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To what extent can drug and alcohol services become better equipped to support service users and their families/dependents?

Improving outcomes for service users and preventing intergenerational cycles of substance use

Elizabeth Goodwin
Research Assistant, Humankind

Madison Pape
Research Assistant, Humankind

Tamryn Matthysen
Research Assistant (Data), Humankind

Cecilia Busari
Research Assistant, Humankind

Mark Crowe
Research and Development Coordinator, Humankind

West Yorkshire Violence Reduction Unit

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Head Office Humankind, Inspiration House, Unit 22 Bowburn North Industrial Estate DH6 5PF.

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Summary and Acknowledgements

This report looks at some of the practical reasons why drug and alcohol services should engage with families to a greater extent than they may currently do. The recommendations reflect aspects of best practice which may already be employed in services as well as some more speculative areas for further work. The report examines the numbers of families affected and issues around their engagement with services. It then looks at the importance of working with families from the point of view of intergenerational substance use. Finally, the report provides a model for a pathway for working with families in drug and alcohol services. The latter two sections are written from a psychological perspective as it is as much the relationships in the family that need to be addressed as the clinical aspects of treatment. The authors are grateful to colleagues in Humankind and the West Yorkshire Violence Reduction Unit for their insights and input into this report.

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Introduction – The Numbers of Families in Treatment Services

Drug and alcohol services are focused on the treatment of individuals presenting with these issues and supporting them through to recovery. Although the data collected in the course of treatment (for the National Drug Treatment Monitoring Service, or NDTMS) references children connected to adults in treatment family units themselves are rarely the central object of attention in terms of treatment design and delivery.

In the 2020/21 NDTMS data there were 8,990 parents in West Yorkshire who used substance treatment services. The total number of children is not recorded but using the national average of 1.9 children per household with children, the total number of children associated with a parent in treatment is estimated at 16,891. This is 4% of the *total population* of under 16s in West Yorkshire (471.082 (Census 2021 data).

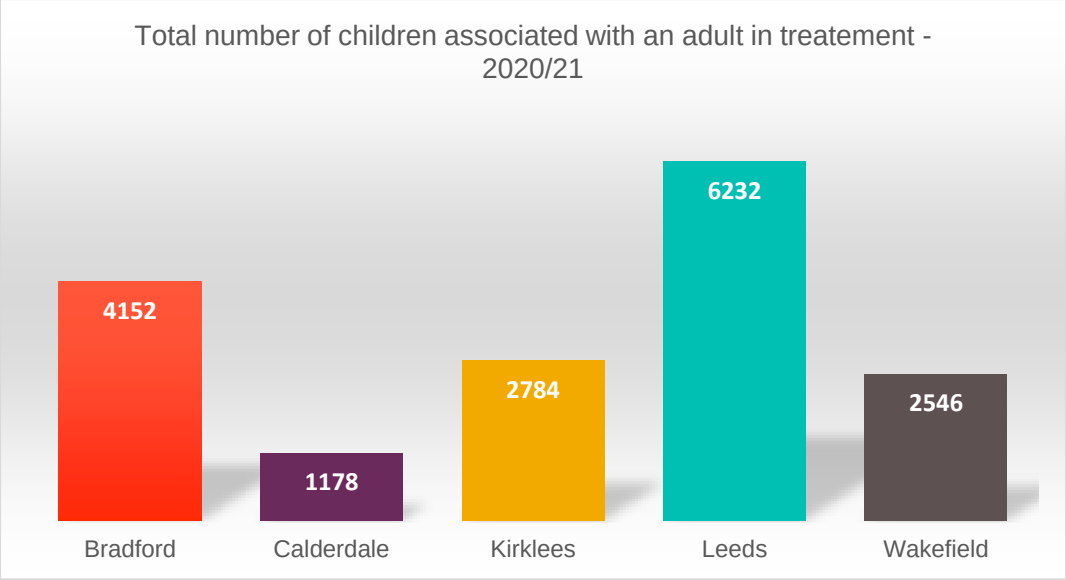

Figure 1 Estimated numbers of children in each local authority area in West Yorkshire associated with an adult in treatment (source https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2020-to-2021/adult-substance-misuse-treatment-statistics-2020-to-2021-report#parental-status-and-safeguarding-children)

What is potentially more significant is that the proportion of adults in treatment for alcohol dependence is between 20% and 30% of the estimated total in need of support in each district, and for those dependent on opiates it is typically around 50% (source: NDTMS - Parental substance misuse, data packs for the West Yorkshire Authorities). This implies that there are a much greater number of children exposed to the harms of parental substance use.

In broad terms the consequences on life outcomes for children of parents who are dependent on substances are well established. While there is some risk of intergenerational transmission of substance use it is the attendant factors of substance use and dependency that are limiting factors for families. These are limiting in the long term, with impacts on education and employment, housing, health and well-being and ultimately life expectancy. There are, however, more immediate impacts on families in terms of additional support needs.

The NDTMS categorises the support given to parents with children as: Early Help; Child in Need; Has a Child Protection Plan; and, Looked After Child. Overall, in West Yorkshire an estimated 3,221 children of parents in treatment receive one of these four types of support (figures rounded to the nearest whole – see Table 1).

All Children of Parents in Treatment				
	Early Help	Child in Need	Child Protection Plan	Looked After Children
Bradford	153	160	322	182
Calderdale	39	41	82	46
Kirklees	83	87	176	101
Leeds	236	247	507	305
Wakefield	85	88	179	102
West Yorkshire	**596**	**623**	**1266**	**737**
Grand Total				***3,221***

Table 1 - All Children of Parents in Treatment source: https://www.ndtms.net/ParentalSubstanceMisuse/Index data packs for the West Yorkshire Authorities

Of these children, 1,736 are living with parents in treatment and 1,485 who are not living with their parents. Those children not living with their parents may be in informal guardianship or kinship care arrangements, in foster care or have been placed in local authority residential care. The breakdown at local authority level for children living with and not living with parents (Table 2 and Table 3).

Numbers of Children Living with Parents in Treatment				
	Early Help	Child in Need	Child Protection Plan	Looked after Children
Bradford	111	113	192	38
Calderdale	29	29	49	10
Kirklees	60	61	104	21
Leeds	164	166	282	56
Wakefield	61	62	105	21
West Yorkshire	**425**	**432**	**732**	**146**
Grand Total				***1,736***

Table 2 - Children Living with Parents in Treatment source: https://www.ndtms.net/ParentalSubstanceMisuse/Index data packs for the West Yorkshire Authorities

Numbers of Children Not Living with Parents Who are in Treatment				
	Early Help	Child in Need	Child Protection Plan	Looked after Children
Bradford	42	46	130	144
Calderdale	10	12	32	36
Kirklees	23	26	73	81
Leeds	72	80	225	249
Wakefield	24	26	73	81
West Yorkshire	**171**	**190**	**533**	**590**
Grand Total				***1,485***

Table 3 - Children Living with Parents in Treatment source: https://www.ndtms.net/ParentalSubstanceMisuse/Index data packs for the West Yorkshire Authorities

Whilst all children with a parent in treatment are adversely affected, this cohort of around 20% are likely to have a start in life that is considerably further impacted by the level of need in the family that the family requires formal intervention by Children's Social Care Services. There is both a human cost (in terms of outcomes) and a financial cost in terms of delivering high level support (such as placing children in local authority care) in the short term. If all the children in Local Authority Care were placed in residential children's homes, the cost across West Yorkshire would be just under £15milliion per month or just short of £180million per year (Unit Costs of Health and Social Care 2021 (unit cost of children's residential care taken from Costs of Health and Social Care 2021; Compiled by Karen Jones and Amanda Burns, University of Kent).There is a "double impact" on the public purse because children who need this kind of support are much more likely to be involved in the criminal justice system, have multiple and complex needs, have poor physical health than even the cohort who do not receive any social care interventions.

There is a strong imperative on both human and financial grounds, therefore, for supporting the whole family when a parent is in treatment. The final reason for providing whole family support is that parents in treatment living with children are more likely to have successful completions than parents who are not living with children (or indeed, those who are not parents). The role of families in people's treatment journey is complex and it should be emphasised that there is no "one size fits all" approach. It is clear, however, from the testimonies of those in treatment that re-connecting with their families is a strong motivating factor in maintaining treatment and recovery.

Successful Completions 2019 (Proportion of clients completing treatment successfully)			
	Parent living with children	Parent Not Living with Children	Not a parent
Bradford	13%	11%	13%
Calderdale	37%	16%	27%
Kirklees	27%	18%	23%
Leeds	34%	26%	28%
Wakefield	23%	17%	19%
England	26%	19%	23%

Table 4 - Children Living with Parents in Treatment source: https://www.ndtms.net/ParentalSubstanceMisuse/Index data packs for the West Yorkshire Authorities

Engagement

The data on unmet needs for treatment services indicate that only about 20% of adults who would benefit from alcohol treatment and 50% of opiate users who would benefit from treatment actually access treatment services. This puts a much larger number of children potentially exposed to these kinds of risks unless their parents are known to other services. Public perception of social work in the 1980s and 1990s was directed by media reporting to removals of children as highlighted in cases of alleged widespread sexual abuse. In later years the media has focused the attention of the public on the failings of social care services leading to the "preventable" deaths of children, notably that of Victoria Climbié which led to the "Every Child Matters" initiative and Child Protection Act 2004. These high-profile cases masked both the changes in social work practice and the pressures children's social care services are under on a day-to-day basis.

Previous work by Humankind has revealed the wariness service users have of interventions by children's social care agencies. There are almost instinctive attempts to deflect the involvement (including support) of agencies that service users believe may lead to social workers' involvement in their families. There are other practical barriers to parents engaging in and sustaining treatment, including the timing and location of services in terms of cost, childcare or employment (especially those with multiple part-time jobs or unpredictable working hours in "zero hours" contracts). For women in particular, issues around how they are perceived and how safe they feel in coming into treatment services are potentially additional barriers to engagement.

The points of referral for parents into services are categorised in the NDTMS as Children and Family/ Social Services; Criminal Justice Services and "Other". The first two categories imply some sort of compulsion or conditionality for parent's attendance. The aspect of referral where there is a significant difference between local authority districts is the proportion of referrals from the criminal justice system More granular analysis of the data is required to see whether there are any substantive correlations with outcomes or the experiences of children and families. Unfortunately, the group "Other" is by far the largest and covers self-referrals as well as those referred by family or other organisations/ agencies involved with families.

Referral Sources to Treatment Services (% of all referrals)									
	Parents Living With Children			Parents Not Living With Children			Not a Parent		
	Children & Family/ social Services	Criminal Justice	Other	Children & Family/ social Services	Criminal Justice	Other	Children & Family/ social Services	Criminal Justice	Other
Bradford	2%	8%	90%	1%	20%	79%	0%	13%	87%
Calderdale	4%	8%	88%	0%	28%	72%	2%	17%	81%
Kirklees	2%	12%	86%	2%	14%	84%	1%	12%	87%
Leeds	1%	6%	93%	1%	15%	84%	0%	11%	89%
Wakefield	2%	2%	95%	2%	24%	74%	1%	13%	86%

Table 5 - Children Living with Parents in Treatment source: https://www.ndtms.net/ParentalSubstanceMisuse/Index data packs for the West Yorkshire Authorities

From a family perspective one area where family issues with substances are often picked up are through schools. Whilst schools are under mounting pressures in terms of staffing and resources to perform their primary educational functions, they are nonetheless one of the few places where a range of family issues can be identified, and support engaged. Outreach work into schools by treatment services performs two functions. One, to provide information and educational opportunities to students about substances: their effects, legal issues and their social impact. Secondly, such visits are an opportunity for students and staff to have an "off the record" or exploratory discussion with an independent and "more expert" adult about their own family or about other individuals/ families in the school.

Case Study - Outreach in Schools

An interview with an experienced Humankind worker who has delivered lessons and support in schools around substance use for a number of years. The interview took place in January 2023.

The content of the worker's lessons is dictated by the school. She explained the differing approaches schools have. For instance, some schools put the lesson in with their science programme. Whilst this is logical academically, it didn't open up broader conversations around self-medicating or other social problems that can lead to problematic substance use. Sometimes the schools approached the service for input when drug problems had become critical, so the service has worked with them to try and embed the work into the curriculum and be more pro-active in their approach.

The worker described the engagement in schools as being "really good" and that the children she speaks to are very open and interested but outcomes of this work are difficult to measure. The worker had attempted to 'track' some students through their school years and had anecdotal evidence that the prevention work has a positive impact. Children tell her that they use the resources she gives them to find "get out" clauses such as phrases to use when feeling peer pressure to use substances.

Often a secondary but vital result of work in schools is uncovering problems that students have which have not been communicated or gone unnoticed by teachers. During the last week in one school, the worker had made several safeguarding referrals, and all seemed to be underpinned by substance abuse in the child's family home. The worker explained that one of the problems can be the sense of shame children/young people have of revealing what is going on at home. Children can often be keeping their family system working by looking after siblings or other household duties, and they felt that whilst they were managing, they did not want outside services intervening and breaking up their family. These were all children who would not be involved in drug treatment services other than Jo delivering her lesson.

The worker had observed that schools often don't know what is going on at home and in some instances, children had been unaware too. This appeared to change during the COVID lockdowns; where children who had been shielded from substance use and other issues at home during school hours the forced closure of schools meant they had been exposed to activity they would not otherwise have seen (e.g., substance use, sex work).

Access and participation by parents and carers are important. The worker had organised events in the past where a school had arranged for several services to be present and available such as police, drug and alcohol services, and DWP staff. She felt this approach was useful as it drove home the idea that substance use is not happening in isolation and

encouraging a multi-agency approach. This is part of the work about challenging the perception of substance use as “normalised” behaviour in society.

There are three main reasons children and young people appear to use substances: boredom, peer pressure and therapeutic needs. The worker had liaised with a partnership who fund diversionary activities in local authority area. They had provided some resources for the worker and fund lots of local sports clubs and activities to try and engage young people. The worker lets her students know about what is going on in their local area and encourages them to take up activities and keep them off the streets.

Where the worker obtains local information, this is passed on to other authorities. For example, recently local shops were reported to Trading and Licensing Standards for selling alcohol/ tobacco to underage customers, and the details of a drug dealer had been passed on to the local police. The worker was also able to pick up on new uses of substances such as nitrous oxide, “dragon soup” (alcohol/ energy drink mixtures) and the impact of specific substance use for students who are taking medication (energy drinks countering the effect of medication for ADHD was the example given). These are all areas which would benefit from further research. What evidence there is, is anecdotal, coming from “chance” conversations rather than “objective research”. The worker felt that it would be useful to properly track a group of children in a longitudinal study to try and gauge the effect the prevention work has. An observation overall was that prevention work may be more of a necessity now/in the future as the number of people in treatment begins to grow.

Recommendations – Engagement

The practices of treatment services are adapting to become more “person-centred” and trauma informed. Developments to be explored include:

- Simplified entry into services – use of triage to select appropriate pathways.
- Shift from a binary assessment of “motivation” to building and maintaining motivation, using peer support and “friend” groups to build a rapport with services and staff.
- Reduce the amount of “upfront” assessment and paperwork as a precondition for “beginning treatment” as this creates a gap between the moment of biggest commitment (coming into the service for the first time) and the positive feedback the service user needs to maintain engagement (feeling like treatment is being started)
- Acknowledging that getting support and participating in treatment is emotionally hard work for service users so putting support that helps build the service user’s wider recovery capital in place at an early stage – this may be family support, support with other issues, peer mentoring, community-based activities etc.
- Focusing on a more relational model of support than a transactional model
- In treatment services there is an “implicit hierarchy” of substances largely based on their legal classification. This means that there is a greater focus on opiate use and substitute treatments which are highly regulated. The anticipated release of national alcohol treatment guidelines (known as the “Orange Book”) should provide a greater emphasis on the treatment of alcohol which is the more prevalent and costly substance from a public health perspective (cutting across policing, health and social care).

These approaches are mostly part of existing treatment service offers but they tend to be delivered at different points in the treatment journey. It is worth noting that the actual

treatment interventions are a relatively small factor in the overall recovery journey (in terms of time, motivating service users and impact). Much greater value is placed by service users on belonging, being active and constructively using time, as well as building relationships with others.

Examples of the Whole Family Approach

The Whole Family Approach provides adults and children in the family with the tools and social support to collectively set life goals, create actionable plans, and achieve those goals. The main reasons for the whole family approaches are: first, the Care Act 2014 requires that children's and adults' services work together to put in place whole family approaches that ensure that no care or support package for an adult or sibling relies on excessive or inappropriate caring by a young carer to make it sustainable. Secondly, taking substance use treatment as an example, although adults are the patient in treatment, the whole family is affected by that individual's substance use. The Home Office estimates there are between 250,000 and 350,000 children of problem drug users in the UK. Thirdly, up to 2.6 million children live with a parent who drinks hazardously, and 705,000 children live with a dependent drinker. Finally, The Care Act 2014 introduces several reforms to the way that care and support for adults with care needs are met. It requires local authorities to adopt a whole system, whole council, whole-family approach - coordinating services and support around the person and their family and considering the impact of the care needs of an adult on their family, including children. In order, to carry out interventions according to the Whole Family Approach strategies some programs/interventions identified in this overview can be implemented to reduce violence in West Yorkshire.

There are some programmes/interventions that have been utilised to solve issues related to domestic abuse, substances use disorders and mental illness for families. Sparks and Tisch (2018) reported that Celebrating Families can help to break the cycle of intergenerational substance use disorders (SUDs). The study showed that a family skills program is an effective intervention program for families at-risk of perpetuating the cycle of addiction, as well as the prevention of family violence, abuse, and neglect. In addition, they noted that agencies that serve families at risk can use the program to prevent costly foster care placements and intergenerational SUDs by providing such programs. Secondly, a Family-Centred Approach which develops a holistic pathway to address the identification of, response to, and prevention of family abuse and violence. Thirdly, Family focused interventions and intervention components that aim at preventing parental domestic violence, mental ill-health and/or substance misuse. Also, it examines the negative impacts these three public health issues can have on children within the family unit. Lastly, Model-based Recursive Partitioning (MOB) produced the following three treatment moderators, which identified subgroups of participants who responded differently to the trauma-informed parenting intervention: (a) caregivers' relationship with the child (kin vs. non-kin/permanent caregivers), (b) caregiver-child attachment, and (c) case history of physical abuse. For the attachment outcome, caregivers' age was found to be a treatment moderator.

Others are Parenting Shop that aim to provide a one-stop 'shop' for a range of parenting support mechanisms. It is designed to increase community cohesion and reduce parenting stress, the intervention includes parenting classes, home visits, lectures and local community initiatives such as counselling. In this program, professional staff and some skilled volunteers offer a range of support, and the 'shops' have been shown to be successful in reducing family tension and difficulties. Therefore, it is believed that if some of these models / programs/ interventions are put in place they can help to reduce violence related to substance abuse, mental illness and domestic abuse within the family unit in West Yorkshire.

A thematic literature review

In data from 2019/20, the Children's Commissioner for England reported that 478,000 children in England were living with a parent with a drug or alcohol problem (Children's Commissioners Office, 2022). As research suggests that substance use is a behaviour that can be transmitted from parent to child (Yap et al., 2017) this could put 4% of children at an elevated risk of developing their own substance disorders. Research shows that adolescents may be more likely to develop problem drinking if their parents drink alcohol than if they do not (Alati et al., 2014). Similarly, the use of marijuana and other illicit drugs are also associated across generations (Pears et al., 2007). Understanding these associations and why they occur could therefore have a positive impact on treatments and services, but the literature is less clear on establishing the link. Investigations suggest both genetic and environmental factors contribute to the development of substance use disorders (Lander et al., 2013) and a number of genes have been identified as implicated in the transmission of substance abuse (Xu et al., 2004). As it would be highly unlikely to know an individual's genotype at point of entry to a service, the scope of this literature review will therefore be limited to the environmental themes which emerge from the research.

Social Learning Theory

Bandura's 1977 theory suggested that young people model themselves through observation of their parents' behaviours (Bandura, 1977). This is, unfortunately, not limited to positive behaviours and can extend to substance use behaviours too. Not only can we be influenced directly by how our parents act, but feedback from others can increase the rate or likelihood of this behaviour through social facilitation. So, if behaviours are met with praise, we are more likely to repeat them whilst we are less likely to continue behaviours which result in ostracism from our social networks. Such social learning processes have been shown to impact on both initiation and maintenance of drug use, as well as the patterns of drug use associated with addiction (Strickland & Smith, 2014). Evidence suggests that family history of alcohol abuse does not necessarily lead to increased consumption, but there is a greater risk for developing substance use disorders. (Elliott et al., 2012).

One of the difficulties in assessing the relevance of this theory to intergenerational substance misuse is that, typically, substance use is measured in adolescents. By this point, individuals are thought to be more influenced by their peers than by their parents. Indeed, adolescents that are living in households with substance misuse have been shown to be more likely to develop strong peer attachments which are kept secret from their family and themselves involve early drug or alcohol use (Velleman & Templeton, 2007).

Attachment Theory

The attachment relationship between a parent and a child is thought to develop in the first few months after birth (Bowlby, 1969). Bowlby recognised four types of attachment which he observed were influenced by the quality of emotional bonds formed with early caregivers. He recognised that a child could develop a secure attachment style when their caregiver is available, sensitive and responsive. Where the care is unpredictable, rejecting, or unresponsive an insecure or disorganised attachment style can develop. Families where there is parental substance use can experience environments of secrecy, loss, violence and emotional chaos (Lander et al., 2013) and, perhaps as a result, scientific reviews have found links between substance use disorders and insecure attachment in both adults and adolescents (Mikulincer & Shaver, 2007; Schindler & Bröning, 2015). A large-scale review of 38 studies into this link found that all of them showed insecure attachment links with substance abuse (Schindler, 2019).

Some researchers have linked this to the effects that substance use can have on rewards receptors in the brain. As substance use floods the brain with dopamine, this can alter the way receptors respond to the pleasure we get from everyday tasks such as caregiving. This circuit change can make what was once enjoyable now seem neutral or, worse, stressful (Suchman & DeCoste, 2018). Managing the stresses of caregiving has been shown as a particular trigger for substance use relapse in previously abstinent parents (Rutherford et al., 2013) creating a vicious circle for families.

For the child, too, this environment can be stressful and anxiety-provoking. Children in these circumstances may develop coping strategies to minimise their stress, which can include taking on the role of parents themselves. This process of **parentification** can present as compulsive self-reliance or compulsive caregiving (Solomon & George, 2011).

Some researchers have explained that individuals can use substances as a way of 'self-medicating' their unmet attachment needs (Schindler, 2019) and it is thought that opiate use particularly might relate to this type of emotional distress. This link is far from proven, however, the cyclical relationship between stress and substance use is something that is suggested in both adults and parents so is worth consideration.

Insecure attachment styles may present difficulties to services, too. Insecure attachments can impact on therapeutic relationships, so a person may find it more difficult to form a therapeutic or working alliance with their drug worker.

Parenting Style

Alongside styles of attachment, parenting styles are also shown to influence how children grow up to behave around substances. Not only parental alcohol use but their attitudes to adolescent drinking and supervised drinking have been shown to increase unsupervised drinking and other drug use in adolescents (McMorris et al., 2011). Aspects of parenting in general, though, have been investigated as a potential answer to intergenerational substance abuse.

Work by Baumrind in the 1960s and Maccoby and Martin in the 1980s has established four parenting styles; one of which seems to link to the likelihood of developing substance use disorders (Baumrind, 1967; Maccoby & Martin, 1983). Authoritarian parenting is characterised by and high expectations but little warmth or nurturing, and data indicates children subject to this style of parenting are more likely to develop drug and alcohol problems (Baumrind, 1991).

It seems likely that parental discipline skills suffer when they are using or abusing substances. Much of the research in this area is focused on the mother-child relationship, finding that children with mothers who abuse substances experience less warmth, encouragement, and engagement than other children. They are more likely to experience authoritarian parenting styles that are harsher and more punitive (Pears et al., 2007). Although less research to date has looked at father-child relationships, some research indicates a similar pattern (Bronte-Tinkew et al., 2006).

One of the difficulties of finding explicit links between parenting styles and substance use disorder is the general lack of long-term research, however one longitudinal study looked at the impact of parenting styles on substance use over three generations. The researchers predicted that substance use and a lack of parental discipline in one generation would lead to problem substance use in the next (Pears et al., 2007). The study, however, presented more complicated findings than expected and found no link between poor discipline and alcohol use, although a link between poor parental discipline and other substance use was evident. Other studies, however, have found that peer relationships are more likely to influence adolescent substance use rather than parenting styles so this might not answer the whole problem (Berge et al., 2015).

Intergenerational Trauma

Individuals can display effects of trauma despite not having experienced the events directly via intergenerational trauma. Much of the literature about this form of trauma emerged from work with populations of Holocaust survivors and Indigenous peoples (Giladi & Bell, 2013; Stevens et al., 2015), but the process of passing on the effects of trauma are not limited to these groups. There is increasing evidence that all forms of trauma can be passed on via parent-child relationships, including living in extreme poverty, child abuse, having a parent in the prison system and/or domestic violence (Isobel et al., 2017).

Whilst the transmission of intergenerational trauma is not an intentional harmful act, early life traumas are shown to be a significant predictor of substance use disorders in later life (Cicchetti & Handley, 2019; Moran et al, 2004). Early trauma can impact on the way a mother forms attachment to their baby and a cycle of trauma can develop (Meulewaeter, 2019). These parents are likely to have feelings of distrust towards services, however research indicates this can be overcome by working with them to increase their self-control and resilience (Yang et al., 2019). Understanding that substance use disorders are underpinned by, sometimes, generations of trauma links to the need to continue to develop and use trauma-informed practice in services.

Conclusion

Overall, the literature fails to find conclusive evidence of one factor being more important than another, and it is likely that the whole family environment plays some part in maintaining intergenerational substance use. Disentangling environmental stressors from trauma is complex and could require macrolevel knowledge of individuals that services may not have the resources to carry out. This suggests a need to look at whole family systems and understand that nothing is happening in isolation. There is evidence to suggest a need to encompass everything occurring in the household in any treatment plans in order to see generational change.

Recommendations

Some research shows precursory traits for later substance use in children as young as 2 or 3 (Eiden et al., 2004). Are there earlier signs that a child might engage in substance use than adolescence? Most of the research is in children aged 10 and above, it could be worth exploring the literature on this point to see if there are indicators either in the family or in individual children that are precursory traits.

How can we better understand if there is a link between “compulsive self-reliance” and a reluctance to seek help in later life, and if so how could that help in developing treatment services? This could relate to other work on “treatment resident” substance users.

Reduce the impact of service users’ insecure attachment styles by reducing the turnover of support workers through:

- Adapting recruitment policies to emphasise recruiting for relationship building not just experience or qualifications.
- Improve staff retention through improving terms and conditions, providing clear progression pathways and professional development opportunities.
- Exploring further the mixed views on reliance on one individual worker versus the consistency that brings.
- Better hand overs, more joint working of clients.

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Pathway for Mental Health Support for Families in Need of Drug and Alcohol Treatment

1.0 Introduction

Context

This approach is designed to assist professionals in evaluating the feasibility of implementing and adopting a whole family approach in the treatment of drug and alcohol related issues. In doing so, this work will help to guide existing providers in West Yorkshire on how they can successfully implement a whole family approach in their provision of services that builds protective factors (resilience) and/or mitigates risk factors (adversity) in relation to violence reduction.

This pathway is built on good practice and evidence-based rationale. Also, this pathway will be based on the Biopsychosocial model with consideration of necessary policies and legislations that support the need for drug and alcohol reduction to prevent violence in West Yorkshire.

Rationale

The pathway provides a structured approach to addressing the common issues related to drug and alcohol abuse/addiction and its association with other mental illness (dual diagnosis).

This pathway sets out the principles of adopting a whole family approach to tackling root causes of violent crime for mental health professionals as a foundation to meet the mental health needs of children and the whole family.

This pathway is not a policy but a guideline that can be followed by mental health professionals involved with children and their families.

The goal of this pathway is to increase consistent, seamless, holistic support and care. In addition, it recognises that improved partnership working will promote a healthy whole family approach programme to reduce violence and crime related to alcohol and drug use. Reducing these issues will produce quality outcomes for children and parent/carers.

Anticipated Outcomes

Public health outcomes

1. Increase the awareness of mental health issues related to alcohol & drug use and other related mental disorders.
2. Promote equality and reduce stigma seen among minority ethnic communities.
3. Safeguard children.
4. Improve the whole family's wellbeing and mental health.
5. Ensure that all parents and families have access to support for emotional health and wellbeing, and all children are supported to reach their full potential.

Indicators

1. Reduce deaths resulting from alcohol & drug use.
2. Reduce/prevent future incidences of serious violence in terms of both families and communities.
3. Strategic plan to deliver a family- focused, trauma-informed, comprehensive, and integrated approach to treatment for families.
4. Use of evidence-based/evidence-informed practices & quarterly client satisfaction survey.
5. Evidence of training and re-training of staffs (at all Tier-levels) in relation to alcohol& drug use in children and adults.

Barriers to Treatment

Treatment Cost: Treatment is costly, and most people believe they cannot afford it.

Perceived absence to the problem: More than a third of people with substance use disorders think they don't have a problem, or they can quit on their own.

Stigma: Almost one-fifth of those who do not seek treatment say they are afraid of what others will think if they go to rehab.

Time conflict: More than three-quarters of people with substance use disorders have jobs, and they are frequently concerned about losing them while in treatment.

Principles of Care

1. Working with and supporting families and carers
2. Building a trusting relationship by maintaining confidentiality where appropriate and providing information in a setting that considers clients privacy and dignity in a respected way.

2.0 Interventions for alcohol misuse

2.1 General principles for all interventions

1) For all people who misuse alcohol, carry out a motivational intervention as part of the initial assessment. The intervention should contain the key elements of motivational interviewing including:

- Helping people to recognise problems or potential problems related to their drinking
- Helping to resolve ambivalence and encourage positive change and belief in the ability to change
- Adopting a persuasive and supportive, rather than argumentative and confrontational, position

2) For all people who misuse alcohol, offer interventions to promote abstinence or moderate drinking as appropriate and prevent relapse in community-based settings. Pharmacological interventions should be administered by specialist and competent staff. Psychological interventions should be based on a relevant evidence-based treatment manual. Also, family focused interventions, defined as any psychosocial interventions that include a parent or child component, should be considered. This may include:

- A focus on parents' skills, knowledge, and attitudes, parenting capacity, the parent-child relationship, and interactions
- Working with the parent(s) in order to improve child outcomes (in the context of parental risk of, or experiences of, domestic violence, mental ill-health and/or substance misuse)
- Working with the child alone to reduce the impact of parental domestic violence, mental ill health and/or substance misuse; family focused interventions may involve the parent and/or child
- Involve other family members in addition to the parent and/or child (for instance, partner/ex-partner/grandparents, etc.)

Where the intervention involves more than one family member, the intervention may be delivered to family members in a group, individually (separately, but simultaneously), or delivered using a combination of the two.

3) For people with alcohol dependence who are homeless, consider offering residential rehabilitation for a maximum of 3 months. Help the service user find stable accommodation before discharge.

2.2 Interventions for harmful drinking (high-risk drinking) and mild alcohol dependence

1) For harmful drinkers (high-risk drinkers) and people with mild alcohol dependence, offer a psychological intervention (such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol-related cognitions, behaviour, problems, and social networks.

2) Offer behavioural couples therapy for harmful drinkers and people with mild alcohol dependence who have a regular partner who is willing to participate in treatment, unless there are indicators that the person is currently experiencing, or is a current perpetrator of, domestic abuse.

3) For harmful drinkers and people with mild alcohol dependence who have not responded to psychological interventions alone, or who have specifically requested a pharmacological intervention, consider referring them to a specialist facility.

Examples of psychological interventions to offer are:

- Cognitive behavioural therapies focused on alcohol-related problems, which should usually consist of one 60-minute session per week for 12 weeks
- Behavioural therapies focused on alcohol-related problems which should usually consist of one 60-minute session per week for 12 weeks
- Social network and environment-based therapies focused on alcohol-related problems which should usually consist of eight 50-minute sessions over 12 weeks
- Behavioural couples therapy focused on alcohol-related problems and their impact on relationships; it should aim for abstinence, or a level of drinking predetermined and agreed by the therapist and the service user to be reasonable and safe; it should usually consist of one 60-minute session per week for 12 weeks

2.3 Assessment and interventions for assisted alcohol withdrawal

1) For service users who typically drink over 15 units of alcohol per day and/or score 20+ on the AUDIT, consider offering:

- An assessment for and delivery of a community-based assisted withdrawal *or*
- Assessment and management in specialist alcohol services if there are safety concerns (see recommendation 5) about a community-based assisted withdrawal

2) Service users who need assisted withdrawal should usually be offered a community-based programme, which should vary in intensity according to the severity of the dependence, available social support, and the presence of comorbidities.

- For people with mild to moderate dependence, offer an outpatient-based assisted withdrawal programme in which contact between staff and the service user averages 2 to 4 meetings per week over the first week
- For people with mild to moderate dependence and complex needs (psychiatric comorbidity, poor social support, or homelessness, etc.) or severe dependence, offer an intensive community programme following assisted withdrawal in which the service user may attend a day programme lasting between 4 and 7 days per week over a 3-week period

3) Outpatient-based community assisted withdrawal programmes should consist of a drug regimen, and psychosocial support including motivational interviewing and family focused interventions (see recommendation 2.1).

4) Intensive community programmes following assisted withdrawal should consist of a drug regimen supported by psychological interventions including individual treatments, group treatments, psychoeducational interventions, help to attend self-help groups, family and carer support, and involvement (i.e., Celebrating Families—a manualized family-centred program focused on breaking the cycle of generational substance use disorders)

Consider referral to specialist adult mental health service if the service user:

- Drinks over 30 units of alcohol per day
- Has a score of more than 30 on the SADQ
- Has a history of epilepsy or withdrawal-related seizures/delirium tremens during previous assisted withdrawal programmes

If there is a need for concurrent withdrawal from alcohol & benzodiazepines, service user regularly drinks between 15 & 30 units/day of alcohol and has: significant psychiatric or physical comorbidities (i.e., chronic severe depression, psychosis, malnutrition, congestive cardiac failure, unstable angina, chronic liver disease) or a significant learning disability or cognitive impairment:

- Consider a lower threshold for inpatient or residential assisted withdrawal in vulnerable groups, for example, homeless and older people by providing housing support for those families who need it
- Drug regimens for assisted alcohol withdrawal

5) When conducting community-based assisted withdrawal programmes, use fixed-dose medication regimens.

- A fixed-dose regimen involves starting treatment with a standard dose, not defined by the level of alcohol withdrawal, and reducing the dose to zero over 7 to 10 days according to a standard protocol

6) Fixed-dose or symptom-triggered medication regimens can be used in assisted withdrawal programmes in inpatient or residential settings. If a symptom-triggered regimen is used, all staff should be competent in monitoring symptoms effectively and the unit should have sufficient resources to allow them to do so frequently and safely.

- A symptom-triggered approach involves tailoring the drug regimen according to the severity of withdrawal and any complications. The service user is monitored on a regular basis and pharmacotherapy only continues as long as the service user is showing withdrawal symptoms

7) Prescribe and administer medication for assisted withdrawal within a standard clinical protocol. The preferred medication for assisted withdrawal is a benzodiazepine (chlordiazepoxide or diazepam). Prescribers should be aware of the legislation on controlled drugs, driving and blood concentration limits, and advise patients accordingly.

8) When managing alcohol withdrawal in the community, avoid giving people who misuse alcohol large quantities of medication to take home to prevent overdose or diversion (the drug being taken by someone other than the person it was prescribed for). Prescribe for instalment dispensing, with no more than 1 day of medication supplied at any time.

9) In severe cases, referral to a specialist team can be offered so as to safeguard issues related to use of overdose of benzodiazepines and preventing children from having any contact with these medications.

10) For managing unplanned acute alcohol withdrawal and complications, including delirium tremens and withdrawal-related seizures, refer to specialist drug treatment.

2.4 Interventions for moderate and severe alcohol dependence after successful withdrawal
Management for moderate and severe alcohol dependence after successful withdrawal - refer for specialist care.

2.5 Interventions for children and young people who misuse alcohol

2.5.1 Assessment and referral of children and young people

1) If alcohol misuse is identified as a potential problem, with potential physical, psychological, educational, or social consequences, in children and young people aged 10 to 17 years, conduct an initial brief assessment to assess:

- Duration & severity of alcohol misuse (standard adult threshold on the AUDIT for referral & intervention should be lowered for ages 10 to 16 because of the more harmful effects of a given level of alcohol consumption in this population)
- Any associated health and social problems and the potential need for assisted withdrawal

2) Refer all children and young people aged 10 to 15 years to a specialist child and adolescent mental health service (CAMHS) for a comprehensive assessment of their needs if their alcohol misuse is associated with physical, psychological, educational, and social problems and/or comorbid drug misuse.

3) If considering CAMHS referral for ages 16 to 17 who misuse alcohol, use the same criteria as for adults (rec. 2.3.5)

2.5.2 Promoting abstinence and preventing relapse in children and young people

1) For all children and young people aged 10 to 17 years who misuse alcohol, the goal of treatment should usually be abstinence in the first instance.

2) For children and young people aged 10 to 17 years who misuse alcohol offer:

- Individual cognitive behavioural therapy for those with limited comorbidities and good social support
- Multicomponent programmes (such as multidimensional family therapy, brief strategic family therapy, functional family therapy or multisystemic therapy) for those with significant comorbidities and/or limited social support.

3) Careful review of risks and benefits, in moderate & severe cases offer referral to CAMHS Tier 3 or 4 for further management.

4) It is generally agreed that prevention programs that target the whole family are most efficacious.

2.5.3 Delivering psychological and psychosocial interventions for children and young people

1) Multidimensional family therapy is primarily for adolescents with substance misuse, behavioural, delinquency, mental health, educational/school, and/or family mental health problems or disorders. It should usually consist of 12 to 15 family focused structured treatment sessions over 12 weeks. There should be a strong emphasis on care coordination and, if necessary, crisis management. Additionally, individual interventions may be provided for both the child or young person and the parents. The intervention should aim to improve:

- Alcohol and drug misuse
- The child or young person's educational and social behaviour
- Parental well-being and parenting skills
- Relationships with the wider social system

2) Brief strategic family therapy aims to achieve improvements in family interactions that are directly related to the prevention or reduction of adolescent behaviour problems. It should usually consist of fortnightly meetings over 3 months. It should focus on:

- Engaging and supporting the family
- Using the support of the wider social and educational system
- Identifying maladaptive family interactions
- Promoting new and more adaptive family interactions

3) Functional family therapy aims to help teens & families find solutions while building trust & respect for each other. It should be conducted over 3 months by health or social care staff, and focus on improving interactions within the family, including:

- Engaging and motivating the family in treatment (enhancing perception that change is possible, positive reframing, and establishing a positive alliance)
- Problem solving and behaviour change through parent training and communication trainings
- Promoting generalisation of change in specific behaviours to broader contexts, both within the family and the community (such as schools)

4) Multisystemic therapy is useful for underage individuals who have had serious legal involvement as well as potential substance use issues. It should be provided over 3 to 6 months by a dedicated member of staff with a low caseload (typically between three and six cases). It should:

- Focus specifically on problem-solving approaches with the family
- Use the resources of peer groups, schools, and the wider community

2.5.4 Reasons for Whole Family Pathway

- The Care Act 2014 requires that children's and adults' services work together to put in place whole family approaches that ensure that no care or support package for an adult or young person relies on excessive or inappropriate caring by a young carer to make it sustainable
- The Home Office estimates there are between 250,000 and 350,000 children of problem drug users in the UK
- Up to 2.6 million children live with a parent who drinks hazardously, and 705,000 children live with a dependent drinker
- The Care Act 2014 introduces several reforms to the way that care and support for adults with care needs are met; it requires local authorities to adopt a whole system, whole council, whole-family approach, coordinating services and support around the person and their family and considering the impact of the care needs of an adult on their family, including children

2.6 Whole Family Approach

The Whole Family Approach provides adults and children in the family with the tools and social support to collectively set life goals, create actionable plans, and achieve those goals.

The guide to implementing the Whole Family Approach is as follows:

1) Connecting with families

- Identify organizations in your community that can provide families with services complementary to your organization
- Individuals known as coaches (family advocates) must be trained in how to provide family-centred coaching that empowers families to decide on their own priorities for the future
- Identify families eligible to participate in the Whole Family Approach program
- Pair families with a coach

2) Set family goals

- Start by getting to know the family's story and talk in-depth about their lives and aspirations, family dynamics, health, educational background, etc
- Set individual and family-wide goals

3) Family action

- Translate goals into short-term objectives
- Connect families to tools, services, and social support

4) Agency Collaboration

- A team of agencies (education, health, social welfare, legal) connected to the coach provides holistic, coordinated support

5) Success

- Families achieve and maintain their goals, assuring stable and healthy future

2.6.1 Whole Family Approach to assessment

An assessment must always be appropriate and proportionate to the circumstances of the individual and their family. This means considering the approach that's likely to allow each individual to express their personal views adequately, as well as getting a picture of how these interrelate. Approaches include:

- Combining assessment: An approach that can be used is 'together, apart, together', where an assessment starts together then works individually with each relevant member and comes back together at the end to look at how the range of identified needs impact on each individual or work together
- Integrated assessment: A local authority may join up with another organisation (such as the Local Authority and NHS or adult social care and children's services) to carry out an , provided the person agrees to this
- Early Help Assessments: "Providing early help is more effective in promoting the welfare of children than reacting later. Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years" (Working Together to Safeguard Children, 2015)

2.6.2 'Best Practices' that can be used to support families with problems related to alcohol and drug misuse and other mental health issues

1) The Think Family agenda recognises and promotes the importance of a whole-family approach which is built on the principles of 'Reaching out: think family':

- No wrong door – contact with any service offers an open door into a system of joined-up support; this is based on more coordination between adult and children's services
- Looking at the whole family – services working with both adults and children take into account family circumstances and responsibilities (for example, an alcohol treatment service combines treatment with parenting classes while supervised childcare is provided for the children)
- Providing support tailored to need – working with families to agree a package of support best suited to their situation
- Building on family strengths – practitioners work in partnerships with families recognising and promoting resilience and helping them to build their capabilities (for example, family group conferencing is used to empower a family to negotiate their own solution to a problem)

3) Helping Parents to parent:

Parenting Shops in Belgium for instance, aim to provide a one-stop ‘shop’ for a range of parenting support mechanisms. Designed to increase community cohesion and reduce parenting stress, the intervention includes parenting classes, home visits, lectures and local community initiatives such as counselling. Professional staff and some skilled volunteers offer a range of support, and the ‘shops’ have been shown to be successful in reducing family tension and difficulties.

4) Celebrating Families:

This is a family-inclusive, trauma-informed, skill-building program. It was designed to improve parenting skills, family functioning, and family relationships for families dealing with a multitude of challenges, including:

- Multigenerational trauma
- Substance use disorders
- Compromised safety (child maltreatment and family violence)
- Resulting physical and mental health challenges and cognitive deficits

Its goal is to help children and families to be healthy, responsible and addiction free. Objectives include increasing resiliency and protective factors and reducing risk factors and adverse childhood experiences (ACEs). Celebrating Families! can be administered via both in-person and online (virtual) formats. The program is available in Spanish, Celebrando Familias!

5) Housing provision:

A holistic approach to assessment, which aims to bring together all of the person’s needs, will include consideration of issues in relation to housing and the impact of this on a person’s wellbeing.

The local authorities should take steps to support the individual to access any support to which they might be entitled to in relation to housing and work with the housing authority on related needs. This could include, for example, a referral to the housing authority to access a disabled facilities grant.

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