aims of the Wired In organisation are to provide genuinely beneficial information and tools to help those engaging with it to really comprehend their problems or those of a loved one. These tools are designed to lead them to find their own pathway to successful recovery. Wired In also works closely with other organisations and groups that can further help to facilitate the recovery process for all family members.
A global online recovery community; a stepping-stone

The organisation also tries to go some way to breaking down the stigma placed on substance misusers and the problems they experience, ‘to create a society that better facilitates recovery from substance use problems’ (Wired In, Online). Wired In offers a global online recovery community. ‘Virtual Recovery communities are intimately linked to the real world. They are a doorway, a bridge and stepping-stone. Our recovery community helps family members understand their loved one’s problems, as well as problems that arise in their own lives as a result of a loved one’s substance use. We help to prepare them for such problems, show them potential solutions to these issues, and ways that can reduce the stress that they are experiencing’. (Michaela Jones, Wired In)

‘After 13 years of hell for my family and I – and especially for my brother who is dependent on Pervitin – your website was the first place I had felt hope. Hope of recovery, hope of a way out – hope that all the doctors and therapists were denying.’

(Misa, sister)

Recovery is about community

One of the key features of Wired In is the trusting relationship the organisation develops with those affected by substance misuse. Wired In’s online community gives people the space to blog about and share their problems, to empower themselves and, in doing so, help others who are part of the same community.

‘It is clear that recovery is related to connectivity. If active addiction is all about isolation, then recovery is about community. Research has shown that social anxiety interferes with willingness to talk to practitioners, speak up in groups, attend AA/NA, SMART Recovery etc. and to interact with others. Other factors, such as childcare responsibilities, geographical isolation and work commitments can mean many individuals are unable to access more traditional recovery pathways.’

(ibid.)

5.5 The Family Support Approach: Family Intervention Projects

Family Intervention Projects (FIPs) were designed to tackle antisocial behaviour, with the express aim of helping high-risk, disadvantaged problem families who are often seen as ‘lost causes’. Families presenting to FIPs will be suffering from multiple problems; substance misuse is just one, although the nature of the work FIPs carry out with problem drug and alcohol users renders it important to explore the approach they employ.
FIP pilot studies uncovered a link between antisocial behaviour and multiple problems that include drug and alcohol misuse (Respect Taskforce, 2006, cited in Debbonaire, 2009). Fifty three FIPs were launched in 2006-07; of these, 24 were delivered by a local authority and 22 contracted out to the voluntary sector (White et al, 2008) to charities such as Action for Children that run a number of FIP services across the country. The remainder are either run by a housing organisation or a combination of those mentioned above.

In the context of public spending cuts, FIPs been subject to intense scrutiny (Cacciottolo, 2011); this scrutiny and a lack of long-term funding has forced many to close down.

It is time to find innovative ways to fund FIP services

Action for Children has revealed that, since May 2010, five of its FIPs have closed, with further services suffering from severe budget cuts (Cooper, 2011). In the face of such drastic cost-cutting measures, FIPs must devise innovative ways to fund the services that so many families rely on to help them overcome their problems and to ensure their children can have a better future. However, FIPs are seen to be cost-effective and Government does acknowledge this fact: ‘Intensive family interventions are highly cost-effective with every £1million invested achieving £2.5million in savings to local authorities and the state’ (HM Government, 2010, 11). It is imperative this statement is stressed effectively so further cuts to successful FIPs might be avoided.

From all available data, it is clear that intensive family-based intervention services do help families to move on from multiple economic, social, behavioural and health problems. The latest monitoring and evaluation statistics published by the DfE shows that, through these services, there was an average 40% reduction in the number of families experiencing drug problems with an average 48% reduction for those experiencing alcohol problems (DfE, 2011).

Government focus on FIPs is ongoing along with other new ways of intervening with the whole family also being explored. Social Impact Bond pilot sites are being set up in Hammersmith and Fulham, Westminster, Birmingham and Leicestershire. ‘These would be the first Social Impact Bonds to tackle multiple problems in a family setting’ (Cabinet Office, 2011). The Government is committed to the success of Social Impact Bonds, this is demonstrated in Graham Allen’s report which recommends and supports the use of Social Impact Bonds to finance and deliver intensive interventions to combat those with drug and alcohol problems. In addition the Department of Health has identified eight pilots sites for the Drug and Alcohol Payment by Results initiatives.
CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusions

Family-based interventions are certainly not a new concept; they're widely recognised as an effective way to deal with multiple complex problems, especially those faced by drug and alcohol users. Indeed, family-based interventions support the wider context of the UK’s national problem of drug and alcohol abuse, which doesn’t just damage the individual; the problem is magnified when the potential effects on the family, particularly the children, is considered. Work with children and other family members who are related to individuals with addiction problems can really deliver positive outcomes for everyone (Copello et al, 2005). However, there's still a long way to go in terms of improving family-based interventions where substance misuse is a problem and creating wider, more accessible provision of these services across the country.

Despite its success in combating parental substance misuse being well documented, current provision of family-based interventions is very limited.

‘It is important to remember that there is no blanket way of approaching families as every family is so different’ (Source asked for anonymity). There is real potential for future development and it is clearly evidenced by the success that current family intervention projects have had. This report has verified that family intervention projects are critical and can achieve truly great success; it is important that services move forward from a concentration on individuals.

Within the projects outlined in this report there are genuine examples of existing projects that target the family and parental substance misuse with significant results. BtC has undoubtedly demonstrated success, with 76% of parents in 2011 having stabilised, reduced or stopped their highly problematic substance misuse that impacts on their family lives so negatively, and hence reducing the associated risk factors. BtC is now ready to expand nationally.

‘We need to keep raising the profile of family-based interventions for those with drug and alcohol problems; it is a problem that lots of children are facing. Conversations around substance misuse need to be normalised and brought out into the open. Hidden Harm doesn’t get the profile it should have yet, but we are on the right tracks’

(Emma Bond, Hidden Harm Coordinator, Tower Hamlets).
However, with the number of problem families estimated to be at least 120,000, it is clear more needs to be done to help them (DCLG, 2011a). ‘I have seen a huge rise of drug and alcohol misuse in the last 20 years, and I have seen how children suffer as a result…I believe that the figures in the Hidden Harm Report were an underestimate’ (Nick Crichton, District Judge). By developing a culture of understanding and an appreciation of the effectiveness of these family-based intervention programmes, more families can get the access to the support that they so desperately need.

The evidence shows that family members of individuals who are addicted to drugs and alcohol can be adversely affected by their behaviour; their development and future can be hindered and can lead children to follow in their parents’ footsteps into a life of substance abuse. Working with the whole family provides an invaluable support network, as an analysis of Addaction’s Breaking the Cycle project and associated results proves.

**Family-based interventions make social and economic sense**

It is estimated that the cost of family members and carers of problem drug users in England is £1.477 million (Copello et al, 2009) and the estimated cost of alcohol harm to the NHS in England comes to a staggering total of £2.7 billion (IAS, 2007). These figures are coupled with the fact that children of problematic drug and alcohol users are seven times more likely to grow up with drug problems themselves. It is obvious that forward-looking, family-based interventions make social and economic sense. This cost to society has never been more important than in a volatile economic climate in which everyone is being asked to deliver more for less.

*Models such as BTC provide a holistic approach to the problem of misuse and provides a useful model which could potentially benefit generations to come.*

### 6.2 Recommendations

The recommendations below provide a framework to implement strategy effectively at a local commissioning level and to offer direction for the future development and success of family-based interventions that tackle substance misuse. It is imperative that local commissioners address these issues. The Commission hopes these recommendations will lead to new tools being put in place and get family-based interventions right to the heart of agenda to tackle inter-generational substance misuse, an issue that simply cannot be ignored.

*1. If this cruel cycle of inter-generational substance misuse is to be successfully broken, local planning must exploit the benefits provided by family-based interventions. The needs of the family must be taken into account at every step and the voices of the children must be heard:*
Currently, the national picture is patchy, to say the least. This Commission recommends all future local commissioning plans include family-based interventions in order to achieve universal and consistent delivery. Such plans should detail accurately how joined-up, family-focused working across all agencies can be both up-scaled and strengthened and should be delivered with a national register that maps out local and national agencies that have the potential to support families with drug or alcohol problems effectively.

Families are at the centre of these projects; it is vital to their success that they’re involved in the creation of services, their voices are heard and their needs taken into account, every step of the way.

2. **A standard framework for the collection of data about these families using a common, cross-service approach should be developed to quantify the true scale of inter-generational substance misuse accurately:**

Although NDTMS does collect national data on drug and alcohol treatment, there must be a more uniformed approach to the collection of information about family situations where substance misuse is a problem; this data can then be cross-referenced against those in the wider family who may also be affected by the addiction.

*Improved data collection means the scale of the problem can be accurately demonstrated and, armed with this knowledge, a more accurate response can be provided.*

When an individual is assessed for drug and alcohol treatment, questions about their family and children must form part of that assessment and should be routinely asked by all services. The resulting information should be recorded appropriately so as to identify local trends, which key decision-makers can then address through relevant commissioning.

This will also ensure problem drug and alcohol users are identified early and are not left under the radar; currently too many remain unknown to these services. This approach should apply to all cases in which drugs and alcohol may be a risk, but should also form part of the information and assessment process for pregnant women and those seeking family planning advice.

3. **Public Health England and local health and wellbeing boards must develop strong, effective inter-agency networks to support the provision of family-based interventions:**

The new Health and Wellbeing Boards should be encouraged to establish effective networks and partnerships at a more local level. Improvements that result in a closer working relationship between drug and alcohol workers and children’s and family services need to be made. This is vital; agencies currently working in isolation can only benefit from the support and advice that comes from close partnerships. As a direct result, they may be encouraged to develop family interventions that work and ensure effective onward client referrals are made.
4. **Drug and alcohol training should be developed and delivered for all frontline workers, regardless of their sector. In addition, drug and alcohol services need to work more closely with children's services, GP surgeries, teachers, Sure Start and other children's support centres:**

Workers should be sufficiently skilled and empowered to recognise how their work can and does make a difference in identifying and providing support for such families. Drug and alcohol training for frontline staff should be compulsory to ensure that parents who misuse substances are encouraged into treatment. With the right training, workers can be helped to successfully identify the multiple and complex problems that drug and alcohol users present to themselves and their families. Furthermore, training can reduce stereotyping and help break down the prejudices, stigma and fear that are so inherent in drug and alcohol users and which, all too often, can hinder entry into treatment.

Drug and alcohol training should therefore become an integral component of degree courses for social workers and other practitioners coming across parental substance misuse in their work.

5. **Longer-term engagement is required with families where there is parental drug and alcohol abuse. Longer-term commitment is needed for continuing care for affected families so their future development can be adequately supported:**

With a recovery-focused drug and alcohol strategy, longer-term engagement is essential when it comes to tackling parental substance misuse. Without this and robust long-term evaluation, the success of family-based interventions that are aimed at breaking the cycle of inter-generational substance misuse will never be known. The impact on children who have been in an environment of drug or alcohol abuse should be monitored. It is not necessary to keep people within drug and alcohol services if they have recovered, but there must be a longer-term commitment to continuing care for affected families so their future development can be adequately supported. This is an investment in the future and should be part of all local commissioning plans.

6. **Communication and support for service users should be enhanced, utilising the opportunities that social networks and the internet provides, to deliver more effective contact channels and family-based, peer-led support:**

To ensure families are helped effectively, new modes of communication must be developed and improved between services and families, utilising the opportunities that social networking and online peer-led recovery can have for families where substance misuse is a problem. It is important families are fully informed of what exactly is available to them, for example services that signpost users to relevant online forums that support the recovery process.
The Breaking the Cycle Commission. A report by Addaction

7. The use of new charity and Social Impact Bond Funding models should be supported, encouraged and embraced to ensure greater coverage of addiction focused family support programmes:

The country is currently in the midst of an economic crisis and a period of harsh public spending cuts; it is inevitable that funding to local authorities and family-based services is limited. The introduction of a Payment by Results approach means services will need to prove their effectiveness through proven outcomes, so, local and national Government must look to new and innovative ways of developing financial resources that support the ongoing development of family-based intervention programmes. The use of new charity and Social Impact Bond Funding models should be supported, encouraged and embraced to ensure greater coverage of addiction-focused family support programmes.

Services are currently faced with seemingly insurmountable challenges in their attempts to measure the effects of inter-generational substance misuse. There are challenges to measuring this unless children are tracked over a longer period of time. However, by implementing these recommendations, they will be able to take steps to deal with parental substance misuse which can damage children and has the potential to expose these children to the risk of becoming substance misusers themselves.
APPENDIX 1

Family Intervention and Related Initiatives
October 2011

Families offered and accepted a family intervention cumulatively 31 March 2011

- over 60
- 31 to 60
- 10 to 30
- no data*

* Includes 1. Figures suppressed to avoid disclosure of counts of fewer than 10;
2. Local Authority has not given permission for their figures to be published.

Not all LA information is available, as some LAs are in trial areas and therefore not included in the National Pupil Database. Where there are no data available, this is because the LA has not given permission for their figures to be published.

Key - Projects and Initiatives

A. Family Intervention Service
B. Community Budget exemplar
C. Walking Families Everywhere
D. Organisations that offer support to all areas under the DE VCS programme (e.g. Interface Associates, Adfam, Addaction, Alcohol Concern, Children’s Society, Princess Royal Trust for Carers, CSV, Place to Be, Adfam, Multi Systemic Therapy, YMCA Derbyshire)

Families offered and accepted a family intervention cumulatively 31 March 2011

- over 60
- 31 to 60
- 10 to 30
- no data*
APPENDIX 2

DERBY BREAKING THE CYCLE FOCUS GROUP: June 2011.

PROJECT DESIGN AND FACILITATOR: Sophie Kydd.

HOST: Addaction.

PARTICIPANTS: Three Breaking the Cycle service users and three Breaking the cycle staff.

AIM: The aim of this focus group was to gather information about the Breaking the Cycle project from service users and staff to support the Breaking the Cycle Commission.

STRUCTURE:

1) Introduction and participants' involvement with BtC.

2) Discussion about previously-used services and their positive and negative feelings towards them.

3) Discussion about Addaction’s Breaking the Cycle project and their positive and negative feelings towards it.

4) Final statements.
INTRODUCTION AND INVOLVEMENT WITH BREAKING THE CYCLE

Nikita

Nikita was self-referred to the BtC project in Derby in April 2010 having seen a poster for the service at a Sure Start centre. She has suffered with a drinking problem for a long time and it had led to her son being taken into care, but, following a year spent working with BtC, Nikita now has her son back at home with her. Nikita said the support she received from her BtC worker was essential, especially since it was conducted in a very personal way and because her BtC worker treated her as an individual and was not official or judgmental. However, she also noted her worker was critical when necessary and helped her to achieve exactly what was required to get her son back. She said that when she hit rock bottom she felt alone, but BtC 'saved her'; she felt social services were only there to help her children, which left her alone and vulnerable to relapsing.

Daniel

Daniel joined the BtC in April 2011 having been referred to the service through probation. He lives with his partner and two children and he takes an active role in their childcare. He has already attended a family day with his daughter, which he really enjoyed. Daniel made a comment that, before BtC, he felt that he had no-one to phone if he had a problem, but now he does. Daniel doesn't want to go back to his bad drinking habits or return to prison.

Sarah

Sarah joined the BtC project in July 2010 following a relapse, having been sober for three and a half years. When it happened, she called the police and was charged with child neglect, however they agreed not to press charges if she consented to work with Social Services who subsequently referred her to Addaction. She found her BtC worker more approachable than the help she'd received before and who was particularly supportive when her daughter, her reason for staying sober, was not there. Sarah has now been sober for just over a year, although she is on a small methadone prescription for an addiction to a drug prescribed by her doctor. Her relationship with her partner has recently ended and she's now facing life as a single mum; she's grateful for the support BtC offers.
### PREVIOUSLY-USED SERVICES

**Friends and Family**

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘They help to support clients’ substance misuse and children.’</td>
<td>‘They can influence the treatment journey through a lack of awareness.’</td>
</tr>
<tr>
<td>‘Lots of support looking out for me.’</td>
<td></td>
</tr>
<tr>
<td>‘Addaction worker and friends and family are very supportive and involved in the treatment journey with practical and emotional support.’</td>
<td></td>
</tr>
</tbody>
</table>

**AA**

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Helped me to think about what alcohol does to the body, which I didn’t know.’</td>
<td>‘You can go there drunk.’</td>
</tr>
<tr>
<td>‘Positive, because others are dealing with same issues.’</td>
<td></td>
</tr>
</tbody>
</table>

**Prison**

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Provides programmes and detox support.’</td>
<td>‘Bad time, no help.’</td>
</tr>
<tr>
<td></td>
<td>‘They just lock you up.’</td>
</tr>
</tbody>
</table>

**Enhanced Training Skills**

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Thinking about the consequences before I do things which helped me a lot.’</td>
<td></td>
</tr>
</tbody>
</table>

**Celebrate Recovery**

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Made new friends.’</td>
<td>‘Too religious.’</td>
</tr>
</tbody>
</table>
### The Elms

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Knowing they're going to help you in hard times, i.e. going to court.’</td>
<td></td>
</tr>
<tr>
<td>‘Support, having someone to talk to about anything.’</td>
<td></td>
</tr>
</tbody>
</table>

### DAMS

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Intensive support, one-to-one work and works closely with other services.’</td>
<td>‘Lack of family support or support for children.’</td>
</tr>
<tr>
<td></td>
<td>‘Only have half-hour appointments and doesn't include the wider family.’</td>
</tr>
</tbody>
</table>

### Probation

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Experienced workers and work with other agencies.’</td>
<td>‘Stops me from doing things and getting on with my life, but it’s my own doing and they give me support.’</td>
</tr>
<tr>
<td>‘Support with getting ex-offenders back to work.’</td>
<td></td>
</tr>
</tbody>
</table>

### Addaction Group Work

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Listening to other adults' experiences.’</td>
<td></td>
</tr>
<tr>
<td>‘Knowing you're not the only one.’</td>
<td></td>
</tr>
<tr>
<td>‘Becoming friends and socialising.’</td>
<td></td>
</tr>
</tbody>
</table>

### Social Services

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Helped me face problems and deal with them rather than drink.’</td>
<td>‘Some social workers do not understand addiction. Doesn't mean you're a bad parent.’</td>
</tr>
<tr>
<td>‘Support, advice, information.’</td>
<td>‘Eligibility criteria, confusing, awareness.’</td>
</tr>
<tr>
<td>‘Learning to deal with children.’</td>
<td></td>
</tr>
<tr>
<td>‘When they help to get the children back.’</td>
<td></td>
</tr>
</tbody>
</table>
ADDACTION’S BREAKING THE CYCLE

All comments regarding Addaction’s Breaking the Cycle project were placed in the positive column and include the following responses:

‘Non-judgmental.’
‘Non-judgmental and always there. Empathy, help with housing, help with life and situations and coping with my older son. Dealing with the upset and trauma I once went through.’
‘One-to-one support.’
‘One-to-one support, approachable, honesty.’
‘Working closely with other services.’
‘Addaction worker recognises the impact on children.’
‘Having someone to help you deal with problems in life.’
‘Non-judgmental support.’
‘Gym, keeping myself fit.’
‘Acupuncture.’
‘Having someone to turn to, anytime.’
‘Learning other ways of coping before reaching for a drink.’
‘Having someone who cares when everyone else has given up on you.’
‘Help with the family.’
‘Coming to court with me, advice and encouragement, advocate, confidential.’
‘Learned how it has impacted on my children and how to deal with problems that come along.’
‘Having someone there to talk to about bad times.’
‘Help with everyday life, housing and jobs.’
‘Signposting.’
‘Acupuncture, coffee mornings, practical stress relief.’
‘Recognise supportive family and friends.’
‘Family days and activities.’

FINAL STATEMENTS

‘I first worked for BtC in February 2009 on a five-and-a-half month placement whilst completing an MA in social work. Following the placement, I was lucky enough to gain full-time employment as a Family Support Worker with the BtC project in Derby. For me, the project is innovative, creative and provides effective and imaginative support for families. The holistic approach, which covers all areas around the family, provides support for both parents and children and, in some cases, extended family members. By working closely with other agencies, services and professionals across the city, BtC can signpost families for the best support. Working for BtC is both challenging and rewarding as we’re involved in supporting clients throughout their treatment journey and recovery.’

Jane Wright, BtC worker, Derby

‘I’ve only been with Breaking the Cycle for three weeks, and up to now, it’s been very good. Had a family day out, which was good because I was bonding with my little girl and meeting new people. They’ve got me back into the gym, which is something I enjoy doing and also I think the one-to-one helps a lot because they’re there to talk about bad times and will help as much as they can to stop me going back to how things were when I was drinking.’

Daniel, BtC service user
'I had my child removed after having an alcohol problem for 22 years. Sarah at Addaction provided me with support and help to beat alcoholism and get my child back at home with me. She helped me face past traumas and difficulties with my mental health problems – depression and post traumatic stress disorder. I've had acupressure and drama therapy, which has helped with my anxiety and confidence problems.'

Nikita, BtC service user

'I first got involved with BtC nearly a year ago after being charged with child neglect; I was drunk whilst being on my own with my two children. However, it was decided that if I worked with Addaction I would not be officially charged, so I've been supported by Sarah Hudson. My experiences have been positive and Sarah works with my children as well. They love seeing her. She is non-judgmental and is there for me all the time.'

Sarah, BtC service user

'I enjoy working as a support worker for BtC. It's rewarding and challenging at the same time and I love seeing how my families progress and gain from the service.'

Sarah Hudson, BtC worker, Derby
APPENDIX 3

DETAILS OF THE EVALUATION OF ADDACTION’S BREAKING THE CYCLE

Evaluation data was collected from all families and provides a broad indication of the client’s progress across 12 key areas:

1) Parental substance use
2) Parental awareness of the impact of risk
3) Harmful behaviours
4) Housing stability
5) Economic stability
6) Health
7) Meaningful occupation
8) Social competence (parents)
9) Healthy development (children)
10) Parenting skills
11) Family functioning
12) Relationship with worker

Breaking the Cycle coordinators will maintain records to monitor quantitative information, including:

- Number of referrals
- Referral sources
- Numbers completing the BtC care plan
- Numbers involved with social services
- Number of children receiving support
- Number of children taken off the ‘at risk’ register
- Breakdown of clients by age and gender
- The number of partner organisations working with the project
- The number of clients and family members attending support group meetings
Dear Ms Kydd,

Thank you for your e-mail of 07/03/2011 3:52:30PM about the number of children in the UK who are living in a family where one or more parents are suffering from an addiction to drugs or alcohol. Statistics on numbers of children living with drug or alcohol abusing parents are not routinely collected.

New analysis to estimate the number of problem drug users with children was undertaken for the Advisory Council on the Misuse of Drugs 2003 Hidden Harm report. The report presents estimates for England and Wales as well as for Scotland and the UK. It estimated there are between 250,000 and 350,000 children of problem drug users in the UK – about one for every problem drug user.

Taking England and Wales separately, it was estimated there are between 200,000 and 300,000 children where one or both parents have serious drug problems. Of these only 37% of fathers and 64% of mothers were still living with their children. The report also found that the more serious the drug problem, the less likely it was for the parent still to be living with the child. Most children not living with their natural parents were living with other relatives and about 5% of all children were in care.

The full report, including information about how the estimates were achieved, can be found at the following link:


In addition, the Department for Education have asked Professor Eileen Munro to undertake an independent review of child protection, which includes some consideration of parental drug and alcohol use and may be of use. The National Treatment Agency provided the following evidence to the review focusing on drug users in treatment only: ‘There were 68,207 adults receiving drug treatment in 2009-10, who had a child living with them at least some of the time.’ Further information can be found at:

http://www.nta.nhs.uk/families.aspx

In terms of parental alcohol use, the Munro review interim report - http://www.education.gov.uk/munroreview/ cites evidence from academic research based on UK national household surveys. This work found that more than 2.6 million children in the UK live with hazardous drinkers, 705,000 live with a dependent drinker and more than 8 million people are affected by a family members’ alcohol use.

The reference for this work is:


Best of luck with the research.

Anna Richardson
APPENDIX 5

BENEFITS OF BREAKING THE CYCLE - REPORT

RESPONSES TO QUESTIONS

Questions

We would like to know:

1) How you collect and use data relating to children and families affected by substance misuse.

2) What your strategy is for implementing family-based interventions where substance misuse is a problem.

3) What your strategy is for implementing early interventions where substance misuse is a problem.

4) How extensive the problem of substance misuse is in your area.

Quantitative Summary

Of the 16 responses to the Addaction request for information, 13 respondents conformed to the four-question structure and gave responses that varied from one brief sentence to a detailed paragraph of around 250 words. Generally, the first question was answered in the most detail and often questions three or four were restricted to very brief responses. For the three other respondents, one provided a very brief, overarching response to the four questions, one attached a recent report regarding drugs misuse only and one simply provided a link to their website, citing the fact that they are in the process of re-tendering their services as a reason for the nature of their response. In one case, Addaction also received additional attachments containing further protocols and data.

Question 1: How do you collect and use data relating to children and families affected by substance misuse?

Summary

The majority of responses (10) contained a reference to the use of NDTMS as a means of gathering data, with others referring to the use of NHS data and DIMIS data. A few mentioned the use of local audits by provider services and some also discussed a desire to ‘join-up' the data and overcome information-sharing barriers.

The overriding use for the data is to inform the needs assessments and the identification of partnership priorities. Others revealed the data is being used to prove the need for better joint working between children's services and the treatment system.
How data is collected

One respondent asserted the importance of collecting children's data, but said the final solution had yet to be decided; the issue being whether data should be collected at the point of entry (which may be before the substance misuse had been identified) or if not at that stage, when? Another respondent stated there was no specific dataset that was centred on children and families, which was a considerable area of [unresolved] discussion in recent workshops on the implementation of joint protocol. Another stated the data collected on NDTMS was fairly basic so they had collected data from their services around referrals to social care last year and were intending to track this annually.

How data is used

Generally, the respondents admitted using NDTMS for ascertaining whether the client was a parent, how many children they have (under 18) and whether the children live with them. One respondent admitted to using the data to prove the need for better joint working between children's services and the treatment system and to engage more parents and support children better. Another stated that their authority also operates a Children and Families Group, combining treatment service staff and family services staff, and which works to problem-solve between the two areas; this improves joint working and the experience for the service user.

Question 2: What is your strategy for implementing family-based interventions where substance misuse is a problem?

Summary

The response to this question was fairly mixed, with some organisations in the midst of organising a new strategy for implementing family-based interventions and remaining upbeat about the progress being made. Others were less positive, admitting that social care services had ‘not engaged’ with the model for joint working protocols, and citing ‘political tensions’ around local authority reorganisation of resources as a concern.

Broadly speaking, the responses were either fairly positive or matter-of-fact about their strategies. However, three respondents in particular admitted to being ‘a long way off’ with their model or that their strategy was ‘not as robust’ as it should be.

Positive responses

The majority of responses contained varying degrees of optimism. One answer was particularly positive, describing their bespoke family training, which is currently being ratified by the Bradford Safeguarding Children's Board. They also plan to deliver family training to 160 staff over the next four months. Another highlighted the ‘Families Also Matter’ service that they are commissioning and which provides group programmes, one-to-one support, couples' counselling, family member meetings, grandparents' support groups and offers training to professionals in the field. A further eight respondents also had answers in a similar vein, with programmes such as ‘Think Family' appearing in a few responses.
Negative responses

Three responses stood out in particular for their pessimism. One stated that, despite a number of multi-agency workshop meetings around implementation, they are a long way off the model for joint working protocol. Another expressed concern that children and young people's social care services had not engaged with this agenda, and also mentioned that they had a number of political tensions to contend with around local authority reorganisation, thresholds and resources. A small borough stated that they were unable to carry out whole family interventions via their substance misuse services and had to be creative with referrals. Others said they were developing this area, admitting that, whilst children's services offer a range of activities and support for families, the pathways and coordination between substance misuse services and children's services is not as robust as it should be.

Question 3: What is your strategy for implementing early interventions where substance misuse is a problem?

Summary

As with question 2, responses contained a variety of positive answers filled with information about the intervention strategies and some more negative responses, which reveal the strategy is problematic. Three respondents admitted to their strategy being a work in progress or not in place due to insufficient funding, although they go on to outline the work they do in schools or in partnership with the police to discourage substance misuse.

Positive responses

The majority of responses were positive or simply matter-of-fact about their work in the area of early interventions. One described their treatment providers as being involved in building working relationships with the Children's Centre and using the Family Information Service to enable them to signpost clients into early interventions. Another mentioned themselves as on the radar of the local Children and Young People's Scrutiny Panel, which had asked to receive and review regular updates in relation to developing both family and early intervention. One described themselves as having local waiting times (48hrs for DIP, three weeks for non-DIP) that apply to all and that rapid access (usually within five hours) is available when serious risk factors are identified. Another stated that all providers had signed up to a local Family Focus Protocol, which encourages all services to consider the wider needs of family members and to refer them where necessary to the appropriate services for the earliest possible intervention. Many respondents also outlined positive strategies that were normally centred on children and families.

Negative responses

Of the 16 respondents, three submitted answers that were more pessimistic. One stated there was not an early intervention strategy for substance misuse as such and that they had no funding to support it. Nevertheless, they do employ young people's workers who both promote drug and alcohol awareness and treat young people in the community. They also have a strong partnership with other internal departments and external agencies in order to recognise substance misuse issues and make the appropriate referrals at an early stage. Similarly, another admitted their strategy for implementing early interventions where substance misuse occurs is a problem, although they work with the police in the Community Alcohol Programme to deliver early interventions at a community level.
Question 4: How extensive is the problem of substance misuse in your area?

Summary

Nearly half of the respondents (seven) simply referred us to their website or report for information on this issue. Of those who answered the question, most contained some reference to the number of problematic drug users in their area and the number of those in treatment. The majority of information was centred on drug users; there was little mention of alcohol users.

Information on alcohol and type of drug use

The respondents provided some information on the nature of drug and alcohol use. One respondent stated that pockets of substance misuse occurred in areas of poverty, with alcohol being the biggest issue and also described a particular area with a GHB problem, although this is only a minority of the population. Two respondents primarily used figures for crack/heroin use when outlining their data.
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The importance of family-based interventions in tackling substance misuse.