

Responding to Alcohol and Drug Problems in the Family: The 5-Step Method Practitioner Handbook

A handbook for people trained to deliver the 5-Step Method

**“As a practitioner,
it is practical, easy
to do and easy to
follow, and the
concept and theory
is good”**



**“The model is
excellent: a
more evidence
based, as well as
a more
structured,
approach”**

**“It is very clear that family
members are less stressed and
more aware of their coping
techniques and their social
networks”**

”

**“It gives both me and the
family member a structured
way to approach the
problems, and the family
members can also follow along
with the self-help handbook”.**

This handbook is based on work undertaken by AFINet-UK (formerly the UK Alcohol, Drugs and the Family [ADF] Research Group). The core members of this group are:

- * Jim Orford (Professor, University of Birmingham).
- * Richard Velleman (Professor, University of Bath, UK & Sangath Community NGO, Goa, India).
- * Lorna Templeton (Independent Research Consultant).
- Gill Velleman (Freelance Management Consultant & 5-Step International Assessor).

This version of the practitioner handbook is based on the original handbook which was authored by Alex Copello, Jim Orford, Lorna Templeton and Richard Velleman. The aim of the handbook is to support training to deliver the 5-Step Method, and is based on extensive practice and research by AFINet-UK. The handbook is therefore the result of many years of research in the course of which data (using both questionnaires and interviews) have been collected from many hundreds of family members whose lives have been affected by living with close relatives experiencing alcohol or drug problems. This handbook, and the 5-Step Method of counselling which it describes, have been employed and successfully evaluated in a series of research studies carried out in both primary care and specialist alcohol/drug treatment services within the UK. Similar studies of the 5-Step Method have been carried out in other countries including Mexico, Italy, India and New Zealand. If you would like to find out more or read more about this programme of work then see later in this handbook.

This handbook is copyrighted and may not be reproduced in whole or in part, or passed on to others, without permission from AFINet-UK.

Over the years there are many people who have contributed to versions of this handbook and to the 5-Step Method programme of work. We cannot list everyone here but we would like in particular to acknowledge and thank Alex Copello, Eva Copello, Sarah Galvani, Akanidomo Ibanga, Mya Krishnan, Jan Larkin, Majid Mahmood, and Ed Sipler. All the images in this handbook are from the Microsoft Office Images website.



To find out more about AFINet
go to www.afinetwork.info

Contents

Key Principles	1
Introduction	2
Section A - Overview of the 5-Step Method	6
Aim of the 5-Steps	8
5-Step Method: Skills for delivery of intervention and for each step	12
Section B – The 5 Steps	17
Before you start	17
Step 1 – Getting to know the family member and the problem	18
Step 2 - Providing Relevant Information	22
Step 3 - Exploring how the family member responds/copes	26
Step 4 - Exploring and enhancing social support	36
Step 5 - Identifying further needs and referring on for further help	43
Putting it all together	49
General considerations and particular problems	50
Section C - Appendices	57
Appendix 1: 5-Step Competency Framework	58
Appendix 2: Short Questionnaire for Family Members (Affected by Addiction) - SQFM(AA) / Family Member Questionnaire (FMQ).	63
Appendix 3: Three Case Studies	65
Appendix 4: Exercises for Family Member	80
Appendix 5: Stresses and strains for family members	86
Appendix 6: Further information on alcohol and drugs	87
Appendix 7: More detailed examples of coping behaviours described by family members in the course of our research	92
Appendix 8: How to respond when the alcohol/drug using relative comes forward for help	94
Appendix 9: National agencies and helplines	95
Appendix 10: Further Reading	99

Key Principles

1. Living with, or being close to and concerned about, someone with an alcohol or drug problem are very common and highly stressful experiences.
2. The needs of the family member in these situations are important in addition to the needs of the alcohol/drug using relative but are often overlooked.
3. Family members of people with alcohol and drug problems show high rates of symptoms of stress and are therefore at risk for physical and psychological problems.
4. It is vital to use an intervention that is evidence-based, and one that family members find helpful. The 5-Step method fulfils both of these criteria.
5. By working with family members, using the intervention outlined in this handbook, positive change can be achieved for both the family members themselves and potentially the problem alcohol/drug using relative.

Introduction

The Handbook

This handbook has been developed to support practitioners working in a range of services to use the 5-Step Method with adults living with alcohol and drug problems within their families. The handbook is intended to support the training you have completed and be a practical guide to understanding the main aspects of the intervention. Evidence indicates that seeking help can improve the health and well-being of family members.

Many family members will be convinced that the only thing that can help is having advice on how to stop the user. Evidence indicates that, when family members are engaged with treatment, or receive help in their own right, this can have a positive effect on the likelihood of the user either entering treatment and/or of that treatment being successful. The risk of relapse is diminished. Nevertheless, the 5-Step Method is about the family member and putting them first by offering help to family members in their own right, regardless of the behaviour of the user or whether they are engaged with treatment. As one family member who took part in one of our intervention studies said, *“it made you feel that you were still a person...that you have rights...that you have a life to live as well”*. It is important for family members to understand that people with substance use problems can change, although this may take time and does not stop family members doing something to help themselves. This can sometimes have a positive impact on other relatives, including the user. One family member who took part in one of our projects said, *“it was the change in me that changed him”*.

Throughout this handbook, those people affected by the alcohol or drug use of someone else within the family are referred to as **family members**. The people in the families about whom they are concerned are referred to as the **using relative** (or **relatives** or the **users**). Much of the material included in this handbook has been developed from our own research into addiction and the family as well as other current international work within this area. The content of the handbook is hence based on research evidence. In addition, the intervention described in this handbook has been evaluated within primary care and specialist drug and alcohol treatment services. However, the handbook is written as a practical guide and references within the text have been kept to a minimum (but you can find out more at the end of the handbook or on the AFINet website). Some family members may find it helpful to read some of the content of the handbook for themselves, or to use the accompanying **self-help handbook**: ‘Alcohol, drugs, the family and you’, also produced by AFINet-UK.

Using the Handbook

This handbook has been produced to support training and is not a stand-alone resource. Enquiries on how to access training in the 5-Step Method can be made via the AFINet website.

The 5-Step Method is primarily an individual intervention between a family member and a practitioner. However, there are alternative modes of delivery, and we say something about these later on.

Dealing with particular issues such as confidentiality, the threat of domestic violence and abuse, failure to attend meetings, telephone consultations, extreme distress, crises, and contact with the drug/alcohol misusing relative is discussed later on in the handbook. Considerations when working with certain groups of family members, such as those who have been bereaved through substance use, or those affected by problem gambling, are also covered.

Additional resources

There is an additional set of resources that we encourage you to use to support your delivery of the 5-Step Method. These include:

1. The self-help handbook for family members: 'Alcohol, drugs, the family and you';
2. A DVD illustrating 5-Step Method practice and principles;
3. A pocket guide to using the 5-Step Method;
4. A competency assessment framework (Appendix 1). This is extremely useful, as practitioners can assess their own practice, to see that they are applying the 5-Step Method correctly. The same competency framework is also used to assess whether practitioners meet competency standards to become accredited as 5-Step Method Practitioners. There is more detail on the competency assessment throughout this handbook. As part of the framework, there are also checklists, scoring tips and other useful information.
5. A questionnaire (the SQFM(AA) – Short Questionnaire for Family Members (Affected by Addiction – Appendix 2¹) which we recommend is used both as a useful assessment tool to clarify the main issues over which a family member is having problem, and as a baseline and then follow-up assessment measure to examine change in individuals who have received the 5-Step Method;
6. A publication (a special supplement of one of the main substance misuse journals) describing the background and current status of the 5-Step Method, including its underpinning evidence base (The ADF Group: Alex Copello, Akanidomo Ibanga, Jim Orford, Lorna Templeton and Richard Velleman, 2010, *Drugs: Education, Prevention and Policy*, Special Issue; Volume 17, Supplement 1).



Usually the first five of the resources in the list above are now given out at each 5-Step Method training course. The ones not included in this handbook can be obtained by contacting AFINet-UK (via the website) if you do not have any of them. Some of the papers from the D:EPP publication are circulated prior to each training course – details of the others are available later in this handbook or from the AFINet-UK website or your trainers.

This version of the 5-Step Method practitioner handbook is primarily for use in the United Kingdom. However, the majority of it will be equally appropriate wherever you are working, although some sections (particularly national and local resources) may need to be locally

¹ – also sometimes referred to as the FMQ – the Family Member Questionnaire.

developed. There are some translated versions of the practitioner and self-help handbooks available and you can find out more from the AFINet website/AFINet-UK.

This handbook is primarily for practitioners who are supporting family members affected by a relative's problem alcohol and/or drug use. However, it is important to note that the work of AFINet-UK also includes families affected by a relative's problem gambling and the National Problem Gambling Clinic in London has been working with us to produce a gambling version of the self-help handbook for family members.

Finally, this handbook is for use with adult family members. There is a version of the 5-Step Method, called *Steps to Cope*, for children and young people, although this is not currently widely available. You can find out more about *Steps to Cope* from the AFINet website.

Layout of the Handbook

There are three main sections to the Handbook:

Section A: Background information to our way of thinking and working, including an overview of the skills required for confident and competent delivery and to maintain fidelity to the model, and a consideration of the core skills underpinning the 5-Step Method;

Section B: A more detailed look at the 5-Step Method, including the skills required for delivery of each step, and the competency framework that is used to assess whether or not practitioners reach the standard to become accredited 5-Step Method practitioners; and

Section C: A series of appendices covering supporting information to help your delivery of the 5-Step Method.

In Appendix 3 are three case studies illustrations, drawn from real accounts which emerged during our work, and which are included to help you become more familiar with the concepts and skills involved in using the 5-Step Method. The scenarios on the training DVD may also help with this. Family members who participated in our projects have told us how valuable they find this aspect of the work, and their experiences are part of this handbook. In particular, reading about other people in similar situations allowed them to feel less alone and to realise that the situations in which they find themselves, the ways they feel and how they manage the situation are normal. Reading about family members who have managed to make positive changes to their situation brings hope to other family members.



What are the Exercises?

There are some exercises in Appendix 4 that you and the family member might like to view. These are also contained within the self-help handbook for family members. Not all family members will want to try any or all of the exercises (for example, some family members do not like writing things down, or are concerned that the using relative will find their notes and increase the risk of conflict and domestic violence), but they might help the family member to think about what you have been discussing, sort out their own ideas and feelings and record their progress. Family members use the exercises in different ways, on their own or with the practitioner with whom they are working. Some family members prefer to think about their responses but not write anything down, and perhaps discuss their responses with a practitioner, family member or friend, or even the user. They may want to discuss their

responses or show you what they write, but they don't have to. We recommend that you discuss with the family member in a collaborative way how to use the handbook.

Is the handbook appropriate for all family members?

We realise that some family members will have been knowingly living with their relatives' alcohol or drug use for months or years, while others will only just have found out about the problem. We have written this handbook to help all family members, whatever their circumstances. However, if in the course of your work with the family member you come across something that you think is not relevant, try to remember that it may help someone else who is in slightly different circumstances. Suggesting that the family member put themselves in someone else's shoes may mean that they get benefit from something that they had initially thought was irrelevant.

Additionally, our work has shown that there seems to be a common core experience associated with living with addiction problems in the family; and hence the handbook is written in such a way that it could be used whether the primary presenting problem is the excessive use of alcohol or other drugs to use a non-substance example. Where differences have been found between alcohol and other drugs in relation to either the impact on the family or the family member's responses, these are highlighted. Some family members who took part in our research projects did not feel that some parts of the handbook were relevant to them as they did not realise the similarity of the experience regardless of the substance of misuse.

Safe delivery of the 5-Step Method

An important issue that often arises in working with alcohol and drug problems in the family is that of violence or domestic abuse within the family setting. Evidence from most approaches that have worked with family members has confirmed the need to take this issue very seriously. Remember that domestic abuse is not just about physical violence. Victims of abuse report that it is often the emotional and psychological abuse that is the hardest to deal with and can take a long time to get over. This often includes living in fear of what will happen next and being criticised and put down on a regular basis. Other forms of abuse include verbal and financial abuse, threats of violence and sexual abuse. At best such behaviours can result in victims feeling worthless, run down, depressed and lacking any self-belief. At worst their safety and those of other family members may be at risk.

People who use substances can be the victim of domestic abuse or the perpetrator of abuse. While most domestic violence is perpetrated by men against women partners, children and male relatives can also experience abuse. There is growing evidence that shows teenage or adult children with substance problems can be violent and abusive towards their parents. Being informed about the different forms of abuse and who may be involved is something you need to be aware of when supporting family members, particularly in discussions around sources of stress and coping mechanisms. Remember that even though there is a risk of violence and domestic abuse in families where there are addiction problems, these issues can be responded to appropriately. When there is a risk, it is essential that you assess and respond promptly and appropriately. It is also vital that you are familiar with and supported by your organisation's procedures and protocols around assessing and responding to such risks.

Section A - Overview of the 5-Step Method

How alcohol and drug use affects the family

The 5-Step Method is based on a particular way of thinking about how family members are affected by a relative's alcohol or drug problem. This is called the *stress-strain-coping-support* model (see Figure 1 on the next page). There are a number of building blocks to this model:

1. When someone develops a significant alcohol or drug problem the family can experience **stress** that is often severe and long lasting.
2. Family members are at risk of medical and psychological health problems – this is named **strain** in the model, and results from their exposure to stress arising from the alcohol/drug problem in the family.
3. Family members actively respond to the stresses through actions and behaviours which we call **coping**.
4. Coping in itself, as well as **social support**, and **information and understanding** about alcohol/drug problems and commonly co-existing other problems or issues, can influence the stress and strain that is experienced by the family member and in addition may influence the course and severity of the alcohol/drug problem.

The 5-Step Method has been developed from this theoretical model. It does not see family members as to blame in any way for the alcohol or drug problem, and it places them at centre stage by offering them a form of help which is for them *in their own right*. The intervention is therefore a brief, structured and non-directive intervention which aims to support trained practitioners to facilitate conversations with family members about their circumstances.

To understand the theoretical underpinnings of the 5-Step Method in more detail we recommend that you refer to the paper which was given to you as part of your training course, and to some of the papers contained within the D:EPP special supplement which we mentioned earlier.

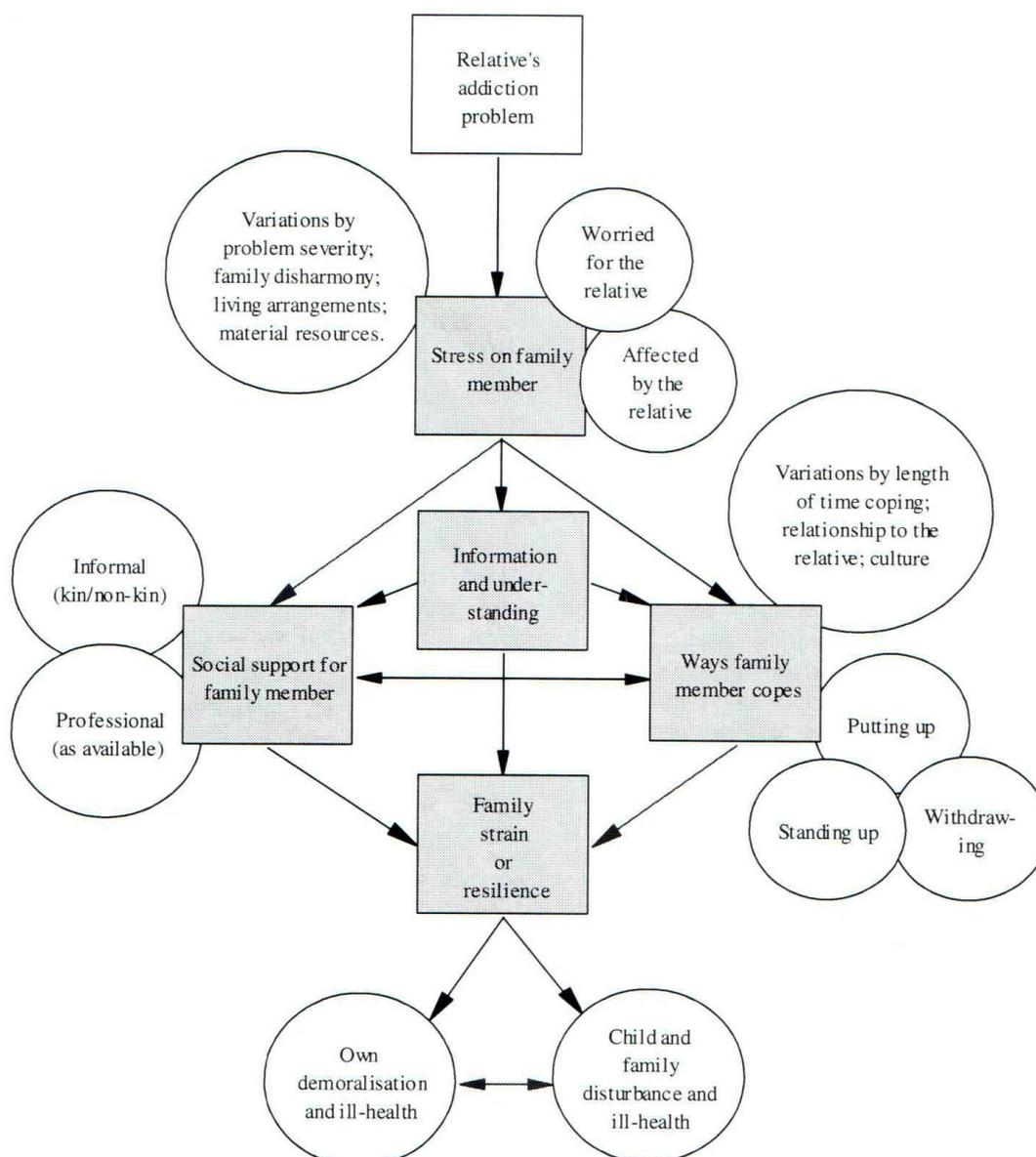


Fig. 1. The stress–strain–coping–support model.

The questionnaire mentioned previously [SQFM(AA)/FMQ, Appendix 2], which we use both as a useful assessment tool to help us clarify the family member’s main issues, and as a baseline and then follow-up assessment measure to examine change, is based on this theoretical model. It asks questions about each of these building blocks, allowing both practitioners and the family member to understand better how his/her situation is affecting their levels of stress, strain, coping and support².

The overall structure of the 5-Step Method approach to working with family members can be seen on the next page. The 5 steps are progressive and should be followed in order. You should aim to complete the whole intervention with each family member that you work with.

² The development of the SQFM(AA) is described in Orford et al (2010) Methods of assessment, one of the papers in the D:EPP Supplement. The SQFM(AA) is also sometimes referred to (in this Handbook and elsewhere) as the FMQ.

Aim of the 5-Steps

Step 1 - Getting to Know the Family Member and the Problem

There are a number of tasks to complete before you start the intervention and these are summarised later and include asking the family member to complete the questionnaire. Your aim for Step 1 is then to elicit from the family member her/his perception of the way in which the alcohol/drug problem is affecting the family and her/himself. This will be achieved through good use of all of the core skills which are outlined below, and can be assisted by referring to the completed questionnaire. Only when you feel that you have a clear picture of the family member and his/her circumstances should you move on.

Step 2 - Providing Relevant Information

Information needs to be relevant and provided in an objective manner. Written information is useful but it should not be used as a substitute for a discussion that allows the family member to voice her/his fears and address misunderstandings or lack of knowledge. Increased knowledge and understanding can significantly reduce stress.

Step 3 - Exploring How the Family Member Responds/Copes

Your aim is to discuss what family members find helpful and unhelpful about their current ways of coping, usually by discussing specific examples rather than general 'ways of coping', and to raise his/her awareness of alternative ways of coping. Your overall goal is to empower family members by supporting them to see that there are alternative ways of responding to their circumstances, each of which have their own advantages and disadvantages.

Step 4 - Exploring and Enhancing Social Support

You need to explore the support available, in order to help the family member build a stronger support system for her/himself and/or work with other family members to improve (if needed) agreed approaches to managing as a family and, where appropriate, communicating with the using relative.

Step 5 - Referring on for Further Help

You need to identify whether the family member needs any further support (e.g. from another service or something like a support group) and, if so, organise or facilitate this. If the problem alcohol/drug using relative is already seeking help with your service, then you may wish to explore ways of joint-working. Towards the end of Step 5 you should ask the family member to complete the questionnaire again and then use a comparison of the 'before and after' scores as part of your review of the work the family member and you have done. It is good practice to have a brief follow-up (even by 'phone) after some weeks (we recommend 6 weeks), and to arrange this in this final Step (e.g. by booking in a telephone call at an agreed time).

Do I need to use all the steps of the intervention?

In general, we believe that it is most useful to work through all of the steps with each family member. In our experience, family members have told us that they like this stepped approach as they are not overwhelmed with too much information at once, but can work in stages and at their own pace. Family members have also told us that the order of the steps is logical and *“followed a pattern which I recognised”*. Most family members have some needs for better information, most find discussions of coping and alternative ways of coping helpful, and most find clarifying what social support they have and whether they might be able to augment that beneficial. The 5-Step Method, as already discussed, is collaborative, where you agree and set the goals in discussion with each family member with whom you are working.

The 5-Step Method is a brief intervention and, as such, we believe that it is feasible for it to be embedded within a range of settings and services. There is evidence to suggest that relatively brief interventions can have a significant impact on people’s lives. This is the case with both family members and people with alcohol/drug problems. These brief interventions may reduce stress, increase knowledge, and/or expand a repertoire of coping or available social support. The intervention outlined in this handbook may not need lengthy interactions. On some occasions, a few key questions and good reflective listening can go a long way in improving a family member’s situation, and you may be able to complete each step with a short consultation. However, as a guide, each step will usually require a session lasting between 30 and 60 minutes; and your contact with a family member using this intervention should not need more than five individual meetings.

The specific needs of a family member may also vary according to whether the family member has been living with a problem for many years, or whether it is something more recent. This may also influence how you use the intervention. Furthermore, in some situations family members will have already, perhaps quite recently, made significant and positive changes to their lives. The intervention is not necessarily redundant in such cases; in fact discussions with a practitioner can serve to support and reinforce the change the family member has already started to make.

In addition to the specific components, we hope that how the intervention is delivered will be similar to the way in which you normally work with your clients.

Before providing you with a more detailed description of each step and its contents, it is important to revisit some of the key principles about the methods³.

The focus of the 5-Step Method is on the affected and concerned family members in their own right

The 5-Step Method stands in contrast to other methods used with family members in the addiction field. The focus is clearly on the family member’s experiences that result from living with an addiction problem at home or with someone close. The method is clearly focussed on the daily experiences family members face and a detailed exploration of their

³ Summarised from *Copello et al., 2010, Principles and Practice, Drugs Education, Prevention and Policy, Special Issue; Volume 17, Supplement 1.*

circumstances, and is based on years of research. A series of studies were carried out initially exploring the impact of addiction upon families and later developing the *stress-strain-coping-support* model upon which the method is based. We also know from the research evidence that positive outcomes are possible for the user of substances when working with family members.

There are other approaches that can be used to help families (see e.g. Copello, Velleman & Templeton, 2005⁴), some aimed at working together with the alcohol or drug user and the family (e.g. family therapy) or the family and wider social networks (e.g. Social Behaviour and Network Therapy). Furthermore, some approaches aim to support family members to bring the user into treatment (e.g. Community Reinforcement and Family Training). There are also more intensive family programmes that support the whole family. A number of services also provide advice, support and signposting and this can be crucial for family members. The 5-Step Method, however, is one of the few methods to support family members in their own right that has developed an evidence base.

The 5-Step Method views family members as ordinary people attempting to respond to highly stressful experiences

The model upon which the method is based conceives of family members as being ordinary people facing highly stressful circumstances. The emphasis is therefore upon the normal nature of the experience of facing severe stress as opposed to a more 'pathological' view of addiction in the family. Unlike other models commonly used in the field, the 5-Step Method does not see the family member as a cause or significant contributor to the development of the addiction problem, but as an ordinary person facing a very challenging and stressful problem. One of the strengths of the model is that once they have an appropriate level of knowledge and support, family members can develop the capacity to cope and respond to an addiction problem much like people are able to cope with a range of very difficult and complex problems in life. There is no room within the method to think of family members as part of the 'disease of addiction', having responsibility for causing the addiction, or being intentionally engaged in 'enabling' behaviours. The 5-Step Method rejects all these notions in favour of a more psychological understanding of dealing and coping with highly stressful circumstances.

The approach is flexible and adaptable to a range of settings, circumstances and relationships

An important feature of the 5-Step Method is that it can be adapted to the specific circumstances and needs of a range of services and settings. This handbook presents the 5-Step Method as being delivered in 1-to-1 face-to-face sessions, but increasingly some practitioners are delivering it in group-based formats; and some are experimenting with telephone-delivery. Similarly, even though the 5-Steps are described (as we did on the previous page) as if they always each take one session, in our research and clinical experience we have found that the steps can be combined and delivered over a shorter number of sessions, including within one single meeting in situations where this is necessary. Similarly, there may be some circumstances when one step requires more time than be given

⁴ Copello A, Velleman R & Templeton L (2005) Family interventions in the treatment of alcohol and drug problems. *Drug & Alcohol Review*, 24(4), 369-385.

within one session. Hence although we provide a clear guide (each step should take between 30 to 60 minutes), it is also the case that there can be flexibility over this. There are, however, two caveats to this. First, we know from what family members have told us that the first step is often the most important. Family members have repeatedly told us that they value the opportunity to tell their story in some detail and be listened to by someone who has got the time and does not judge the situation or jump into a discussion about possible action too early in the interaction. On the basis of the research evidence we would suggest that, if possible, the first step should always be delivered and that enough time should be devoted to this. Second, a premature discussion of coping methods (i.e. Step 3) may leave family members feeling that they are not coping in the right way and they may perceive the discussion of coping behaviours as a criticism of how they are coping. This can have a detrimental effect on their experience and their relationship with you.

The orientation of the person delivering the 5-Step Method is essential and highly important

We have found that the 5-Step Method can be delivered by a range of practitioners without the need for lengthy training. However, it is important to remember that the style and orientation of the practitioner is crucial for the success of the work. Those delivering the intervention should approach the work using a non-judgemental stance, being curious about the family member's circumstance and be prepared to explore the experience in depth using a problem solving approach. As much as the method is flexible, so should be the person delivering the five steps, looking for opportunities to increase knowledge and confidence to reduce stress for the family member. The overall orientation is not that of an expert providing advice but someone who works within a collaborative framework, exploring options in detail and supporting the family member in considering different courses of action.

The orientation of the person delivering the 5-Step Method requires them to be familiar, confident and competent with the skills which are necessary to successfully deliver the intervention. Before moving on to outline each step in detail we will give an overview of the skills, and take some time to look at the core skills which are relevant to delivery of the whole intervention.

5-Step Method: Skills for delivery of intervention and for each step

The 5-Step Method has been described as *deceptively simple*. While the model and the steps are straightforward to understand and follow, the skills to deliver them successfully and in line with the theoretical model which underpins the intervention are more nuanced. For example, facilitating rather than directing, maintaining focus as much as possible on the family member *in their own right*, and using the correct language and avoiding the use of terms such as enabling and co-dependency. To support delivery, our work over the years has led us to develop a competency framework and this is now a central part of the 5-Step Method training. The competency framework allows a practitioner to continually check and reflect on their delivery, ensuring that this is in line with the model and that they are building competence and confidence in using the intervention. Hence, it serves an important function for professional development.

There are six sets of skills which a practitioner requires for successful delivery of the 5-Step Method: one set for each of the 5 Steps, plus overall general counselling skills. The set of skills for each Step will be covered in more detail when looking at each individual Step later in the handbook. Here we will focus on the core counselling skills which run throughout the whole intervention. These are listed in the box below, following which we look at some of these skills in a bit more detail. Numerous reviews⁵ have shown that these are the key counselling skills to be an effective counsellor.

Core Counselling Skills

5-Step Method: Core Counselling Skills

1. Creation of a relationship of trust (warmth, genuineness, and empathy).
2. Careful listening, the giving of minimal encouragers, the asking of appropriate questions, reflecting both the verbal and emotional content of what has been said, summarising, and sensitivity to cues whether verbal or non-verbal, direct or indirect.
3. Allowing silences and the expression of emotions - anger, anxiety, depression, sadness; expression of feelings can be cathartic, and can alter feelings and improve self-esteem.
4. Offering positive encouragement, reassurance and support, reminding people of their strengths and expressing hope and optimism that change is possible.
5. Management of issues associated with risk and safety if relevant – e.g. domestic violence and abuse, safeguarding concerns, and/or mental health.

Active Listening

This is perhaps the most important skill for the whole intervention. You should be able to listen to a family member's experiences, feelings and dilemmas. You can do this through asking questions, giving time and silence for the family member to respond, and then reflecting, summarising and asking further questions to keep the discussion going.

⁵ (as summarised in the FINDINGS Alcohol Matrix cell B4: Practitioners; Psychosocial therapies - see <http://findings.org.uk/PHP/dl.php?file=Matrix/Alcohol/B4.htm&s=eb>)

Questions

It is important to know the difference between closed and open questions and to learn skilfully when to use each sort of question. Throughout the 5-Step Method, open questions should be used as much as possible as they help to establish rapport, gather information and increase understanding. For example, in Step 1, think about how asking 'what can you tell me about how you are affected by your partner's drinking?' rather than asking 'are you affected by your partner's drinking?' will influence your session. Open questions focus on the who, where, how and when – care should be taken with asking 'why' as it can be interpreted as having a critical or judgmental tone even when that is not the intention.

Reflecting

Reflective listening can often be a pathway to engaging with someone and building trust. It can appear straightforward but requires skill to do well. A reflection is a statement rather than a question, as questions may have a more significant impact on conversation flow. There are four different types of reflection: repeat, rephrase or paraphrase, complex reflections (where you 'guess' an interpretation about what you hear, making sure that you give the family member the chance to disagree with your reflection and explain what they meant), and double-sided reflections (where you may for example capture both sides of a family member's dilemma). There are a number of reflection 'stems' which you can use, and you should be familiar with a number of these as using the same one all the time can make a conversation appear stilted. Examples of reflection stems are: 'so you're staying that', 'I get the impression that', 'it sounds like, from your point of view'.

Summarising

It is important at points during each session, and at the end of each session, to be able to accurately summarise what you have heard. You may also want to summarise the previous session when you start the next. Summarising demonstrates to a family member that you have heard and understood them, but also allows you to check your understanding of the situation and for the family member to correct you if there was anything that you missed or misunderstood. It may be helpful for you to take some notes during your sessions, but make sure that the family member knows that you will be doing this (it can affect eye contact for example).

Counselling Style

There are four key principles within this intervention that reflect the overall philosophy of the approach and are particularly important at the early stages: listen actively, develop empathy, deal with emotions, and express and promote realistic optimism. Each of these is discussed in turn below and they are all demonstrated in the relevant section of the 5-Step Method training DVD.

1. Listen actively

In relation to the style of the conversations you have with family members, one of the most important things that you can do for a family member is to encourage open talk about the circumstances that he or she is facing at home, and to respond in a non-judgmental and reassuring way. It is important that sufficient time is given for family members to tell their stories, to express the distress that they may be feeling about their circumstances and to feel

that you have responded in an understanding way. A useful strategy at this early stage of the work is the use of active listening. Active listening creates a process by which not only are you listening but you are also checking your understanding of the information through the use of open questions and/or reflective statements. The following example illustrates some of these points:

Practitioner	Perhaps you could tell me how you felt when you found the needles in your son's room.	Open Question
<i>Mother</i>	<i>I felt desperate, not knowing what to do. I felt frightened and worried.</i>	
Practitioner	It sounds like you experienced a number of feelings	Reflection
<i>Mother</i>	<i>Yes, that's right. I felt overwhelmed but most of all frightened, for him and for the whole family.</i>	
Practitioner	So you felt frightened that something might happen to your son and your family	Reflection
<i>Mother</i>	<i>Yes, I am worried for his health. I have heard that people can catch AIDS when they use drugs ...[the mother continues to describe her fears]...</i>	
Practitioner	This is clearly causing you a lot of worry. I can provide you with some information later but before that, it would be helpful to understand clearly how all these fears are affecting you and the other family members. Perhaps you can tell me more about this.	Open Question
<i>Mother</i>	<i>Well, I am finding it difficult to sleep at night, particularly if he is not at home.....[mother continues to describe the impact upon herself and the rest of the family].</i>	

Hence, listening should not be carried out in a passive way but should be a process by which the listener constantly checks the understanding of the statements conveyed by the family member. Simple reflections that repeat the key elements of the last sentence given by the family member in a tone of voice that reflects genuine interest in finding out more about the problem, are helpful (although as said above, simply repeating things all the time can make a conversation appear stilted).

When you listen attentively to what family members have to say about their experience of living with a drink/drug problem, what emerges is usually a mixed description of disruption, pain, sometimes abuse, concern for the user, and concern for the family as a whole. Some of the issues relevant to this exploration are discussed in the following sections.

During your contact with the family member, you should pay particular attention to non-verbal expressions, and notice any discrepancy between verbal and non-verbal communication e.g. the family member describing something and minimising the impact upon her/himself while at the same time physically looking extremely tense.

Some approaches can interfere with listening and result in blocking exploration of the family member's feelings. This might result in the family member feeling not listened to and isolated,

a common experience described in our research. **The strategies to be avoided include giving advice, persuading or lecturing, disagreeing or agreeing, interpreting and judging.** Note that while you may wish to use some of these strategies at some stage (e.g. advice about sources of help), these should not be used while you are trying to encourage family members to tell their stories and express and explore their distress.

Your conversations with the family member should be centred on the family member and be guided by their worries and concerns. **You should accept and respect family members as they are** and remember that while people talk about their experience they may learn, increase their understanding or make new links and connections that they hadn't thought of before. All of these can be very beneficial.

2. Develop Empathy

To be empathic means being able to put yourself in the family member's place and being able to understand his or her experience. Comments such as, '*That must have been very difficult for you,*' facilitate the expression of emotions and the family member feeling that he or she is being heard and understood, for example:

Wife: "Since that time [when he became violent] I am always uneasy when he is out in the evening".

Practitioner: "*It must be very difficult to live with that worry every time he goes out in the evening*".

Wife: "Yes, you are right. I worry about what he might do to the children".

3. Deal with Emotions

Talking about the experience while faced with alcohol and/or drug problems in the family can be very painful for the family member. In addition, the family member might feel embarrassed or a deep sense of shame about what is happening. On other occasions, family members may feel responsible for the alcohol and/or drug use of their relatives. It is important that you feel able to deal with these emotions. A number of techniques can be helpful in order to achieve this:

- (a) **Be warm, interested and respectful.** This can facilitate communication of emotions. However, in some cases this might not be enough. For example, when the family member becomes very agitated or breaks down in tears.
- (b) **Allow the expression of emotions.** It is important that you allow family members to express their distress and to allow family members to express and explore their feelings in their own time. You will also need to give them permission to stop the session and continue at another time if they so wish.
- (c) **Attempt if appropriate to normalise the family member's feelings.** It is important that you convey the message to the family member that it is normal to feel distressed when faced with her/his situation. As mentioned before, the family member might feel responsible for the drug or alcohol problem and hence it is important that you clarify the notion that there is no person who is solely responsible for the problem but that the causes of excessive drug and alcohol use are many. They include deeply held cultural attitudes that encourage heavy use, the availability of substances which can cause dependence or harm, and social conditions that fail to provide security, opportunities and

regular employment. Hence, as stated before, when excessive drug or alcohol use takes place, both users and their family members are victims.

4. **Express and promote realistic optimism.**

An important principle of this intervention is that it is based on the notion that things can change and improve for the family. There are two different aspects of positive change, namely an improvement for the concerned family member and a positive change in the drug or alcohol user. It is important to convey the idea that it is not necessary for change in alcohol or drug use to take place in order to achieve improvements. Once again, a common experience reported by family members is that of being told that there is nothing that can be done, unless the relative stops drinking or using drugs. In contrast to this, the aims of the present intervention are to convey the feeling that the family member has the power to initiate change for her/himself, irrespective of whether the relative modifies his/her drug or alcohol use.

Section B – The 5 Steps

Before you start

There are a number of tasks which should be completed before starting the intervention itself, and these are listed below.

1. How we start our interactions with family members will impact on the whole intervention. Although there are a number of administrative tasks to be completed, it is vital that we welcome and greet the family member in a warm, open and helpful manner, and that we use these early minutes to start to develop an important therapeutic relationship.
2. Complete any other organisational paperwork such as confidentiality and information sharing agreements. An example would be *“Apart from my supervisor who I need to discuss my session with to help me improve and give the best possible service, everything that you say here is completely confidential, unless it involves things that I legally have to report elsewhere, and even then we’d talk about that before I did that – these are things like if you tell me that you are about to harm yourself or someone else, or if you tell me about a child that is being abused”*.
3. If you are going for accreditation or generally record your sessions, ask the family member about recording the session and explain why e.g. *“What you say is really important, and I need to be able to go back and listen again, and see that I have caught all of what you’ve said. Also everybody can do what they do better, so all of us here discuss our work with someone who is our supervisor, who is experienced and who helps us work out if we are asking the right questions, and offering the best help.”*
4. Complete an assessment with the family member if they are a new client, and discuss with the family member whether they are interested in working through the 5-Step Method with you. The assessment can follow usual practice in your organisation but, if possible, should include completion of the SQFM(AA)/FMA for the first time.
5. Briefly introduce the 5-Step Method to the family member so that they have an overview of the model and how the sessions will work. This can include discussion of the self-help handbook and whether and how this will be incorporated into the sessions.
6. Discuss the details of the sessions with the family member – how many, how long, how regularly (although some flexibility may be required), and how you will keep in touch between sessions. These areas are so important that they are included within the competency framework, within the first skill for each step, where what is done at the start and end of each session is listed.
7. Complete a safety assessment (such as whether it is safe for the family member to keep a copy of the self-help handbook at home, and how to handle contacts between the practitioner and the family member, for example if there is any danger of the using relative answering the telephone or intercepting a letter).

Step 1 – Getting to know the family member and the problem

Your aim is to elicit from the family member her/his perception of the way in which the alcohol/drug problem is affecting the family and her/himself. This can be achieved through good use of all of the core skills which are outlined above. Only when you feel that you have a clear picture of the family member and his/her circumstances should you move on.

Step 1 – Skills

Step 1 is the most important so don't rush it. The skills for Step 1 focus on the family member, the problems they are facing, how they and others are most affected, and the fears and concerns held by the family member. It is important to maintain focus on the family member as much as possible, achieving the right balance between this focus on themselves and their inevitable focus on the person who they are concerned about. While the core counselling skills are required for all of the five steps, their skilful use is particularly important here as it facilitates you building a good relationship with the family member and having a full picture of the family member's situation from which you can move on to the rest of the steps. You are not trying to fix or change anything in Step 1 so listen and use your core counselling skills. Remember also that how you start and end each session is as important as the bulk of the session itself. Starting and ending each session are combined together in the competency framework; this is only done because if they were separate they would take on a disproportionately high value when assessing practitioners for accreditation.

Step 1: Skills with examples of good practice

(NB: FM= Family member)

1.1	Beginning of session - introduce 5 step, confidentiality, purpose of Step 1. Complete SQFM(AA) (if not already completed) and use to guide the session. Ending session - summarise the main FM issues, use of handbook and next steps. Clarify what the information needs are to be discussed in Step 2. Check if session was helpful. Practical issues of contact and date of next session.	<i>"The purpose of this session is for you to tell me your story and explain your concerns and fears."</i> <i>"Let me summarise what you have said today and what we will do next time."</i>
1.2	Allow FM to describe situation and tell their story, listen to and ask about the FM's concerns and fears. Summarise the situation to check if understood correctly. Acknowledge emotions being expressed.	<i>"Your main concerns are xxx, does that summarise it correctly?"</i> <i>"You have spoken about the problems for your son but what is it like for you?"</i>
1.3	Identify relevant stresses and how the FM has been affected.	<i>"It would be helpful to understand clearly how these worries are affecting you, can you tell me more about this?"</i>

1.4	Identify relevant stresses and how others have been affected.	<i>“So we have talked about how you are affected, are there other people in the family who have been affected?”</i>
1.5	Normalise the experience of FMs giving an indication that they are not alone with their experiences.	<i>“Your situation sounds very stressful and from having talked to quite a lot of family members, your feelings and reactions are very normal.”</i>

When you are faced with a family member of someone with a drug or alcohol problem who is prepared to talk about the experience, you should remember how difficult it might have been to take this important step. In some cases the family member might have already attempted to talk to others and received negative or hopeless messages about the situation. This is not uncommon as the following examples illustrate:

“People always say it’s the wife’s fault. I went to see the doctor because of my nerves. The doctor said he could only help if my husband went. I do not feel he realised that I needed help for myself” (Wife of a drinker)

“I got the impression that the counsellor was not listening. He was just trying to calm me down. I wanted to get some information. I found the experience frustrating and came away not feeling any different” (Brother of a heroin user)

It is crucial that you should avoid this situation arising, and you should take advantage of the family member’s acknowledgement of the problem and encourage her/him to talk about the experience. The sub-sections above on General Counselling Skills and on Interview Style are of paramount importance here, in order to facilitate this communication. The style adopted at the start of the 5-Step Method work will determine the overall quality of the relationship for the whole of the intervention. It is highly likely that these are skills that you already use in the course of your routine work but we have raised them here for clarification and application to working with family members. So, even if you already know the family member and may have already done some of this work, please give it the time it demands as part of this intervention. It is one of the aspects of the work that family members find most valuable.

Stresses and strains for family members

It is important to facilitate the identification of stressors and the ways in which stress is manifested in family members (Appendix 5). This will be of use to those of you who are not so familiar with this information, and may also be of potential benefit to your work with family members, who may appreciate seeing and discussing this information for themselves. It is essential that you familiarise yourself with the various manifestations of stress as, in our experience, family members have told us that they feel reassured when the person delivering the 5-Step Method is familiar with the range of possible stressors that can occur. Some examples of common sources of stress are:

1. Drinker/drug user not pleasant to live with.
2. Concern over drinker/drug user’s health or performance.
3. Financial irregularities and effects.
4. Impact on the whole family and the home.

5. Other members of the community become involved.
6. Concern over frequency or quantity of the relative's drinking/drug taking.
7. Alcohol/drug user disappears or comes and goes.
8. Social life for the family member or whole family affected.
9. Incidents, crises.

While there are some common stressors which can be experienced by all family members, it is also the cases that there are stressors which are more common for certain groups of family member. For example, spouses and partners may be at particular risk of violence/abuse or will want to try and keep the family together; parents may feel that they have somehow failed in their role; children may be particularly confused or frightened about what is going on or will find themselves taking on inappropriate caring roles; and grandparents may have the double stress related to both their child who is misusing alcohol and/or drugs and their grandchild[ren], sometimes having to take over care responsibilities of their grandchildren.

Problem substance use commonly co-exists with domestic abuse. Where a family member is suffering domestic abuse it is unlikely that they will come right out and say it. They may talk of it in subtler ways, for example, 'being in trouble' for doing something, or their partner or child 'having a temper' or they may disclose having a 'major row'. Listening and picking up on these clues is therefore vital. Remember people who suffer domestic abuse often feel embarrassed and ashamed so these are not easy matters to discuss. Reflecting what they are saying in order to explore the situation further can help you to determine when these phrases mean domestic abuse and when they do not. Reflecting back that a situation 'sounds frightening' for example can give the family member permission to disclose abuse and how they are coping with it. If someone is afraid or feeling unsafe at home they will be focussed on coping with that first and foremost. It may also be that the family member is the perpetrator of the abuse and the relative is the victim. It is important in these circumstances to listen but take care not to encourage such behaviour. **The priority for working with any family member where there is domestic abuse is always to 'think safety'. Where there is any doubt you may need to fast forward through this handbook to Step 5 and provide advice, information or a referral to a domestic abuse agency. This should be done in line with your organisation's protocols in this regard and you should seek the support of a team leader or manager.** Further information on working with perpetrators and victims of abuse can be found in the section: general considerations and particular problems.

The value of this first session, and of the overall approach of the intervention to having someone to talk to, cannot be over-estimated – *"just wonderful to share my issues, just get it off my chest really, share the load.....it made me feel better. To me it was worth a million dollars"*. One family member told us that reading about the illnesses and symptoms helped her realise that she and her children were suffering from most of them, and that this was because of the drinking. This really brought home how things were for her and her children. Another family member said that she didn't get headaches any more, whilst others reported feeling more confident and more positive. Another family member had been having bad panic attacks, but these had reduced after completing the 5-Step Method and she was able to go out more.

Exercises One and Two (see Appendix 4) are tools that may help you work through this Step with the family member. **Exercise One** encourages the family member to think about the stressful behaviours they are facing and the feelings that arise as a result of these behaviours, both for the individual family member and the family as a whole. **Exercise Two** encourages the family member to consider the impact of these behaviours and stressors upon health for both the family member and the rest of the family.



Overall, your aims for Step I should usually include all of the following:

1. Use the core skills throughout the session.
2. Allow the family member to describe his or her situation until you feel confident that you know the family member's story.
3. Identify specific stresses and strains relevant to the family member and to key others in the family.
4. Normalise what the family member tells you as common to the experiences of many family members. Communicate realistic optimism about moving forward.
5. Listen for hints of, or disclosures about, possible violence and abuse and respond appropriately, prioritising safety.
6. Identify the need for further information to be discussed during the next stage.
7. Identify the needs of the family member which will determine the amount and content of future contacts.
8. Agree on a way of communicating in case of missed appointments.

Step 2 - Providing Relevant Information

Information ought to be relevant and provided in an objective manner. Written information is useful but it should not be used as a substitute for a discussion that allows the family member to voice her/his fears and address misunderstandings or lack of knowledge. Increased knowledge and understanding can significantly reduce stress.

Step 2 – Skills

Application of the skills for Step 2 will allow you to understand from the family member what information needs they have and to help address these gaps and needs. Aspects of Step 2 should have been started during Step 1. While the focus may be towards alcohol, drugs, treatment etc., the family member may have questions and a need for information relating to a range of other issues, such as mental health, benefits or other financial issues, domestic abuse, alternative activities for the family member to try out, and many other possibilities. Your approach should be the same regardless of what you are providing information about and this is demonstrated in the relevant section of the 5-Step Method training DVD. The process in which information is provided is extremely important – you should establish what the information needs are, clarify how it is best for the family member to get that information, and then check with the family member that the information is what they wanted and has helped them in some way. Remember that you do not need to be expert in every area that the family member may need information about, and that you do not need to be the person who provides every bit of information. The key skill is to clarify what will be most helpful and useful for the family member – sometimes that will involve you giving the information, sometimes it will involve you going away to find the information out and then providing it, sometimes it will involve you helping empower the family member so that s/he can go and find the information for her/himself (on the internet or at the library or the citizens advice bureau). Also, remember the core skills, and how you start and end the session.

Step 2: Skills with examples of good practice

2.1	Beginning of session - check if previous session helpful. Give purpose of Step 2. Ending session - summarise the main FM issues, use of handbook and next steps. Check if session was helpful. Practical issues of contact and date of next session.	<i>“The purpose of this session is to look at what information would be helpful to you, what do you think would be useful?”</i>
2.2	Identify/check areas where FM needs more <u>Addiction-related information</u> (about the substances or behaviours involved – e.g. details of drugs, units of alcohol, forms of gambling - or about addiction/dependence – e.g. how difficult it is to give up, reasons for relapse etc.), present targeted & relevant information to FM, and discuss this. Utilise results of FMQ to guide the session.	<i>“We have talked about giving you some information on the health effects of alcohol, so I have a leaflet here and there are also some websites which may be useful so you can find out more. Shall we look at this information and then you can let me know what you think and if it throws up further questions for you?”</i>

2.3	Identify/check areas where FM needs more <u>General information</u> (about anything not directly addiction related - e.g. anxiety, sleeping and other health issues, housing, debt management, benefits, educational courses), present targeted & relevant information to FM, and discuss this. Utilise results of FMQ to guide the session.	<i>“You mentioned dealing with your relative’s anger, is there any help you would like with this? You also mentioned when we filled in the questionnaire your sleep problems, would information on relaxation techniques be helpful?”</i>
2.3	Identify/check areas where FM feels other family members may need information - both addiction and general information.	<i>“Is there information that members of your family may find useful”</i>
2.5	Support FM to find out more for themselves about identified issues e.g. FM could use websites, reading, library, organisations, etc.	<i>“You have said you don’t have a computer, so you can get more of this information from the local advice centre or the library has computers so you can access the internet. Also, here is the name of a very good website.....” “Would it help if we logged onto the computer after the session to have a look at useful websites?”</i>

An important contributor to stress for most family members is their lack of accurate knowledge about alcohol and drugs, their effects and issues of dependence. You are in a good position to provide family members with useful information. Some of the key areas that you may need to cover include: types of drugs or alcohol that the relative might be consuming; patterns of harm-free and harmful drug or alcohol use; the links between substance use and behaviour; and issues related to dependence on substances, including understanding addiction and why people become addicted, relapse etc.

The information section later in the handbook (Appendix 6) is a useful starting point for a discussion with the family member. Much of the information will be already known to you but may be of use to the family member who does not have this level of knowledge. Family members have often found written information very useful, since it may be difficult for them to concentrate fully during an interview or indeed remember later all the information discussed. Obviously, you may have additional resources available at your service that you can give to the family member. The Internet is packed with information although it is important that you support the family member through the process of searching information from the Internet in order to avoid the family member becoming overwhelmed or exposed to confusing and unhelpful information that may increase stress. Also, it is important not to assume that people will automatically have access to and use a computer or a smartphone – increasingly, many do, but there are still many who do not.

Some common questions include: Is my son an addict? Has she got mental health problems? What does dependence mean? He sleeps a lot, is that part of the effect of the drugs? We thought she was in treatment but...? All of a sudden he becomes very cocky and we feel frightened, is that to do with the drugs? It is impossible to anticipate all possible questions.

The important issue is that you remain attentive to the family member's needs and avoid unnecessary labelling or complicated, blaming and confusing messages.

An important consideration is how to tailor information taking into account the needs of the family member. Too much information may be overwhelming and increase anxiety whereas too little information may give rise to further fears based on unknown facts or erroneous knowledge. You will need to strike a careful balance between relying mostly on written materials that the family member can read and study carefully and providing information yourself through an open discussion of fears and concerns. Some specific issues may not be covered satisfactorily within the written material you have given the family member. In addition, some information may raise new concerns for the family member, which she/he will need to discuss further. A further option is to look at the information together with the family member e.g. on the Internet, while at the same time discussing concerns as they arise. This goes a significant way to promoting a true collaborative style of working.

For those living with domestic abuse it may also be appropriate to provide information on the links between substance use and domestic abuse. Evidence shows that victims may use substances to cope with violent and abusive behaviours, and that perpetrators may use their substance use as an excuse to be abusive, 'I didn't know what I was doing'.

If the family member is the victim of abuse you may also want to provide information about who to contact to if legal or housing advice is needed. Family members who suffer domestic abuse can often blame the substance use for their relative's abusive behaviour and while it can make the abuse worse and more frequent, it is not the cause of domestic abuse. This is important because if people believe stopping or reducing the substance use will stop the abusive behaviour they may continue living in, and trying to cope with, a situation that is unsafe for them (and their children) in the hope that things will change. Discussing it with them may be the best way to provide information in this situation as it may not be safe for the family member to take written information home. However, looking at leaflets together and/or helping them to find information on the Internet would be another good option.

When working with a family member who may be perpetrating abuse you can also provide information on agencies that work with perpetrators of abuse, for example, Respect (see Appendix 9).

Finally, you may find that some family members have read a lot of information in their search for an answer or in sheer desperation to try and understand what is going on within their family. In such cases this Step may not be so relevant, but it would be important to check what information the family member has and that there are no misconceptions or gaps. The handbook and the work that you do may act to confirm and reinforce the knowledge that they already have.

Exercises Three and Four may help you work through this Step with a family member. **Exercise Three** encourages the family member to write down questions related to the areas or issues that she or he feels would like to understand better.



Exercise Four allows the family member to summarise the valuable information that they have obtained and how she/he feels about this now that the information is available.

Overall, your aims for Step 2 should include:

1. Check if previous session was helpful and if any areas need more time.
2. Identify/check areas where family member needs more information or where there are misunderstandings, both addiction-specific, and related to other important areas.
3. Provide relevant, specific and targeted information that will increase the family member's knowledge and understanding of the situation.
4. Identify/check areas where family member feels other family members may need information, both addiction-specific, and related to other important areas.
5. Explore whether family member has any other needs in relation to knowledge and information.
6. Support family member to find out more for themselves about identified issues e.g. they could use websites, reading, library, organisations, etc.
7. Check with the family member at the end if the session has improved knowledge, understanding and awareness, and/or reduced stress and anxiety.

Step 3 - Exploring how the family member responds/copes

Your aim is to discuss what the family member finds helpful and unhelpful about his/her current ways of coping; and to raise his/her awareness of alternative ways of coping. Your overall goal is to empower family members by supporting them to see that there are always alternative ways of responding to their circumstances, and that it is not the case that one way is 'right' and another 'wrong' but that every way of responding will always have advantages and disadvantages associated with it.

Step 3 - Skills

The skills for Step 3 are designed to support you in guiding and facilitating a conversation with a family member so that they can assess for themselves how they are coping, what they find helpful and unhelpful about each coping strategy that they use and whether they have considered alternative ways of coping and what the benefits and drawbacks might be to such alternatives. Good use of the core and specific skills will mean that you can build up as full and detailed a picture as possible of this area. It is also important that you deliver this session of the intervention in such a way that the family member will not feel that they are doing anything wrong by using coping strategies which are in fact unhelpful. Terminology is important: we try not to talk about 'positives/negatives' as that might imply right/wrong; instead we use 'benefits/drawbacks', 'helpful/unhelpful' and 'advantages/disadvantages'. Skills in starting and ending this session, as well as ongoing use of the core skills, continue to be required here.

Step 3: Skills with examples of good practice

3.1	Beginning of session - check if previous session helpful. Give purpose of Step 3. Ending session - summarise the main FM issues, use of handbook and next steps. Check if session was helpful. Practical issues of contact and date of next session.	<i>"The purpose of this session is to look at how you currently respond to the situation with your [relative], can you tell me what normally happens?" "Can we look at a specific example? What did that last happen?"</i>
3.2	Ask FM about current coping responses. Get specific examples and situations. Discuss the 3 main ways of coping. Utilise the handbook and its exercises. Utilise results of FMQ to guide the session.	<i>"The handbook shows various ways of coping, shall we look at these and see which ones you may have used in the past or may find useful to use in the future?"</i>
3.3	Explore advantages and disadvantages of current coping responses. Again, use specific examples and situations.	<i>"Let's look in more detail at what are the advantages and disadvantages of coping like this. Tell me what the benefits are...Now tell me what the drawbacks might be."</i>
3.4	Facilitate FM to see that there is no right or wrong way of coping.	<i>"You have talked about your ways of coping and lots of FMs feel there ought to be a best way, but there is no right or wrong method, just advantages and</i>

		<i>disadvantages depending on the situation.”</i>
3.5	Explore advantages and disadvantages of alternative ways of coping, again utilising specific examples and situations.	<i>“We discussed that you think it may be better to talk to your son the next day about the effect his behaviour has on you, what would the advantages and disadvantages be of this?”</i>

When faced with alcohol/drug problems within the family, family members attempt to respond to their circumstances. They usually try different strategies depending on their personalities, their previous experience, the severity of the problem etc. The responses, which we call ‘coping’, are broader than just actions. Actions are usually accompanied, and indeed influenced, by attitudes and feelings. Different ways of coping lead to different results, both for the family member and the relative using the alcohol/drugs. The fact that results are varied is one reason why family members find it difficult to decide on the best course of action, and their attempts to make these decisions are seen as dilemmas and often experienced as ambivalence. How to help the family member think through possible responses, weigh up pros and cons of each response and make decisions about the perceived best way of coping is the essence of this step.

Our research has supported the idea that the family member’s coping efforts fall into three broad categories. These have been named **engaged or ‘standing up to it’, tolerant or ‘putting up with it’** and **withdrawal or ‘withdrawing and gaining independence’**. Each one of these will be described in more detail later in this section and how to present these to a family member is demonstrated in the relevant section of the 5-Step Method training DVD. More detailed examples on coping are in Appendix 7.

The important aim of Step 3 is to explore with the family member their current ways of responding to the situation at home. It is important to use the core skills well and to be curious about the family member’s circumstances. This stands in contrast to a more prescriptive style that would favour one or other form of coping. In essence, we know from research that no particular way of coping is universally the best. Each family is unique and any response from a family member will be associated with potential advantages and disadvantages that the family member will have to weigh up.

It is also important to discuss specific situations with a family member and not simply have a general discussion about ‘how s/he generally copes’. It is helpful to try to get specific information, for example – “can you tell me about the last time he came home drunk? Can you talk me through what happened, who said and did what, how did you and your relative react to each part of the interaction”.

As a rough guide it is useful to think of four key tasks within this step, and this process is demonstrated in the relevant section of the 5-Step Method training DVD.

1. Discuss the family member’s current ways of coping (familiarity on the part of the person delivering the intervention with the three types described in this handbook is essential).

2. Explore advantages and disadvantages of the current ways of coping as perceived by the family member
3. Explore alternative ways of coping with the family member; and
4. Explore advantages and disadvantages of these new alternative ways of responding.

It is important that during this process of exploration of both existing and alternative coping responses, the practitioner is aware of the need for safe practice, remaining aware that family members may also be coping with domestic abuse which is likely to affect their coping response. In our experience, family members, once they have carefully considered the various options, are able to make their own decisions based on this exploration, and they tell us that they find the process of discussion very helpful.

Exercises Five and Six may help you discuss with the family member how she or he responds. Both exercises help family members to look at how they respond to their relative's behaviour, how they feel about their responses including what was helpful and unhelpful about the response[s] used, and consider other options for responding in the future.



In the next sections we provide a more detailed description of the various ways of coping that have emerged from our programme of research with family members.

Engaged Coping (Standing up to it)

This category is about the family member trying to get involved in changing the relative's drinking or drug use, or reducing its impact on the family member and others in the family. This includes responses that involve active attempts by the family member to influence the relative's behaviour or protect the family from the impacts of this behaviour. The following can all be seen to be forms of engaged coping.

1. Attempts to **control** the use, e.g. encouraging the alcohol/drug user to promise not to drink or take drugs, or trying to control his or her money in some way.
2. Expression of strong **emotions** on account of the alcohol/drug use, e.g. starting an argument about the drug taking or drinking, or making threats that the family member may not mean (or may be unable) to carry out.
3. **Assertive** communication which involves the family member expressing in a calm and open way feelings about the relative's alcohol or drug use.
4. **Supportive** actions from the family member towards the relative and/or the relative's efforts to change, e.g. standing up for the relative when others criticise her/him or trying to encourage the relative to take up alternative activities to using alcohol or drugs.
5. Attempts to **protect the family members and others in the family** from the impacts of the problem e.g. looking after the family member's own safety and well-being; making sure that the children are safe and well looked after.

Being a rather broad category, it is hence associated with a range of thoughts. At the more emotional end it includes thoughts such as, "it is not fair on me", whereas in its more controlling form it is associated with thoughts such as, "there must be something I can do". The core aspect of this category is the active attempts by the family member to influence the

situation, driven by a desire to resolve the problem of excessive alcohol or drug use or minimise the impact on the family. The following are some examples:

“I used to get annoyed and shout at him but this may work in the short term and not in the long run. I would shout at him for example when I knew that he was injecting in the bathroom and this might stop him doing it for a few days but after a while it would all start again.” (Wife of a drug user)

“We have made it plain to him that it upsets us when we see him in a state and we have told him that we don't want him coming to us drunk. This seems to have had some benefit.” (Father of a young problem drinker)

“Shouting has been the most helpful thing for me...I can get it out of my system. It is still a good release...I feel better for shouting...than walking away and ignoring the situation...if I walk out, it's almost like giving him approval. At least by shouting I know he knows the effects he's had on me.” (Male partner of a man with a drink problem)

“I now make sure that the children are never left alone with my relative for longer than about half an hour.” (Female partner of a man with a drink problem)

Tolerant Coping (Putting up with it)

This category includes actions that protect problem users from the negative consequences of their drinking/drug taking. The following are examples of tolerant coping.

1. **Actions that put the drug and alcohol using relative's needs before that of the family member**, e.g. clearing up the mess the relative makes when he/she has been drinking/using drugs or giving money to the relative knowing that he/she will spend it on drink/drugs.
2. **Inaction**, e.g. the family member not knowing what to do or not thinking about the situation.
3. **Joining the user** in drinking or taking drugs.

This form of coping is usually associated with feelings of worry and guilt. The family member might be using this way of responding to his/her predicament as a result of thoughts such as, *“other people do not understand him/her”*, *“it may be my fault that he/she is drinking/using drugs”* and/or *“I would rather have him/her as an addict than not have him/her at all”*. Underlying these coping responses, there may be a strong sense of powerlessness over the situation. The main contrast with the engaged coping described previously is that this way of coping is not a direct attempt to change the alcohol/drug use.

The following are some examples that emerged from our research:

“I supply him with whisky which I buy from the supermarket. I change where I buy it from each day so that people don't recognise me. I am too soft towards him and always give in to him. If I did not give in to him and buy him the alcohol, life would be impossible. I am part of the problem because I always buy the alcohol for him. I am resigned to the situation.” (Female partner of a man with a drinking problem)

“He can look like an animal and that is the time to keep quiet because he is not going to take any notice of what anyone says. The textbooks might tell people to be consistent but in reality if he is confronted he will throw everything about; you will clear it up; he's out the door; he will be back next day as if nothing has happened and you are so relieved at that, that you carry on from there.” (Father of a problem drug using man)

“I ring in for him at work and cover for him because he is my son. I feel I shouldn't ring in...but I don't want to see him lose his job.” (Mother of a man with a drink problem)

“I know my husband makes a load of mess, so I clear it up for him. I don't want anyone to think that my home is messy or that I can't keep my home tidy.” (Wife of a man with a drink problem)

Withdrawal Coping (Withdrawing, trying to distance self from the relative's drinking or drug use, or gaining independence)

This category includes actions that aim to put physical or psychological distance between the family member and the problem alcohol/drug using relative. The family member's attempts to distance him/herself from the problem or to gain some independence can arise for two main reasons.

1. A family member may feel a sense of resignation about the problem, associated with thoughts such as *“the less time we spend together the better”*, and with emotions such as sadness, bitterness or feelings of hurt.
2. Desire by a family member to look after her/his own needs. This may be associated with thoughts such as *“I've got my own life to lead”* and/or *“I can't help him/her if I go under too”*.

The emotions in this case tend to be related to self-reliance. Withdrawal coping contrasts with both engaged and tolerant coping in a number of ways. It does not involve attempts to change the drinking or drug use in the same way that the engaged coping actions attempt to. In contrast to tolerant coping, these actions do not involve protecting the using relative from the negative consequences of the drinking/drug use, or joining in with the user of alcohol or drugs. The core aspect of this way of coping is the attempt at distancing, mental or physical, between the family member and the relative's alcohol/drug problem.

The following are some examples:

“I have tried to keep up my interests as much as possible. I enjoy walking the dog, and in general I have changed my mind about the nature of happiness. I now accept happiness whenever it comes, even small moments of happiness rather than seeing it as a long term thing. I sometimes buy clothes to cheer myself up or go to the theatre.” (Mother of a man with a drinking problem)

“I am trying to keep life as normal as I can. I play an active role in the community as a school governor for example. So far we haven't had a crisis that has interfered with these activities, only with our attendance at church and I have been able to explain my absence. Both me and my husband make sure that we have an evening out. We have decided to lead our own life and deal with this on the side. We are much stronger now. We will go to work and to

church regardless of what's going on at home unless he is ill. We sometimes wondered whether we ought to be doing these things, but you can't be yourself unless you have some time away from the problem.” (Mother of a young drug user)

“Despite there being nobody fully aware of the problem I find it useful to sometimes get away for a while. I will sometimes spend a week at my mother’s or go round to a friend’s although I have never stayed the night at a friend’s house.” (Female partner of a man with a drinking problem)

Drawing it all together

Looking at the area of coping in a rather simplified way, one can see that the family member is faced with three options; to let alcohol/drug use continue and at times even join in with it (Tolerant Coping), to try actively to change it or minimise its impact (Engaged Coping), or to distance oneself from the whole situation (Withdrawal Coping). Of course, simplifying it in that way hides some of the difficulties associated with living with alcohol/drug problems and ignores many of the precise dilemmas that family members experience on a day-to-day basis. Some of these dilemmas result from the fact that both positive and negative outcomes can result from the same ways of coping. This may generate a state of ambivalence and uncertainty in the family member, as to which way to follow. It also ignores the fact that these forms of coping do not always present in pure form and that on occasions there appears to be overlap between the different categories. It is often very difficult for family members to know, for example, where independence may become rejection, or attempts to support the user become over-tolerant.

Our aim within this intervention is NOT to try to convince the family member that one way of coping is better than another. The stance taken in the 5-Step Method is that there is no one right way of coping – instead, we believe that people do the best that they can in very difficult circumstances, and that our job is to help people think through what alternatives they have, and help them clarify what the competing advantages and disadvantages are of these alternatives, in different situations (e.g. when the relative is intoxicated versus when they are not; or what might be said or done late at night versus in the daytime etc.).

So our aim in this Step is to discuss the advantages and disadvantages of the family member’s current ways of coping, to raise her/his awareness of alternative ways of coping, and the possible advantages and disadvantages of these. Our overall goal is to empower family members by enabling them to see that there are alternative ways of responding to their current circumstances. Many family members adopt a TINA attitude or belief – ‘There Is No Alternative’. A key task for the practitioner here is help the family member change that view, into a TAAA one – There Are Always Alternatives.

Table 2 summarises some key aspects of each of the three ways of coping, illustrating examples of thoughts and associated emotions and providing an example of a possible advantage and disadvantage as perceived by the family member. Note that not all family members will feel the need to alter their responses, and it is not an imperative part of this intervention that they try such alternatives. But it is important that they recognise that there

are alternatives, and that every form of coping carries both positives and negatives, and that it is the balance between them that helps someone decide on the best way to respond for them.

Further, more detailed, examples of coping behaviours and the family members' views as to what constitute advantages and disadvantages of the different actions are illustrated in Appendix 7. These are all sub-types of the three main categories described earlier and shown in Table 2 below.

One important point to bear in mind is that evidence suggests that certain forms of engaged and tolerant coping tend to be associated with worse physical and psychological symptoms for the affected family member. It is sometimes the case that these ways of coping can fairly quickly be modified through discussion, with a consequent reduction in the experience of stress by the family member. These forms of coping include engaged actions, such as responding with verbal or physical aggression or trying ineffectively to interfere with the relative's substance use, as well as tolerant forms of coping that clearly remove the consequences of the drink or drug use at the expense of the family member or the family's well-being. Some examples of the latter have already been described and include: clearing up mess the using relative had made after he/she had been drinking/using drugs; giving the user money even when the family member thought it would be spent on drink or drugs; or making excuses and covering up for the using relative, or where the family member takes the blame her/himself.

Nevertheless, as stated above, the stance which is taken in the 5-Step Method is that family members are always doing the best that they can, in difficult circumstances; and it may be that the reason that some family members are using types of coping which research has shown are generally associated with worse outcomes is because their choices are constrained by their circumstances.

For example, if the family member is a victim of domestic abuse they may be coerced into responding in a particular way to minimise further violence and abuse. Perpetrators of abuse can be highly controlling and behaviours can involve threats of abuse if the partner or parent does not behave in a certain way. It is therefore important to ensure that domestic abuse has been identified and talked about so that discussions around coping are appropriate to the family member's situation. Further discussions about changing coping response should then include talking about the potential impact on the family member's safety of different coping responses and whether they may put the family member at greater or lesser risk. Where the family member is the perpetrator of abuse, discussing coping offers an opportunity to reflect back their abusive behaviours when disclosed and discuss the impact those 'coping' behaviours may have on the family member's relationships and on the safety of the user and other family members. Highlighting support for non-abusive behaviours while giving clear messages about the need to change abusive coping mechanisms provides an important balance. However, it is important to consider whether you need to take action to protect other family members through the involvement of other agencies including the police and social services.

Hence it is important to have the discussion with family members about their current ways of coping, and alternatives, and the pros and cons of each. We must be prepared to help the family member move from a TINA (There Is No Alternative) approach to a TAAA (There Are Always Alternatives) position, and to helpfully challenge them over ways of coping which are generally less helpful, such as the certain forms of engaged and tolerant coping outlined above. But we must also recognise that family members are in very difficult situations, they have major dilemmas in deciding which of various ways of responding might be best, and our job is to empower them by helpfully getting them to go through the process of examining the advantages and disadvantages of the various alternatives open to them.

Table 2: Three ways of coping with excessive alcohol/drug use in the family

	Standing up to it (engaged)	Putting up with it (tolerant)	Withdrawing from it and gaining independence (withdrawal)
Description	Active interaction between the family member and the alcohol/drug user focused on attempting to deal with the problem or minimise its impact	Sometimes involve interactions, sometimes lack of action. The main result is that it removes negative consequences for the user	Attempts to put distance between the family member and the problem. Sometimes driven by uncertainty, sometimes by a need to look after self
Thoughts	"I ought to be able to change him/her"	"Others do not understand him/her"	"The less we are together the better"
Emotions	Angry, hurt, responsible	Powerless, guilty	Self reliant or hurt
Actions (examples)	"Watched his/her every move or checked up on him/her, or kept a close eye on him/her"	"Given him money even when you thought it would be spent on drink/drugs"	"Avoided him/her as much as possible because of his/her drinking"
Possible advantage	May help the family member, to feel that they are doing something positive	Conflict may be avoided	May prevent family members becoming over-involved
Possible disadvantage	It may be very stressful and make the user feel resentful	Family members may feel they are being taken advantage of	Family members may feel that they are rejecting and/or excluding the user

The following example illustrates a discussion with a family member, in an attempt to explore an instance of tolerant coping:

Practitioner: I was interested in that last example that you mentioned...

Wife: You mean what I told you about going to the off license to buy him drink.

Practitioner: Yes. You seemed to be unhappy about doing that.

Wife: Well, I think it makes me feel a part of the problem.

Practitioner: Would it be helpful to think about the advantages and disadvantages of continuing to buy him drink.

Wife: OK.

Practitioner:What do you think are the good things about buying him drink.

Wife: Well, I guess that if I do not, he may become angry and abusive.

Practitioner:Anything else?

Wife:It makes me feel more in control. At least I know what he is drinking.

Practitioner:So, it avoids possible arguments and makes you feel in control.

Wife:Yes, I guess that is right.

Practitioner:What, on the other hand are the things which are not so good about it?

Wife:Well, I feel that I am being taken advantage of and it makes the problem continue. But I am not sure what I can do. I feel pretty hopeless.

Practitioner:Would it be helpful to think together about the options?

Wife:Well, I suppose I could try to say to him that I will stop buying him his drink...[the discussion continues focusing on the potential difficulties and also the advantages that the family member can foresee if she were to carry out each of a range of possible options.]

Later on in the meeting the wife states:

Wife:I can see more clearly now that I am only making the problem worse by continuing to buy him drink. This evening when the situation arises I will say to him as calmly as I can that I am not going to carry on buying his drinks and that I am happy to stay with him if he does not drink. If he starts shouting at me I will leave the room and say that I will talk to him when he calms down.

Practitioner:That sounds like a positive way to tackle that problem. Let me know how you get on when we meet again.

At the following meeting the wife reports some success in refusing to buy her husband's drink. She felt very pleased with herself and once she tackled him once, she found it easier to become more assertive and confident. Her husband's reaction was not aggressive but one of surprise. Her husband continues to drink, but she has managed to reduce her tolerant behaviour and hopes that she will be able to talk to him more assertively now that she feels more confident.

The benefits to a change in coping cannot be underestimated. One family member said that, "*I didn't criticise myself as much*". Another said that having the intervention made her stronger because it gave her choices and she made a choice to react differently to the situation. Another said that she initially dismissed the possibility of changing her response, but after conducting a roleplay in her head she thought that it might in fact work and after trying it, realised that a change in coping was more beneficial. The change that another family member made led to an improvement in communication between her and her son (the user) – they were more honest with each other and there were fewer arguments. A wife of a drinker told her husband that she had sought help; he was shocked that the situation had got bad enough for his wife to seek help.

For some family members an outcome to the situation (sometimes due to an intervention like this) is that a relationship will break up. In such cases the family member will be clearly upset and you may need to support the family member through such times or look for appropriate additional services to provide help with this particular scenario. Other family members will not feel able to make changes to their situation (for example, a commitment to their marriage

vows, financial circumstances or presence of young children) and you will have to find a way of supporting the family member through these scenarios.

So, in summary, this step is about exploring coping responses and using the information described to assist the family members in exploring and evaluating current responses whilst at the same time considering alternatives.

Overall, your aims for Step 3 should include:

1. Discuss and explore the family member's current ways of coping. This is best done by looking at detailed examples of actual coping ("*tell me about the last time he came home drunk what happened ... what did you say/do? What did he say/do?*"), and not by general discussions about how the family member generally or usually copes.
2. Using these actual examples, discuss the advantages and disadvantages of the family member's current ways of coping.
3. Help the family member to generate alternative ways of coping. If they find it difficult to think of alternatives, use the '3 ways of coping' to help them clarify what they are currently doing, and then see how they might cope differently.
4. Discuss the advantages and disadvantages of these alternative ways of coping (including considerations of safety where appropriate).
5. Support the family member to see that there are always alternative ways of coping, and that in general there is no right or wrong way of coping, as everybody's situation is different, and people generally do the best that they can.

Step 4 - Exploring and enhancing social support

You need to explore the support available in order to help the family member build a stronger support system for himself/herself and/or work with other family members to improve (if needed) agreed approaches to managing as a family and, where appropriate, communicating with the using relative.

Step 4 - Skills

Good use of the skills for Step 4, supported by the core skills, will allow you to work with the family member to build up as full a picture as possible of their support networks. It is important to be as comprehensive as possible and to find out, for each potentially supportive person discussed, what the family member finds both helpful and unhelpful about their support. Understanding all of this will then allow you to work with the family member to both enhance positive support, particularly where there may be gaps in support, and minimise interactions which a family member does not find helpful. An important skill for Step 4 is drawing a network diagram; good use of the core skills of questioning, listening, reflecting and summarising will support this exercise. Remember also to ask the family member about self-support, for example the activities that they engage with and which they may find distracting or helpful in some way – examples include an evening class, reading, yoga or sport.

Step 4: Skills with examples of good practice

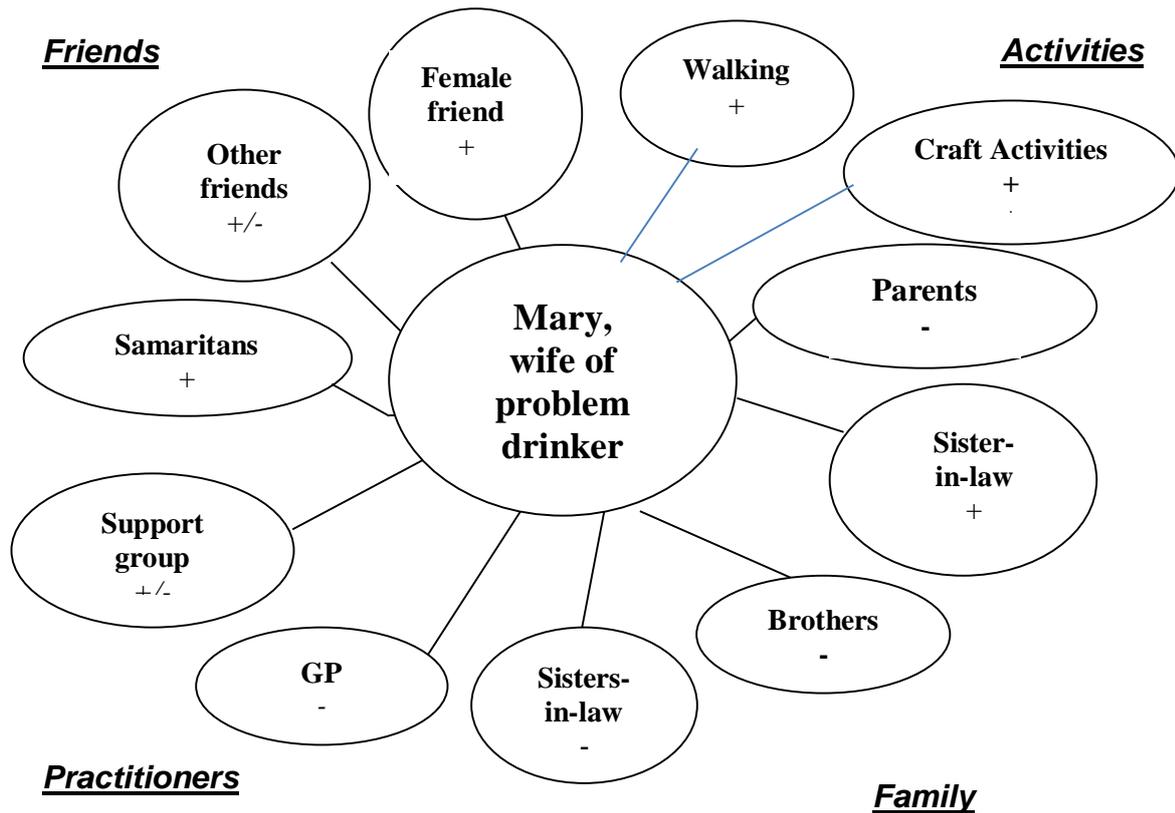
4.1	Beginning of session - check if previous session helpful. Give purpose of Step 4. Ending session - summarise the main FM issues, use of handbook and next steps. Check if session was helpful. Practical issues of contact and date of next session.	<i>“The purpose of this session is to look at your social support and what you find helpful or unhelpful. Lots of people find it helpful to draw a diagram so shall we look at this in the handbook and then we do a diagram together which summarises your support?”</i>
4.2	Discussion of who/what/why is helpful and unhelpful in terms of social support utilising a network diagram - to include people, activities, other agencies/groups. Utilise results of FMQ to guide the session.	<i>“So you have identified 3 supportive people, what do they do that is helpful? The 2 people who are unhelpful - why is this?”</i>
4.3	Explore how to develop/continue to develop positive social support.	<i>“You mentioned doing more exercise, how could you go about this this?”</i>
4.4	Explore potential new sources of support (could be linked to those named in the network diagram or filling in gaps in social support).	<i>“You have identified family support from your sister, are there any other people (from work maybe or friends) who could give you support?”</i>
4.5	Discuss how family members can support each other and agree on approaches when communicating with the using relative.	<i>“You mentioned that your husband takes a different approach and confronts your son which you say doesn’t help, what would you like to say to your husband so you have the same approach? Would it help if we role-played what you might say to him?”</i>

As already discussed, the level of social support available for family members can have a significant impact on their ability to cope and the stress experienced. Exploring the support available to a family member can help them think about how they can build a stronger support system for her/himself and/or to improve joint problem solving in the family. People's social resources vary enormously, and when supporting family members you will need to understand what sources of helpful and unhelpful support are available, which of these are already being used, and which remain as a potential source of future help. Equally, you will need to understand what sources of support, which may be meant to be helpful but which are experienced as unhelpful or unsupportive, are on offer. Frequently, other people say things which they feel will be received as supportive but which the family member perceives as being highly **unsupportive**. In general, people who say 'if I were you' or 'in your shoes I'd do ... or say ...' are perceived as unhelpful or unsupportive. This is because affected family members usually want support for the pathway they have already gone down/decided to go down, so someone else telling them that they should do something else is not helpful. Often family members have had negative experiences of this or other ways of getting help from others, or they feel too guilty, embarrassed or ashamed to seek help. Others simply do not know what help is on offer.

It is also the case that support is not only provided by friends and family. Support can be provided by involvement in activities (going to the gym or attending an evening class can feel very supportive for some people) and/or by being given help and support from an organisation or agency (a self-help group, for example, or social worker, or a family support organisation).

In order to illustrate the complexities mentioned above, one case study is presented and discussed below, followed by an outline of the main points arising from our research. It was developed from interview data with family members (Figure 3) and represents the support perceived by Mary, a 32 year old female partner of a 33 year old male with a drinking problem. Using some kind of network diagram to facilitate and summarise this step is strongly recommended, and we say more about this later in this section of the handbook.

Figure 3: Mary, partner of an alcohol user



Key (note that you can also use ++, +++, --, --- and so on, to highlight where a person is particularly supportive or unsupportive).

+ Overall Supportive +/- Overall Mixed Support - Overall Unsupportive

All references to support were categorised into four sections; family, friends, activities and professional/self-help agencies. Overall, Mary felt largely unsupported. In her case, the majority of references made were to people within her own and her partner’s family. Mary described what in our experience is fairly typical of other family members, involving a reluctance to talk about the problem for fear that it will have a negative effect not only on the relationship with herself but equally importantly, on the relationship between her partner and other family members. In her own words she describes: “...after one or two conversations [with friends about the problem] they start to tell you to leave him, which I do not want to do and therefore I talk about it less and less. I also want my friends to like him and therefore I shy away from telling them too much.”

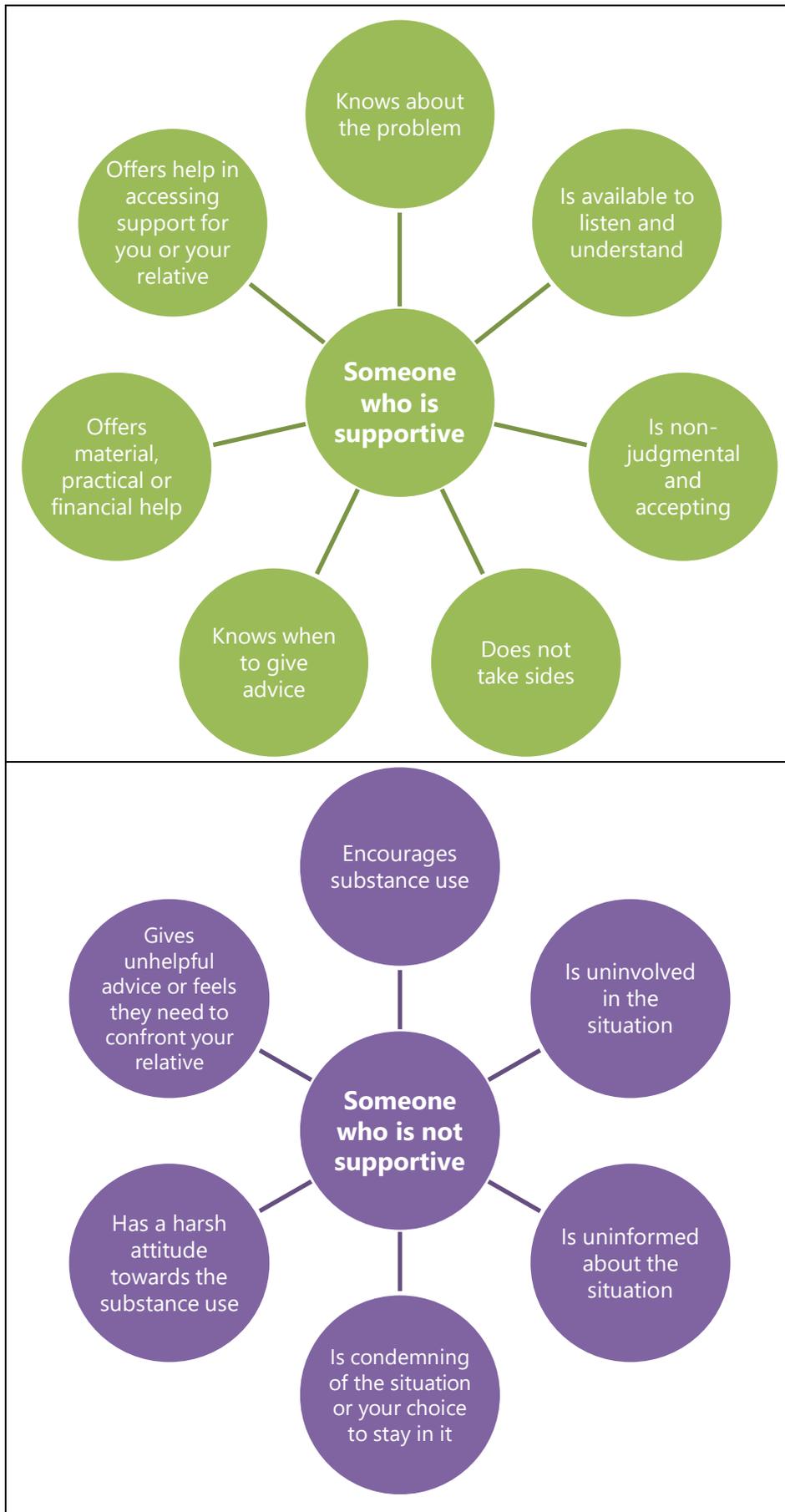
The sources of positive support from the family included those family members who listened and tried to understand. Mary stated, “I want understanding rather than sympathy when I talk to people”. One such person, for example, was her sister-in-law who, in her words, had had a, “rough life herself and could offer advice based upon her own difficulties and knowledge.” Mary also found some of her activities supportive, mentioning both a few craft activities that she is involved in and also occasionally going walking.

The sources of unhelpful support for Mary, on the other hand, involved her feeling unable to talk to a number of relatives like her brothers, her parents and some of her partner's sisters. Some of her friends had been supportive in the past, for example by offering shelter when she needed to get out of the house, but again on some occasions the perception was one of mixed support. Support from professional and self-help agencies was perceived as mixed. The Samaritans had been good listeners during a crisis. Al-Anon had been both supportive and unsupportive in that, although they provided contact with other relatives in the same position, they were not always accessible at the time when she needed them. Finally, Mary's GP was someone who she felt she could not approach about the problem and in addition she did not want the problem to appear on the doctor's records.

This case illustrates some of the main findings emerging from our work. An important point is that although references are made to a number of people including relatives and practitioners who could *potentially* become part of the family member's support network, this does not always take place. It seems that the least supportive messages reported by the family members are the messages where other people suggest he/she 'leaves the relative' or 'lets the relative get on with it'. Note that this is not unhelpful per se – it is unhelpful simply because the advice she is receiving goes contrary to what she herself wants to do. She wants understanding and support, not advice telling her that her decision is wrong. Confused or mixed messages sometimes coming from practitioners and/or negative attitudes towards their relative with a problem are also perceived as unsupportive. Relating to this latter point, as illustrated by the case above, is the importance for the family member of the presence and maintenance of a good relationship between other people and their problem alcohol or drug using relative. Consistently positive reports were found about those people who related positively both to the problem drinker or drug user and the family member. Actions that were negative towards the problem alcohol and/or drug user were felt to be unsupportive to the family as a whole.

As can be seen from the above, an important aspect of step 4 is to explore with a family member how people can be both supportive and unsupportive to them. Figure 4 on the next page summarises what our research suggests family members find helpful and unhelpful about those who they name in their support networks.

Figure 4: How people can be supportive or unsupportive



In some cases, the ways in which you can help family members build strong support networks may involve a discussion and review of available supports paying particular attention to the need to increase positive sources of support and neutralise or reduce unhelpful ones. A partner or other family member who is behaving abusively is generally not a positive support and should not be considered as such and invited to join any sessions. To do so risks inadvertently exacerbating abuse through discussions or results in a lack of openness and honesty in sessions for fear of the consequences. In some cases, you may want to enlist the help of one or two other key members of the family or friendship network. This should only include those who are concerned and with whom the family member feels that he/she could work with as a problem solving unit. Family members often report disagreements or inconsistencies in the way that other relatives and friends approach the drinker/drug user. Family members can find interactions from other family members with the drug and/or alcohol user unhelpful.

The drawing of a **social network diagram** is key to this step and we strongly recommend that you do this. It is also clearly demonstrated in the relevant section of the 5-Step Method training DVD. A social network diagram allows for a review of the family member's current social support network and is a useful tool to facilitate and summarise the discussions. You can take the lead with writing or you can ask the family member if they wish to do this – some may find this helpful and empowering. There are various forms which such diagrams can take so you can use one that works best for you and the family member. Sufficient time should be allocated to this task as the process of discussion and identification of the network members in itself can be very important. You should encourage the family member to think about all the significant people in the current social network, and also those who they may have lost touch with. You should not be selective at this point e.g. only focus on people who are supportive or live close by. Remember also that some people seek help from things like online forums or groups, or by making time for sport or other activities (such as yoga, reading, gardening or baking). The more comprehensive and inclusive the diagram the better. You can encourage the discussion through the use of specific questions e.g. When did you last see Mary? What does she think about the situation? Do you see Robert often? Who did you meet last week? If this exercise is carried out well, by the end of it, you should be familiar with the social network surrounding the family member and feel that you have some knowledge about each one of those recorded in the diagram, their relationships to the family member, and their knowledge and views/attitudes towards the problem.

One possible way of introducing the idea of social networks and building up a picture relevant to your family member is illustrated below:

Practitioner: *A useful way to gain an overall picture that will help us understand who is supporting you or has the potential to support you is to think about those people with whom you are involved on a day to day basis or those from whom you feel you gain support even if you only see them occasionally. Sometimes, relationships might have become strained and distant. It is also important to consider those people with whom this has happened as there may be opportunities to reverse this if we feel it is important and useful for you. The best way to get an overall view of your social network is by drawing a network diagram that includes*

everyone you are in fairly regular contact with or who are important to you even if you are not seeing them often at the moment.

Following the introduction, you need to draw a diagram (see Figure 3 above for an example) with the family member. As far as possible record people by name in the diagram e.g. Stuart as opposed to brother-in-law. Some family members may not want to name people in their network, but we find doing so can make the work more personal, and it can also make discussions easier.

You need to encourage open communication within the family regarding excessive drug or alcohol use so that covering up, minimising the problem or keeping it secret from other family members can be reduced.

Exercises Seven and Eight may help you work through this Step with a family member. **Exercise Seven** encourages the family member to consider people around her/him, think whether they are helpful or unhelpful, and how their support makes them feel. **Exercise Eight** focuses on additional needs for support. It asks the family member in a structured way to think about additional support needs and how to meet these. These exercises could be combined and complement the drawing of a network diagram or could provide information that helps to complete the network diagram.



Overall, your aims for Step 4 should include:

1. Discussion of who/what/why is helpful and unhelpful in terms of social support (use a network diagram to guide this conversation).
2. Exploration of how to develop/continue to develop positive social support, and what new support might be needed.
3. Exploration, if possible and necessary, of how to introduce new sources of support e.g. self-help groups.
4. Discussion of how family members can support each other and agree on approaches when communicating with the using relative.

Step 5 - Identifying further needs and referring on for further help

You need to identify whether the family member needs any further support (e.g. from another service or something like a support group) and, if so, organise or facilitate this. If the problem alcohol/drug using relative is already seeking help with your service, then you may wish to explore ways of joint-working. Towards the end of Step 5 you should ask the family member to complete the questionnaire again and then use a comparison of the 'before and after' scores as part of your review of the work the family member and you have done. It is good practice to have a brief follow-up (even by 'phone) after some weeks (we recommend 6 weeks), and to arrange this in this final Step (e.g. by booking in a telephone call at an agreed time).

Step 5 - Skills

The skills for Step 5 are designed to help you work through the different tasks which need to be completed at this final stage of the intervention. This includes reviewing the work that you have done, and how it has hopefully benefitted the family member, as well as facilitating a discussion about further help for the family member, and potentially also help for key others including children and the person with the alcohol or drug problem.

Step 5: Skills with examples of good practice

5.1	Beginning of session - check if previous session helpful. Give purpose of Step 5. Ending session: summarise the main FM issues; check if session was helpful; remind on use of handbook; agree post-5-Step work; inform FM that will send another FMQ at 3 months. If possible in your place of work, inform that will contact them in about 6 weeks to check how they are.	<i>“The purpose of this session is to review progress to date, clarify further needs and develop an action plan.” “We’ve discussed what further work you may need to do now we’re finishing. Don’t forget the handbook which has got lots of useful material in it.”</i>
5.2	Review Steps 1-4 to explore what FM has found helpful about the sessions and what changes FM has made. Redo FMQ from 1 st session to clarify changes. FM/Practitioner to summarise key issues and progress to date.	<i>“So looking back over our sessions, you have told me about the situation and how that affects you, we have looked at what information would help you, the current ways you cope and alternatives and your social support. From this, what do you feel have been the main issues and the main changes you have made?”</i>
5.3	Discuss FMs need for further help and how this can be actioned.	<i>“From what you have said you have made some really substantial changes and are feeling better about thing, are there other changes you would want to make?”</i>

5.4	Discuss help needs of other FMs/key people and how these can be actioned.	<i>“You mentioned that your husband finds the situation very difficult, would it help if we all had a session together to discuss the issue?”</i>
5.5	Discuss help needs of the using relative and how these can be actioned.	<i>“Do you think that your son needs any other help? Is he interested in getting more help?”</i>

In some cases, both the family member and you may feel that there is a need to contact further specialist sources of help. Specialist help may include something that is already available in your service and that you are familiar with. If continuing support is required after the intervention, or specialist input such as couple therapy might be helpful, a number of agencies accept family members self-referring to them and hence you may need to encourage the family member to think about how to organise this. In other instances, you may want to refer the family member to see a member of another specialist service or request an assessment for further specialist therapy. It is important to discuss this with the family member and agree what course of action needs to be pursued.

While not all possible scenarios can be predicted, the following guidelines are aimed to help you in your decision to access further sources of help. **One issue to remember is that brief interventions can be very effective, so do not underestimate the impact that your work might have on a family member.** We can anticipate, however, four broad alternatives in relation to further help:

- 1) Further help needed for the family member in her/his own right.
- 2) Further help needed for the alcohol/drug problem user in her/his own right.
- 3) Further help needed for the family as a whole.
- 4) Further help needed for other members of the family (i.e. not the family member that you are in contact with).

Each one of these areas is discussed in some detail. Step 5 on the 5-Step Method training DVD also presents a number of examples. It is worth noting that some family members will seem not to need any further help or onward referral. In such cases, it may be helpful to suggest to the family member that you will make contact (via telephone or e-mail, for example) in about six weeks to see how they are and see if things are continuing to go well, and to get permission to do this. Evidence from general counselling suggests that offering a routine follow-up improved the longevity of positive effects and makes continued progress more likely.

1) **Further help for the family member in her/his own right.**

You may identify the need for ongoing support for the family member. This may involve facilitating contact with self-help groups like Al-Anon or organisations like Adfam which provide information on local groups across England. One possible difficulty is that not all self-help groups are active in all areas, so you will need to have an up-to-date list of local groups in your area. Most self-help organisations run a system of sponsors so that new attendees can be introduced to the rest of the group.

Support groups for family members are sometimes run by drug/alcohol services although, if they are available, attendance tends to fluctuate and hence at any particular time the group may not be meeting regularly. So, while some family members may want to be put in touch with others in a similar situation this might not always be possible. Other family members do not like group work and you may need to discuss this as part of your intervention with them. In addition, some services offer individual counselling for family members.

Some family members may want information on services that provide support for their children and/or for themselves on dealing with overlapping issues such as domestic abuse (victim or perpetrator services) or mental health problems.

A further scenario may involve the family member experiencing severe psychological distress in the form of panic attacks or depression for example. In most cases, it might be possible to organise a referral to a primary care professional like a GP, counsellor or psychologist (e.g. IAPT [Improving Access to Psychological Therapies] services). In some cases, where this is not available, you may need to explore the availability of psychological services either through the local psychology department or community mental health teams. Services tend to vary in the way in which they deal with these problems and hence it is difficult to provide a general rule. Your team should have the relevant information to help you out.

2) **Further help for the alcohol/drug user in her/his own right** (see Appendix 8).

A lot depends on whether the alcohol/drug using relative wants to seek help, or is already receiving help.

Sometimes family members are referred to the 5-Step Method because their relative is already receiving help, and sometimes, once the 5-Step Method sessions are completed, the family member might be invited to participate in the help that their relative is receiving.

Other times, the relative has not been receiving or seeking help, but we often find that, after the family member has received the 5-Step Method sessions, the relative starts to be more interested in obtaining help. If the relative is interested, or at least willing to consider it, then they are best referred to community-based alcohol/drug services, who in turn may decide to refer to other services, particularly with more complicated cases. The user may need specific help in relation to a physical dependence on the drug(s) of choice. In the majority of cases this can be dealt with at the primary care level. In cases of more severe alcohol dependence, further help could be obtained from a community alcohol team or in some cases, where this type of service is not available, by specialist services with access to beds for detoxification. In the case of other drugs such as heroin, for example, the most adequate referral would be to the local community drug team. Although there has been an increase in focusing help on abstinence in recent years, many services for drug users have tended to adopt a goal of harm minimisation. This approach may involve the prescription of substitute drugs for a period of time, aiming at helping individuals to achieve stability and reduce reliance on illegal substances. In some practices, general practitioners may feel comfortable themselves prescribing substitute medication, as part of a shared care plan with a specialist team. In general, prescriptions need to be supplemented by key working, counselling services, and access to a range of community supports, which are available through the community teams.

Finally, there will always be alcohol/drug using relatives who still do not want help, and who maybe state that they do not have any problems with their use. We may need to discuss with the family member what alternatives there are for them, using the same skills we have used throughout – asking questions, exploring options and the advantages and disadvantages of each, and empowering the family member to make a decision about what is best to do.

These options might involve:

- Raising the topic with the using relative;
- Asking the relative to go for help;
- Leaving out some information leaflets which might make them realise that their drinking/drug use is problematic;
- Discussing with the relative that even though they feel that their use is not problematic for them, it IS problematic for the family member, and possibly other family members.

It may also be useful to raise with the family member issues of terminology. Many relatives may argue that they do not require help because they are not ‘alcoholics’ or ‘addicts’, or that they use no more than their friends, and hence they cannot have a problem. It may be worth practicing with the family member how they might deal with such arguments from their relative, so that they can feel confident that they can respond. Possible responses might include emphasising that someone does not need to be an alcoholic/addict in order to have developed a problem, and that even if their friends drink/use as much as they do, the fact is that their use is causing the family member problems.

3) **Further help for the family as a whole.**

In some cases, given the complexity and extent of the problems faced by a family, you may feel the need to access more specialised therapy services. Access to family therapy services will vary from area to area.

4) **Further help for other members of the family.**

This category may include children or adolescents presenting with a range of problems. Your intervention may go a long way in reducing the severity and extent of these problems. In some cases, as with other relatives, you could facilitate access to self-help or support groups. In other cases, you may need to access child and adolescent services locally, particularly if the relative connected to the family member you are working with has developed severe psychological problems.

This category may also include considering what support might be most helpful for other adult family members. Solutions might including inviting them in to your service to talk about the 5-Step Method and if also want to work through the intervention, or providing them with details of local support groups.

Getting help for other issues

There are many other difficulties that people experience when a loved one has a drug or alcohol problem and which the family member may feel s/he would like to find out more about. There are just too many to consider in detail in this handbook but some are listed below:

1. Debt or other financial advice.
2. Family planning or contraception advice.
3. Marital or couples counselling⁶.
4. Legal advice.
5. Specific health problems, including mental health problems.
6. Getting help and support if your relative is in prison.
7. Support because of bereavement, including bereavement through substance use.
8. Domestic violence and abuse.

Some of these issues are discussed in a bit more detail later in this handbook, in the General Considerations section. Additionally, some of the organisations listed at the end of this handbook may offer some help with these problems, or make suggestions as to who else could be contacted. Other sources of help to deal with some of these problems could include the GP or surgery, the Citizens Advice Bureau, the Library or other community resources, and the Internet.

Finally, as part of the intervention they receive, family members may think about other things they would like to address or pursue. This could include wanting to go to college to gain a new qualification or take up a new interest, wanting to work as a volunteer or get involved in the community in some other way, engage in sport or other activities, or gain advice about particular issues such as family planning or your finances.

Exercise Nine might help you work through this Step with a family member. As part of this exercise the family member is encouraged to consider in a structured way the additional needs for help for themselves, the relative and the family as a whole.



⁶ Where there is recent/ongoing domestic abuse this is not recommended for safety reasons.

Overall, your aims for Step 5 should include the following:

1. Clarify what has been helpful over sessions, and reinforcing those elements.
2. Establish whether there is a need for the family member to receive further help and support, and discuss possible options for help with the family member.
3. Consider the support needs of others, including children, other adult family members and the alcohol/drug user.
4. Review the 5-Step Method work that you and the family member have done. This should include asking the family member to complete the SQFM(AA) again, and comparing the 'before and after' scores from the two questionnaires.
5. If possible, arrange for a brief follow-up contact between yourself and the family member, to see how they are, and if possible, pre-arrange how this will happen and a time for it to happen.
6. It is good practice to also send a further copy of the SQFM(AA) to the family member (as long as safety concerns do not preclude this) three months after they started work with you. Some organisations do this as a matter of course; others feel they cannot devote the resources to this, but it enables you to compare how the family member is now with how they were at the start, and at the end, of their 5-Step Method sessions.

Putting it all together

In summary, when someone drinks or uses drugs in a problematic way, multiple stresses and strains can arise that can be extremely disruptive for the whole family. In response to these stresses, family members try to act in different ways, which are often associated with attitudes and feelings that they have about the problem. Family members usually experience ambivalence and face dilemmas when attempting to decide which actions to take and this should be explored and understood as a normal response to the problem. Finally, social resources and their use by family members can sometimes provide a source of support but on other occasions, become the focus of conflict. This needs to be carefully managed in order to maximise the support and reduce the conflict.

The key tasks of the 5-Step Method are to allow the family member the space to express his/her situation and the emotions that go along with that; and then to work through the various areas (information needs, coping approaches and alternatives, support needed and available, remaining issues requiring help) by careful listening, questioning, probing, and clarification of alternatives.

A range of positive outcomes can result from completing the 5-Step Method. When a family member seeks help, listening, reassuring and providing accurate information can go a long way in meeting her/his needs. In addition, discussing the pros and cons of alternative ways of responding and accessing social support may also lead to a positive outcome, by allowing the family member to examine her/his own ways of responding, explore new ones and the implications of change. Although it is not the main purpose of the 5-Step Method, change for the family member may in turn lead to a positive change for the user, in at least two ways:

1. It might improve the situation at home and hence increase the user's motivation to change.
2. It might lead to the user coming forward and asking for help, or making further progress with help that she or he may already be receiving.

General considerations and particular problems

Our work to develop the 5-Step Method and introduce it in to a range of settings often raises a number of general considerations and particular problems. Many of these will have been covered in your training, but are summarised here also. These issues include confidentiality, dealing with violence and abuse, failure to attend meetings, telephone consultation, working with groups, crises, extreme distress, problem gambling, bereavement through substance use, contact from the drinking/drug using relative, and dealing with relapse.

Confidentiality

Confidentiality is a paramount concern to all those offering a service. It is important that the right to confidentiality is preserved although it is generally agreed that under certain circumstances, such as danger to children or other adults, the practitioner may need to breach any confidentiality agreed with the patient. The 5-Step Method is designed to sit with the confidentiality practices that your team/service/organisation adheres to.

When dealing with family members, issues of confidentiality are bound to arise. In some cases, family members may want to have access to information that you may possess from your contact with the problem alcohol or drug using member also registered with your service. In some cases, you may need to consider whether you are the best person to offer help if there is a conflict of interests. On the other hand, you should take care not to miss a good opportunity given that you may be in an even better position to understand what the family member is going through, as a result of your knowledge of the family from other members. This can be done without needing to disclose information. Two additional useful strategies can be used when questioned directly about information that you are not in a position to provide:

- 1) Encourage the substance user (if the latter is seeing you or another team member), if at all possible and if it seems helpful within the context of your contact with the family member, to come to the session so that you can establish a three-way discussion. Obviously, safety concerns must be considered and may override any attempts to bring families together.
- 2) Re-direct the focus of your discussion towards the needs of the family members themselves, encouraging them to talk about their ideas, thoughts and perceptions. This might also give you a chance to clarify some misunderstandings or lack of knowledge held by either party.

It is extremely important to convey the idea of confidentiality with sensitivity. In our experience, family members often report feeling isolated and as if they are hitting a 'brick wall' when confidentiality blocks communication between them and helping practitioners.

Dealing with Violence and Abuse

An important issue that will often arise in working with alcohol and drug problems in the family is violence or domestic abuse within the family setting. This is a serious issue and one that needs to be considered when working with family members who may be a victim or perpetrator of domestic abuse. There may also be children or others (e.g. elderly relatives) in the family whose safety you need to be concerned about.

When working with someone suffering violence and abuse, your priority must always be safety. It is important to be able to provide advice and support for the family member, the children and the abusive partner if he or she is willing to seek help.

It is also important to help the family member to plan ahead and consider what options they have when faced with an abusive situation. In the 'midst of the abuse' people may feel too frightened and confused to think clearly so advance planning is vital. There is information easily accessible on the Internet about 'safety planning' including checklists that you could discuss with the family member when appropriate, e.g. leaving a spare set of car keys and a spare set of clothes with a trusted friend. You may be the first person to have this discussion with them so your role in enhancing their safety is crucial. You could then offer supported referrals to other specialist agencies.

It is helpful to be aware that some people can feel disloyal if they talk about or seek help for their experiences of domestic abuse. It is important to talk to the family member about the fact that seeking help doesn't mean they don't love the relative or have given up on them. What it does mean is that the family member is not going to let the person continue with the abuse. It means taking back some control and getting the support needed and, importantly, what the children (if there are any) need as they can't usually do it for themselves.

It can be difficult to hear about domestic violence and abuse and it can be upsetting at times, even for the most experienced practitioner. It is important that you also receive support from specialist partner agencies as well as from your manager and other colleagues. Overall, when responding to violence and abuse you should follow your organisation's protocols and, where possible, foster joint working relationships with organisations which specialise in working with victims and perpetrator of abuse. Safe practice needs to be embedded in your agency's work and not viewed as an 'add on' or an incidental consideration

There are organisations that can help family members in this situation be they adult or children, on the phone, via the Internet, or in person, including Women's Aid, ManKind, Refuge, the Samaritans, or your local Citizens Advice Bureau (further details are given later in this handbook). For people who are behaving abusively and violently there are also places to go for help (see later on for details).

Failure to Attend Meetings

When your contact with a family member goes beyond the first meeting, a situation may arise whereby you have agreed to meet again and the family member fails to turn up. Failure to return can arise from a number of reasons including a sense of hopelessness and the belief that nothing is going to change, the misunderstanding that the only useful situation is for the

drinker/drug user to come forward for help, ambivalence about the help offered, or a sense of guilt, or the feeling that the problem alcohol/drug using relative is being betrayed. All of the above reasons are worthy of further exploration as they may significantly increase stress.

If, towards the end of the first meeting, there is an agreement that a further contact should take place, you should aim to establish a form of communication between yourself and the family member and you should discuss with the family member the best way[s] of contacting them. You might be able to write to the family member at home or make contact by telephone (including SMS) or e-mail. In some cases this might prove difficult if the family member is worried about the problem drinking/drug using relative finding out that she/he has been in contact with your agency. In such cases, contact (always with their permission of course) via a friend, or another family member, or through another service that they may be attending, can often be a useful way of managing this. Every effort should be made to establish a way of communicating with a family member. If the family member fails to attend the next meeting, it is important to utilise one of the methods you have worked out with the family member to contact him/her. One possibility is to write, acknowledging the difficulties and suggesting that the family member can approach you or your service to make a further appointment. A sample letter is illustrated below – this letter could also be adapted to be sent via e-mail, or shortened to be sent as an SMS. You might be able to minimise the risk of family members dropping out from your contact by discussing any thoughts related to not continuing. Such thoughts are not uncommon and open discussion can lead to the resolution of problems before the family member drops out. The family member should be encouraged and advised to discuss openly the range of feelings outlined above.

Dear 'X' (e.g. Louise),

I was sorry not to see you today for your appointment. I am aware of how difficult it may be to talk about what is happening. I am dropping you a line to suggest that you could make a new appointment so that we can continue talking about your present situation and how it affects yourself and your family. Details of how you can contact me are at the bottom of this letter/e-mail.

If you decide not to make an appointment at this point in time, I would like you to know that the door will always be open in the future if you change your mind or require further help and advice. Perhaps in any case you could let me know what you decide.

Yours sincerely,

Care must be taken when there is domestic abuse (and thought must be given to the fact that this may exist but be undisclosed). So it is always the case that no letters can be sent unless you have had the family member's permission to do so. For similar reasons, it may also be difficult for family members to use a computer (and hence e-mail or Skype). Some perpetrators of abuse will often open mail or check e-mail or 'phone messages, and you need to avoid placing the family member at further risk through your contact with them. This is why it is vital that a discussion is held in the first session about safe (as well as preferred) methods of contact. As outlined above, an alternative is contacting them through a friend, relative or another service that they may be attending and for whom they have given you permission to

contact. If you are fearful for their safety, don't hesitate to seek specialist advice or call the police, if you think they are in danger. Again, think safety first.

Alternatives modes of delivery of the 5-Step Method

This handbook focuses on 1:1 delivery of the intervention between a family member and a practitioner. However, alternative modes of delivery are also possible, applying the principles of the intervention and the skills of each step in the same way. This includes working with more than one person in the same family or with groups of family members (from more than one family) – although please be alert to issues of safety that may arise. The intervention can also be delivered over the phone or by Skype, or as guided self-help using the self-help handbook for family members. Two of these alternative modes of delivery are briefly discussed below. They may have been covered in your training course, but you can also approach your trainers or AFINet-UK to talk further about any of these options.

Telephone Consultation

In some cases you may be contacted by telephone between meetings. An attempt to keep such contacts brief rather than providing advice by telephone should be made unless there is an emergency or need for urgent help. In these cases, you may need to deal with the situation straightaway in the same way in which you would deal with other emergencies. In non-urgent cases, you should encourage the family member to make a careful note of the points that she/he is wanting to raise in order that they can be discussed at the next meeting.

Note, however, that it is possible to deliver the 5-Step Method via a series of telephone (or Skype) calls. Some family members may prefer this, or may find it hard to travel to attend face-to-face meetings (e.g. they may live in a rural area, not have access to a car, or have a disability which makes travelling difficult). If you are delivering the intervention like this then the same skills and principles apply, although the mode of delivery can make it harder to use silence or to follow emotions or non-verbal cues. Wherever possible you should ensure that both you and the family member are somewhere quiet and private when you have the calls, and be prepared for how you will deal with problems such as erratic mobile phone signals or Skype connections.

Working with groups

It is possible to deliver the 5-Step Method with groups of family members (from different families) and your 5-Step training may have considered how each step can be applied in a group setting. We recommend that you contact your 5-Step Method trainers if you want to work with groups and this was not covered in detail as part of your 5-Step Method training course.

By and large the skills and principles of group delivery are the same, and the exercises and self-help handbook can be useful tools to support work in this way. However, group dynamics can greatly influence how each group will function and support each other. We strongly recommend that any group work is co-facilitated (with both people having completed the 5-Step training) and that facilitators also complete some form of groupwork training. You and your co-facilitator should still complete an assessment process with each family member to check their circumstances, their suitability for a group, and to go through with each family

member how the group intervention will work. This process will also allow you and your co-facilitator to build up a picture of the group, prepare sessions accordingly (for example, focus more on alcohol or drugs, or plan how an exercise can work in a group setting) and be alert to any difficulties which may arise (for example, participants who may be more dominant or forthcoming with their views).

In the group sessions themselves it is important that you take time at the first session (perhaps even doing a pre 5-Step introductory session) to establish group rules and to cover things like confidentiality. The sessions themselves can then be very similar to individual work, perhaps combining large group discussions with work in small groups or pairs. A key benefit of delivering the 5-Step Method in groups is the support which group members can give to each other although it is important that you dissuade family members from giving advice to each other. In some cases group members may well stay in touch with each other after the steps have been completed.

Crises

Crises may arise during your contact with the family member. It is important to remember that crises simultaneously provide danger and opportunities for learning and change. Some crises will require an immediate response e.g. medical emergencies, or risk of violence, whereas others may require the need for the person to come to terms with the event and look for possible solutions, e.g. loss of job, loss of accommodation. If crises present during your contact with the family member, you will need to deal with them either as part of your contact with the family member or through referral to the appropriate service for the crises faced. A list of some services that may be relevant is included at the end of this handbook.

Extreme Distress

As a rule you should remember to validate the family member's feelings (i.e. "*There is a reason for you to feel this way*"), allow the family member plenty of time and space to express distress, and if appropriate and with the family member's agreement explore the possible options for the future.

When responding to crises or extreme distress it may be necessary for you to temporarily take a break from the 5-Step sessions, and this is fine. Obviously, the skills and principles of the intervention will still apply to your work, and there may be exercises or information in the handbooks which are useful to you and the family member.

Problem gambling

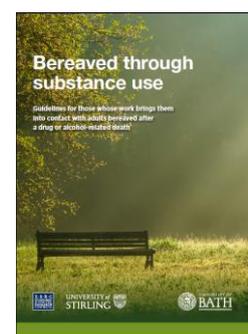
Problem gambling has been found to be as prevalent as the problematic use of illicit drugs in the UK. It is also the case that problem gambling is more common amongst people with alcohol or drug problems than in the general population. Sometimes gambling and substance problems coexist and sometimes substance problems arise after gambling problems have been resolved, or vice versa. You are therefore very likely in the course of your work to witness the family effects of excessive gambling. But a gambling problem can be very well hidden and you may not be aware of it. Indeed, the family member you are meeting may not be aware, or fully aware, of the gambling element either. If it becomes apparent that gambling is itself causing problems, this should not be ignored and should be explored and discussed as part of each of the steps in the application of the 5-Step Method. You may want to seek specialist advice about gambling. In that case the first port of call in the UK is the national organisation GamCare which offers advice to practitioners as well as help for those with gambling problems and affected family members. The NHS National Gambling Problem Clinic in London provides specialist treatment and advice.

Bereavement through substance use

It is possible in your work that a family member's loved one will die as a result of their substance use, or that part of the stress and strains they are experiencing about their loved one will be connected to someone else who has died as a result of their substance use. While the 5-Step Method has not been developed for those who have been bereaved in this way, no doubt you will want to offer support, and many of the same skills can be applied.

Bereavement through substance use can be extremely distressing for family members, particularly if it comes at the end of a long period of dealing with their person's alcohol or drug misuse. Further, the death itself may have been traumatic and, for some, will require a post mortem and involvement of other agencies like the coroner or the police. All of these things, coupled with the stigma that is often associated with substance use, can exacerbate or complicate grief.

There is little guidance out there to support those who come in to contact with this group of bereaved people, and also few specific services for them. However, some organisations such as Adfam, DrugFAM, or Scottish Families affected by Alcohol and Drugs do offer direct support – see the end of the handbook for details. Also, one research project in this area (see the further reading section for details) has produced a set of practice guidelines to support those who come in to contact with and want to better understand and support this group of bereaved people. You can access the guidelines for free at www.bath.ac.uk/cdas



Contact from the Drinking/Drug Using Relative

You might be approached by the user, requesting information about your contact with the family member. In these cases, you should encourage the problem user to discuss the situation with the family member, or if you feel that it is feasible, helpful and safe, and with the

agreement of the family member you are working with, you might arrange a three-way meeting considering what has already been discussed about these meetings within Step 5.

Dealing with relapse

Many family members feel that if their relative stops drinking or taking drugs then everything will be okay. It is important to convey to the family member, in an appropriate way, that this is not necessarily the case – it is a positive step but one that can bring its own further issues to be managed. Furthermore, your experience with your clients who are substance users should help you to convey to the family member that relapse (often happening more than once) is an expected part of the process. Discussing relapse may be something that you wish to do with the family member(s) that you work with as part of the provision of information in Step 2. A key message to give to a family member is that they are not to blame for any relapse that might occur.

Section C - Appendices

This section contains additional information that may, where appropriate, be useful to you in the course of your work with family members. Some of the information within this section will be familiar to you. However, we include it within the handbook in case it is helpful; it may be helpful for the family member(s) to see some of this information (and have the opportunity to discuss it further with you) or have it photocopied to take away and read in their own time.

Appendix 1: 5-Step Competency Framework

5-Step Competency Assessment (See 5-Step Instruction Sheet for Scoring Assessments)		
Name of Practitioner:	Session Date:	
Name of Rater:	Completed Assessment Date:	
Code for FM:		

Scoring: 0 = No Evidence. 1 = Very Poor. 2 = Poor. 3 = Acceptable. 4 = Good. 5 = Excellent. Can use .5 scores as necessary e.g. 3.5
 FM=Family Member. *FMQ= Family Member Questionnaire (full name = Short Questionnaire for Family Members (Affected by Addiction) or SQFM(AA)).
 L=Tape Length in Mins- applicable for those recording their tapes

Table 1: 5-Step Skills

No	Step	Score 1-5	Evidence of meeting criterion/ What was missing / Summarise main information gained. <i>If any criterion scores less than 5, give feedback on improvements.</i>
1	Step 1: Listen, reassure and explore concerns		
L	Tape length = x mins		
1.1	Beginning of session - introduce 5 step, confidentiality, purpose of Step 1. Complete FMQ* (if not already completed) and use to guide the session. Ending session - summarise the main FM issues, use of handbook and next steps. Clarify what the information needs are to be discussed in Step 2. Check if session was helpful. Practical issues of contact and date of next session.		
1.2	Allow FM to describe situation and tell their story, listen to and ask about the FMs concerns and fears. Summarise the situation to check if understood correctly. Acknowledge emotions being expressed.		

No	Step	Score 1-5	Evidence of meeting criterion/ What was missing / Summarise main information gained. <i>If any criterion scores less than 5, give feedback on improvements.</i>
1.3	Identify relevant stresses and how the FM has been affected.		
1.4	Identify relevant stresses and how others have been affected.		
1.5	Normalise the experience of FMs giving an indication that they are not alone with their experiences.		
1.6	Step 1: Total Score No/%		
2	Step 2: Provide relevant, specific and targeted information (both about drugs/alcohol and/or other key issues of relevance)		
L	Tape length = x mins		
2.1	Beginning of session - check if previous session helpful. Give purpose of Step 2. Ending session - summarise the main FM issues, use of handbook and next steps. Check if session was helpful. Practical issues of contact and date of next session.		
2.2	Identify/check areas where FM needs more <u>Addiction-related information</u> (about the substances or behaviours involved – e.g. details of drugs, units of alcohol, forms of gambling - or about addiction/dependence – e.g. how difficult it is to give up, reasons for relapse etc.), present targeted & relevant information to FM, and discuss this with FM. Utilise results of FMQ to guide the session.		
2.3	Identify/check areas where FM needs more <u>General information</u> (about anything not directly addiction related - e.g. anxiety, sleeping and other health issues, housing, debt management, benefits, educational courses), present targeted & relevant information to FM, and discuss this with FM. Utilise results of FMQ to guide the session.		
2.4	Identify/check areas where FM feels other family members may need information - both addiction and general information.		
2.5	Support FM to find out more for themselves about identified issues e.g. FM could use websites, reading, library, organisations, etc.		
2.6	Step 2: Total Score No/%		

No	Step	Score 1-5	Evidence of meeting criterion/ What was missing / Summarise main information gained. <i>If any criterion scores less than 5, give feedback on improvements.</i>
3	Step 3: Explore coping responses		
L	Tape length = x mins		
3.1	Beginning of session - check if previous session helpful. Give purpose of Step 3. Ending session - summarise the main FM issues, use of handbook and next steps. Check if session was helpful. Practical issues of contact and date of next session.		
3.2	Ask FM about current coping responses. Get specific examples and situations. Discuss the 3 main ways of coping. Utilise results of FMQ to guide the session.		
3.3	Explore advantages and disadvantages of current coping responses. Again, use specific examples and situations.		
3.4	Facilitate FM to see that there is no right or wrong way of coping.		
3.5	Explore advantages and disadvantages of alternative ways of coping, again utilising specific examples and situations.		
3.6	Step 3: Total Score No/%		
4	Step 4: Discuss social support and communication		
L	Tape length = x mins		
4.1	Beginning of session - check if previous session helpful. Give purpose of Step 4. Ending session - summarise the main FM issues, use of handbook and next steps. Check if session was helpful. Practical issues of contact and date of next session.		
4.2	Discussion of who/what/why is helpful and unhelpful in terms of social support utilising a network diagram - to include people, activities, other agencies/groups. Utilise results of FMQ to guide the session.		
4.3	Explore how to develop/continue to develop positive social support.		
4.4	Explore potential new sources of support (could be linked to those named in the network diagram or filling in gaps in social support).		

No	Step	Score 1-5	Evidence of meeting criterion/ What was missing / Summarise main information gained. <i>If any criterion scores less than 5, give feedback on improvements.</i>
4.5	Discuss how family members can support each other and agree on approaches when communicating with the using relative.		
4.6	Step 4: Total Score No/%		
5	Step 5: Discuss and explore further needs (can be about drugs/alcohol and/or other key issues of relevance)		
L	Tape length = x mins		
5.1	Beginning of session - check if previous session helpful. Give purpose of Step 5. Ending session: summarise the main FM issues; check if session was helpful; remind on use of handbook; agree post-5-Step work. If possible in your place of work, inform that will contact them in about 6 weeks to check how they are.		
5.2	Review Steps 1-4 to explore what FM has found helpful about the sessions and what changes FM has made. Redo FMQ from 1 st session to clarify changes. FM/Practitioner to summarise key issues and progress to date.		
5.3	Discuss FMs need for further help and how this can be actioned.		
5.4	Discuss help needs of other FMs/key people and how these can be actioned.		
5.5	Discuss help needs of the using relative and how these can be actioned.		
5.6	Step 5: Total Score: No/%		
6	Total Score All Steps: No/%		

Table 2: Counselling & Other Skills

No	Skill	Score 1-5	Comment on where and how to improve
1.1	Creation of a relationship of trust (warmth, genuineness, and empathy).		
1.2	Careful listening, the giving of minimal encouragers, the asking of appropriate questions, reflecting both the verbal and emotional content of what has been said, summarising, and sensitivity to cues whether verbal or non-verbal, direct or indirect.		
1.3	Allowing silences and the expression of emotions - anger, anxiety, depression, sadness; expression of feelings can be cathartic, alter feelings and improve self-esteem.		
1.4	Offering positive encouragement, reassurance and support, reminding people of their strengths and expressing hope and optimism that change is possible.		
1.5	Management of issues associated with risk and safety if relevant – e.g. domestic abuse/ violence, safeguarding concerns and/or mental health.		
1.6	Total Score/%		

Rating - State A, B, C:

- A) Pass: Table 1, 5-Step Skills:** Above 65% for all Steps (majority of scores are 3.5 and above) **AND Table 2, Counselling & Other Skills:** A total of above 65% (majority of scores are 3.5 and above)
- B) Pass with Reservations: Table 1, 5-Step Skills:** Generally 60% and above and below 65% (some scores of 3 or below) **OR Table 2, Counselling & Other Skills:** Generally 60% and above and below 65% (some scores of 3 or below)
- C) Resubmission required for a Step or all Steps: Table 1, 5-Step Skills:** Below 60% (scores of mainly 3's and below) **AND Table 2, Counselling & Skills:** Below 60% (scores of mainly 3's and below)

SUMMARY: Overall Comments on Tables 1 & 2. State improvements and action plan as needed.

Appendix 2: Short Questionnaire for Family Members (Affected by Addiction) - SQFM(AA) / Family Member Questionnaire (FMQ).

(NB. The full copy of the FMQ has additional notes on completion and scoring)

Family Member Questionnaire (FMQ)⁷



To your knowledge, have any of the following happened in the last 3 months, as a result of your relative's drinking/ drug use? Please tick one answer to each question

	Never	Once or Twice	Sometimes	Often
1. Have the family's finances been affected?	0	1	2	3
2. Does your relative's drinking/drug use get in the way of your social life?	0	1	2	3
3. Are you worried that your relative has neglected his/her appearance or self-care?	0	1	2	3
4. Has your relative picked quarrels with you?	0	1	2	3
5. Has your relative sometimes threatened you?	0	1	2	3
6. Has your relative upset family occasions?	0	1	2	3

In the last 3 months, how frequently have you experienced each of the following symptoms? Please tick one answer to each question

	Never	Sometimes	Often
7. Worrying	0	1	2
8. Being irritable	0	1	2
9. Had thoughts that you cannot push out of your mind	0	1	2
10. Had parts of the body feel weak	0	1	2
11. Cannot concentrate	0	1	2
12. Awakening early and not being able to fall asleep again	0	1	2

With respect to your relative's alcohol or drug use, in the last 3 months have you ...

	Never	Once or Twice	Sometimes	Often
13. Started an argument with him/her about his/her drinking/drug use?	0	1	2	3
14. Got moody or emotional with him/her?	0	1	2	3
15. Watched his/her every move or checked up on him/her or kept a close eye on him/her?	0	1	2	3
16. Sat down together with him/her and talked frankly about what could be done about his/her drinking/drug use?	0	1	2	3
17. Made it clear that you won't accept his/her reasons for drinking/taking drugs, or cover up for him/her?	0	1	2	3
18. Made clear to him/her your expectations of what he/she should do to contribute to the family?	0	1	2	3
19. Put yourself out for him/her, for example by getting him/her to bed or by clearing up mess after him/her after he/she had been drinking/taking drugs?	0	1	2	3

⁷ The full name for the questionnaire is the *Short Questionnaire for Family Members (Affected by Addiction)* or SQFM(AA). The SQFM(AA) has been developed by AFINet-UK and should not be altered, used or copied in ways other than those agreed with AFINet-UK.

	Never	Once or Twice	Sometimes	Often
20. Given him/her money even when you thought it would be spent on drink/drugs?	0	1	2	3
21. When things have happened as a result of his/her drinking, made excuses for him/her, covered up for him/her, or taken the blame yourself?	0	1	2	3
<i>In the last 3 months, have these things happened when you have been concerned about your relative's alcohol or drug use:</i>				
22. Pursued your own interests or looked for new interests or occupation for yourself, or got more involved in a political, church, sports or other organisation?	0	1	2	3
23. Got on with your own things or acted as if he/she wasn't there?	0	1	2	3
24. Sometimes put yourself first by looking after yourself or giving yourself treats?	0	1	2	3
25. Friends/relations have listened to me when I have talked about my feelings	0	1	2	3
26. Friends/relations have been there for me	0	1	2	3
27. Friends/relations have talked to me about my relative and listened to what I have to say	0	1	2	3
28. Health/social care workers have given me helpful information about problem drinking or drug taking	0	1	2	3
29. Health/social care workers have made themselves available for me	0	1	2	3
30. I have confided in my health/social care worker about my situation	0	1	2	3
31. Friends/relations have said things about my relative that I do NOT agree with	0	1	2	3
32. Friends/relations have said that my relative does NOT deserve help	0	1	2	3
33. Friends/relations have said nasty things about my relative	0	1	2	3

Appendix 3: Three Case Studies

Included in this section are three case studies that will help you to get further understanding of some of the problems that family members may have to deal with. The material included in the cases has been developed from accounts given by family members, although names and details have been changed to preserve anonymity. The case studies are followed by an overview of what might be achieved through following the intervention with the family member.

Family members have told us how helpful and valuable they have found the case studies and they may want to read them for themselves. In particular, it helps them to see that they are not alone and that there are other people in similar situations to themselves – “*at one or two points I thought, God that’s me*”. This instils a message of **hope**. Please also note that some of the case studies are also included in the self-help family member handbook in a format that describes the family members in the case studies using the self-help approach.

It is worth noting that some family members will need some guidance in applying the case studies to them – if it does not instantly relate to them then some family members assume that they are unhelpful. For example, a husband of a drinker could not relate to the first case study because it was about the wife of a drinker, whereas another husband of a drinker found the first case study really applicable because he was able to reverse the roles so he took the part of Wendy and his wife was the husband with the drinking problem.

Case Study 1: Wendy

Background Information

Wendy is in her late 30's and married to Paul, who is in his 40s. They have two teenage children, Sam (16) and Mark (14). Wendy has an evening office cleaning job to help ends meet. Paul's drinking has been very heavy for about ten years. In recent years it has been causing a great deal of friction at home and his job is now at risk.

Wendy feels desperate about the situation and has been to see her GP for depression. The GP has seen Wendy with increasing frequency recently because of her depression and eczema. He says, "If I were you, I'd leave him", which Wendy does not find very helpful. She worries about Paul and his health and the future of the family. A few years ago she did not see Paul's drinking as a problem; on the contrary, she saw it as something to be enjoyed. Gradually, however, she saw how the drinking increased, and it is difficult to know precisely when, but at some stage it became more of a problem. Paul started spending more time away from home and less time with the whole family. Looking back, she can see how the situation has changed from the family being fairly happy and normal to her constantly worrying and the atmosphere being tense. Mark is constantly arguing with his father. Wendy herself finds him increasingly difficult to control and worries because he also seems to be spending more time away from home. He feels that Paul is not a good father and he keeps telling her that he is "bad news" and to "get rid of him". Wendy tries to reason with Mark and suggests that Paul can be a very good and caring father when he is not drinking. Wendy's daughter is very responsible and perhaps 'older' than her years. She appears calm and collected but deep down she feels a deep sense of fear, worry for her mother and the future, and great sadness.

Wendy feels isolated and lonely. She finds Paul at times difficult to be with, particularly if he has been drinking very heavily. She worries about Paul's health and his performance at work. "What if he loses his job?" she asks herself. His contribution to the family finances has become less and at this rate they may not be able to make ends meet. Paul's boss has already warned Paul about losing his job. The problem is clearly affecting the children. The atmosphere at home is very difficult and they hardly talk to each other or do things as a family. Last Christmas Paul drank so much that he collapsed and fell asleep before their meal.

Initially, Wendy felt that she could try to do more to deal with the problem. In the early days she used to try to talk to Paul about the situation, although, looking back, she could see that she found it very difficult not to become emotional and break down in tears or become extremely angry. All that happened was that Paul drank more and more. In the past, she would clean up the mess after he had been sick and to some extent try to support him in any way she could think of. These days, she tries to not think about it. She avoids him as much as possible and leaves him alone, particularly if he has been drinking. She finds it very difficult to come to terms with her response to the problem. She feels extremely angry towards Paul while at the same time she cares for him and feels worried for his future and that of the family as a whole. She feels particularly angry and bitter when Mike, a long term friend of Paul and a fellow heavy drinker, comes to meet him and takes him out.

A number of members of the extended family live close by and are in fairly regular contact with Wendy and her family. Paul's dad is in his late 60's. He is very concerned about Paul, but is separated from Paul's mother and is now remarried and living about two hours drive

away. When he rings Wendy's home and talks to Wendy, he asks how things are. Wendy "knows that he knows" but the problem is never openly discussed. Wendy worries that if she discusses the problem with members of Paul's family she is being disloyal. Paul's mum is very close to Paul and he is the apple of her eye. After her own marital separation she lived with them briefly and now lives alone in a house in the next street. She sees the family a lot but there is tension between her and Wendy. Paul's mum is very protective of him and Wendy feels that she thinks that Wendy is not supportive enough. Indeed she remembers one occasion when she was accused of making things worse for Paul and driving him to drink.

Wendy's mum is a widow and lives a short bus ride away. Wendy has always got on very well with her mother but the latter is now in poor physical health. Lately, Wendy has not wanted to trouble her with all her tribulations. A few weeks ago, however, while visiting her mother after taking her for a shopping trip, Wendy became very tearful. Her mother tried to find out what was happening but Wendy played the whole episode down as she felt that it was not fair to worry her mother. Her mother, on the other hand, keeps asking her how she is feeling and offering her help. Deep down, Wendy feels that perhaps she is partly responsible for Paul's drinking and "maybe I should be able to sort everything out".

On one occasion, while Paul was attending a treatment service for his problem, Wendy decided to write to them to find out how he was progressing and see whether she could be helpful in any way. A letter came back stating that they appreciated her concern but the nature of services for people with alcohol problems and confidentiality prevented them from even acknowledging whether someone was in contact with them. She could, however, see someone herself. At that time, she felt that this would be pointless. If they were not even prepared to acknowledge that he was in contact with the agency, it made her feel as if they did not recognise that she had a real problem. Wendy had also heard a psychiatrist from the detoxification unit speak at a local meeting. She was worried by the unit's attitude which seemed to be that patients were free to continue drinking if they wished. She did not think this took into account the experiences of families and the efforts families made to get their relatives to enter treatment.

Sheila is a friend of Wendy and goes regularly to a local support group for families and carers affected by a loved one's substance use. Sheila has been trying to persuade Wendy to go to meetings. Wendy went twice but found it too upsetting. She felt disloyal to Paul and felt the other members were very hard on their drinking relatives.

Today, Wendy has become more desperate. She feels hopeless and is now taking medication for her depression. Whereas before she felt that she wanted to fight for her marriage and the welfare of Paul and their children, now she feels sad and lonely and with little hope that anything will change.

Wendy: Applying the Intervention

Step 1 - Getting to know the family member and the problem

During the first step in your interaction with Wendy, you would need to encourage open communication and build a picture of the stresses and strains that are resulting from living with the problem. The more familiar you are with the material covered within the main part of the handbook, the more able you will be to identify common stresses.

Some of the issues you would be hoping to elicit from Wendy include her **experience of friction at home, Paul being away and spending longer periods out of the house, the uncertainty as to where he is or what might be happening to him, the financial**

difficulties, threat of loss of earning and the **effects of the drinking on the rest of the family**, particularly Mark and Sam. You might want to explore further for example:

1. **What does Wendy mean by friction in the home and in which ways this manifests itself** (keeping vigilant to indications of domestic abuse).
2. **Wendy's understanding of alcohol problems and what it is about Paul's alcohol consumption that she is concerned about.**
3. **What are her specific worries in relation to this area.**

Her relationship to Paul, and the fact that they have children, implies stresses associated with her role as a parent and her worries about how the situation will affect the children. These may need to be discussed. In relation to environmental factors, which support the continued drinking, you would also find that Mike, Paul's friend, and his visiting would be a constant source of worry for Wendy. Note, however, that at this early stage you do not want to start exploring her responses or how to respond.

When looking at the way in which these stresses might be impacting upon Wendy's health, you are likely to discover that she has been experiencing **depressed mood** and has already been given medication for this. She may also feel that she is increasingly **feeling hopeless** about the possibility of change and **feeling isolated** and **lonely**.

A short illustration of how you could elicit some of this information is illustrated below:

Wendy: Things are not the way they used to be. I worry when I am at home. We are not a normal family anymore.

Practitioner: *It must be worrying to realise that things have changed for the worse. Perhaps you could tell me more about what are the things that you find most difficult.*

Wendy: I constantly **worry about the future**. Paul has been warned by his employers and if things don't change **he will lose his job**. We are not very well off and if this happened, life would become very difficult. I **worry** when I think **about the children**.

Practitioner: *So you are worried about the fact that Paul might lose his job and that this might have all sorts of ramifications.*

Wendy: Yes, that is right. I also generally **worry about Mark's behaviour**. He seems extremely angry and bitter and keeps telling me that I should leave Paul.

Practitioner: *And you feel that all this is resulting from Paul's drinking.*

Wendy: Yes I do. (Wendy continues to describe her particular concerns in relation to the children).

Step 2 - Providing relevant information

As part of this Step, it would be helpful for Wendy to understand more precisely the nature of alcohol use and misuse and clarify some of her worries and fantasies. Some of the information at the back of the handbook, or information available to you as a specialist worker, may be helpful here. It may be helpful for Wendy to take some information away to read, or to find further information for herself, e.g. via the Internet. You could discuss this again at the start of your next meeting. Alternatively, discuss the information now, which gives Wendy the opportunity **to explore her understanding, ask questions and correct misconceptions**.

Step 3 - Exploring how the family member copes

Your aim within this Step would be to explore the advantages and disadvantages associated with the family member's current ways of coping. In Wendy, you can see a clear change in her way of coping as time has progressed. Her early attempts were both of an **engaged** and **tolerant** type. In relation to the former category, she used to **try to talk to him and try**

and change the situation but found it rather difficult not to become emotional. At this stage she would also carry **out behaviours that put the needs of the user before the needs of the family member** e.g. clearing up the mess after he had been sick. Currently, she seems to have moved to a position where she tries to withdraw and **distance herself from the problem.** This is not an unusual scenario for family members but you could see from the example that Wendy still finds it difficult to come to terms with her response to the situation. This illustrates further the ambivalence associated with both positive and negative outcomes arising from the different coping actions.

An example illustrating how to carry out the necessary work at this stage follows:

Practitioner: Wendy, it sounds from your description as if you have changed quite a lot over time and currently your way of responding to Paul is by trying to keep your distance and almost forget that the problem is there.

Wendy: Yes, in the early days I thought I could do something to change the situation. Now I feel that **the less time we spend together, the better.**

Practitioner: And how does that make you feel?

Wendy: Well, obviously it **helps me not to be worrying all the time,** but on the other hand **I feel as if I have given up on Paul. I also sometimes feel very upset** because I still love him and it is as if I am rejecting him with what I am doing.

Practitioner: So it sounds like on the one hand it helps you to avoid not becoming too involved and upset through worry but, on the other hand, you feel as if you are rejecting Paul and perhaps even not loving him enough.

Wendy: Yes, that is right. Perhaps I have gone too far and I should think about other ways of dealing with the situation.

Practitioner: Well perhaps we could think about the previous ways in which you were coping and their advantages and disadvantages and then think about what may be alternative responses.

Later on within that meeting Wendy reflects on her options.

Wendy: Having talked to you, I feel that I need to face the situation and talk to him. directly.

Practitioner: What would you like to say to Paul?

Wendy: Well, I am really worried about the impact that this situation is having on the children and I need to tell him about this. I am prepared to support him but I also need to let him know how all this is making me feel. I also need to start doing something for myself, so that at least even if he does not change I can feel more positive about myself and the family.

Step 4: Exploring and enhancing social support

In attempting to carry out this Step, it might be helpful to talk to Wendy about all her contacts and how supportive, unsupportive or mixed she perceives these to be. You should use a network diagram to build up a comprehensive picture of Wendy's support and how each person is helpful or unhelpful. There are a number of people within this network whom Wendy does not experience as supportive:

- Paul's mother's views appear to conflict with those of Wendy and it might be helpful to think how Wendy could deal with her criticism in a way that minimises her own stress.
- Other potential sources of support, such as Wendy's mum, are not being used and it might be helpful to discuss with Wendy what are her fears about sharing her experience of the problem with her.
- Close friends of Wendy are not evident, apart from Sheila. Are there any other friends from whom Wendy can derive support? This could be discussed and explored further.

Step 5 - Referring on for further help

The discussion about the need for further referral need not be restricted to Wendy. In this case, it is clear that other members of the family are experiencing significant difficulties and it would be worth considering, for example, whether Mark or Sam would benefit from further contact with any services.

Inviting Sam and Mark to Come to a Meeting

Given Wendy's concerns, it might become important to raise the subject of inviting Sam and Mark to come along to a meeting. A possible way of raising the subject is illustrated below:

Practitioner: You are clearly worried about the impact that this problem is having on Sam and Mark. Do you think that it might be helpful to invite them to our next meeting so that they can talk about how they feel about it?

A number of concerns may arise from Wendy, which could then be explored. She may worry about making the situation worse. In reality, based on her account, the family is already experiencing severe disruption and giving Mark and Sam a chance to express their concerns might alleviate some of their distress and bring Wendy and the children closer together. You will need to discuss this with Wendy. If you are successful in engaging either both or one of them you should then remember to:

- 1. Express how positive it is that they have come forward to join the meeting.**
- 2. Encourage open communication between all family members.**
- 3. Be aware of potential sources of help for the children. You will find relevant information later in this handbook.**

Case study: Conclusion

If you were able to conduct a series of sessions with Wendy and cover some of the areas outlined you would have greatly improved the situation in a number of ways including:

- An increase in Wendy's awareness of the stress that she is experiencing and where it is arising from.
- An increase in Wendy's awareness of the impact of the excessive alcohol use on the family as a whole.
- Wendy's access to further information and sources of new information.
- A review and stock taking of her past and present responses and a careful consideration of other courses of action.
- A review of current social support and how it could be enhanced.
- Raising the question of further help for the other members of the family.
- Providing Wendy with a link to services.

Three months later

- Things have improved for Wendy. Most importantly, Paul has stopped drinking. He underwent detoxification at home and now goes to regular counselling sessions. Sometimes Wendy and the children go as well.
- Wendy decided that she really didn't want to worry her mother but she has talked to Paul's mother. She didn't believe Wendy at first but Paul has also been more honest with his mother and so both of them have additional support.
- Wendy goes to regular support group meetings and talks to other family members on the phone.

Case Study 2: Malcolm

Background Information

Malcolm is 52 and married to Lynn. Their 18 year old daughter Sylvia is currently living at home. Malcolm feels rather desperate and has recently experienced difficulty sleeping during the night. During the last 2 years, Malcolm has witnessed the unfolding story of his daughter's drug use. It started as a series of events that made him think that something was not right. At that time, Sylvia was living with them and her moods were becoming increasingly difficult but Malcolm thought that it was all part of growing up and that it would sort itself out.

Time has proven him wrong. The first shock came when Malcolm saw marks on Sylvia's arms and hands and with it came the realisation that she was injecting drugs. Even today, Malcolm is unsure as to what Sylvia is using although he is fairly certain that she has used heroin at different times. In the last 6 months Sylvia has been arrested on a number of occasions for shoplifting. Malcolm thinks that this is related to her need for money for drugs.

Malcolm has found used needles in the house. He confronted Sylvia and remembers being very upset at the time, but her reaction was rather surprising to him. She was very matter of fact and replied that he should have broken the ends before throwing them away. Sylvia is very difficult to live with, her moods are very changeable and she is often rude and irritable. At other times, she gets very low and deep down Malcolm wonders what he has done wrong as a father for Sylvia to be in this situation.

Malcolm has not discussed this with anyone at work as he feels it might create problems. This makes him feel isolated. When he tries to sit down and talk to Sylvia, their conversation normally "degenerates". On one occasion, he become so frustrated that he said to her "I haven't got a daughter now". He felt very upset after this event and wished he had not said that. Lynn, Malcolm's wife, is also very worried but she deals with the situation in a different way. She tries to support Sylvia and does not talk about the use of drugs. At times, Malcolm and Lynn have had disagreements as to how to deal with Sylvia and this has created further tension in the home. Both are, however, very careful to avoid talking to anyone about the situation as they feel a great deal of shame.

Malcolm is finding it increasingly difficult to concentrate at work. Deep down, he feels at a loss and unsure as to how to respond. If he tries to talk to Sylvia they end up arguing. If he stays away, he worries to the point of not being able to think about anything else. Strangely, Malcolm can relax more when he knows that Sylvia is upstairs even though she is usually in a bad state. At least he knows that she is not "out there".

On one occasion Sylvia came off the drugs and Malcolm felt as if they had recovered their daughter. She came off heroin with the help of the doctor who prescribed some medication and something to stop her feeling sick. It was a bad time for everyone at home. Sylvia was tearing her clothes off but when she came through the withdrawal, she was completely changed. But then, it took just one party for the situation to revert and the shutters came down again. Today Malcolm feels desperate. Recently he has broken down a couple of times at work. He does not know where to turn.

Malcolm: Applying the intervention

Step 1 - Getting to know the family member and the problem

During your first meeting with Malcolm, your main priority would be to listen carefully and to encourage him to talk openly about his situation and the aspects of his life which he is finding particularly worrying. The more familiar you are with the handbook, the easier it will be for you to identify the main stresses experienced. In Malcolm's case you would hope to elicit concerns regarding: his uncertainty about the drugs which Sylvia is using, Sylvia's changeable moods and shoplifting, his feelings that he has been a bad father, his feelings of isolation and shame, not being able to talk with Sylvia, tension between him and his wife, difficulty concentrating at work and uncertainty about Sylvia's safety when she is not at home. You might wish to explore the following issues in more detail:

1. **Malcolm's understanding of drug use.**
2. **What are Malcolm's specific worries.**
3. **Malcolm's feelings of shame and guilt.**
4. **Why conversations between himself and his daughter are difficult.**
5. **The tension between him and his wife, Lynn.**

Malcolm's reluctance to discuss his problems with anyone outside the family and the fact that he feels a great deal of shame may result from a sense of guilt and responsibility about Sylvia's drug use. This is one issue that may need to be discussed further. However, the fact that Malcolm feels a great deal of shame may make it hard for him to be open about the situation and it may take him some time to feel that he can talk frankly with you.

With regard to Malcolm's health, you may discover that these stresses have led to **insomnia** and **difficulty concentrating** as a result of **anxiety**. In addition, you may find that Malcolm is feeling increasingly **isolated** and **desperate** about his situation. The following is a brief illustration of how you may elicit such information:

Malcolm: I just don't know what to do.

Practitioner: I see that you're very upset. Maybe you could tell me about what's worrying you at the moment.

Malcolm: I don't know. Everything just seems to be getting on top of me lately. Take yesterday for instance, I just couldn't concentrate at work and ended up making a right mess of last month's sales figures.

Practitioner: So you feel that everything's going wrong. You seem to be concerned that your work's suffering. Was there anything in particular that was worrying you when you were at work?

Malcolm: Well, for a start I'd hardly had any sleep the night before. I'd spent most of the night tossing and turning wondering what I'd done wrong to make Sylvia turn to drugs.

Practitioner: So you've been finding it hard to sleep at night because you've been worrying about Sylvia, is that right?

Malcolm: Yes, that's right.

Practitioner: You seem to think that you're somehow to blame for Sylvia's drug use. What makes you think this?

Malcolm: [Malcolm continues to voice his concerns about Sylvia and how he feels that her drug use is somehow his fault.]

Practitioner: [Explains to Malcolm that drug use has multiple causes and that Sylvia may be taking drugs for a number of reasons. Continues to tell Malcolm about some of the reasons that young people take drugs. For example, peer pressure, availability.]

Step 2 - Providing relevant information

During this Step it would be a good idea to help Malcolm understand more about drug use and injectable drugs in particular. Some of the information at the back of the handbook, or information available to you as a specialist worker, may be helpful here. It may be helpful for Malcolm to take some information away to read, or to find further information for herself, e.g. via the Internet. Similar to what is described in the previous case study, you could suggest to Malcolm that he reads the information and you can discuss it at the next meeting or alternatively, you could look at the information during your meeting. You should give Malcolm the opportunity to ask you about anything which he doesn't understand and this will enable you to correct any misconceptions he may have.

Step 3 - Exploring how the family member copes

During this Step you need to explore how Malcolm currently **responds to Sylvia's drug use** and help him to identify the advantageous and disadvantageous aspects of his coping actions. Malcolm's attempts at coping have become **engaged** after the realisation that Sylvia was injecting drugs. An early example of Malcolm's attempts at **engaged** coping is that he confronted Sylvia about her drug use after finding needles in the house. A more recent example of Malcolm's **engaged** coping is illustrated by his attempt to sit down and talk to Sylvia. However, it is evident that such conversations rapidly deteriorate and they end up arguing. Malcolm finds it hard not to become emotional and often feels guilty afterwards about things said in the heat of the moment.

The following is an example of how Malcolm may be helped to identify the advantages and disadvantages of his current ways of coping.

Practitioner: From what you've told me it sounds like you've tried to talk to Sylvia about her drug use but the discussions tend to deteriorate.

Malcolm: Yes, that's right. We always end up arguing. **I get so worried about her** that I end up telling her exactly what I think. I suppose that I'm not that tactful. I still see her as my little girl and **feel responsible for her**, but she says she's old enough to look after herself and that I should stop interfering. The conversation then escalates into a row and we end up saying hurtful things in the heat of the moment.

Practitioner: So, you seem to end up arguing because of a difference of opinion. You still see her as a child and she sees herself as an adult who's old enough to control her own life. Have I got that right?

Malcolm: Yes, She's only eighteen. I'm her dad and I can't just sit back and watch her destroy her life.

Practitioner: You said that sometimes you find it hard to be tactful because you're so worried about her. Can you think of any way that you might be able to have a more constructive conversation?

Malcolm: Maybe I should think of other ways of approaching the situation. I suppose I could try to keep calm and talk to her on a more equal level and then she might not be so defiant. I mean, in some respects I suppose she's right. She is an adult now.

Practitioner: So you think you might be able to have a more constructive discussion this way. If you were able to do this, what would you like to talk to Sylvia about?

Malcolm: I need to explain to her how we feel. I'd tell her that I'm prepared to support her but she must start to help herself.

Practitioner: [Encourages Malcolm to consider advantages and disadvantages of his proposed course of action.]

Step 4 - Exploring and enhancing social support

In this Step it would be appropriate to discuss the support which Malcolm gains from his contacts, using a network diagram to do so. This should include positive support, perceived

unsupportive actions and potential sources of untapped support. It would appear that Malcolm has very few people in his support network. This is likely to result from the fact that he feels a great deal of shame with regard to Sylvia's drug use:

- Malcolm views his wife as unsupportive as she deals with the situation in a very different way. This leads to disagreements and tension.
- Work colleagues are a potential source of positive support for Malcolm. However, it is evident that Malcolm feels that discussing his situation at work may create further problems and it may be helpful to explore this with him.
- Malcolm has not mentioned any other friends or relatives. These are all potential sources of positive support. You may wish to discuss with Malcolm the possibility of deriving support from such persons.

The following illustrates how to discuss issues relating to potential sources of support:

Practitioner: From what you've told me, it seems that you're carrying a lot of weight on your shoulders. Have you discussed your situation with anyone other than your wife?

Malcolm: No. I just can't bring myself to tell anyone else. I feel so ashamed. I mean, what would people think if they knew that my daughter was injecting drugs.

Practitioner: So you feel you can't discuss it with anyone because it will reflect badly on you and your family.

Malcolm: That's right. The only person I feel I can trust is Lynn, but she won't talk about Sylvia's drug use.

Practitioner: Why do you think that is?

Malcolm: I suppose she's as ashamed as I am and feels that the problem will go away with time. It's just so frustrating. I need someone to talk to and yet she refuses to discuss it. If I don't talk to someone soon I think my head will explode, but there's no one else I feel I can trust.

Practitioner: So you desperately need to talk to someone but it's got to be someone you trust. Have you got any friends or relatives who you could talk to?

Malcolm: Not really. I've heard that there are confidential support groups for people who have children who are using drugs. Do you think it might be a good idea for me to contact one?

Practitioner: Possibly. If you don't feel that you can talk to any of your family or friends then you may find a support group beneficial.

Step 5 - Referring on for further specialist help

During your final session with Malcolm you may wish to discuss further the possibility of him attending a self help/support group. A number of national agencies are listed in the back of the handbook, which will be able to provide advice on local services. In addition, there may be local alternatives for Malcolm to try. Details are provided at the back of the handbook. You may wish to have a discussion with Malcolm about the different organisations which are available and how he might approach them. It is evident that Malcolm's wife, Lynn, is also concerned about Sylvia. Although it would appear that Malcolm's wife does not talk about the use of drugs, it may be worth considering whether or not she may also benefit from contact with specialist services.

Case study: Conclusion

If you managed to conduct a series of meetings with Malcolm and covered some of the areas outlined you would have improved his situation by:

- Listening to Malcolm's problems and helping him to understand the stresses which he is currently experiencing.
- Increasing Malcolm's awareness of drug use and its effects.
- Identifying the advantages and disadvantages of his coping actions.

- Reviewing his current social support and ways of enhancing it.
- Helping him to access further information and support.

Three months later

- Malcolm is sleeping better and his performance at work has improved.
- Sylvia still takes drugs but Malcolm and Sylvia have managed to talk about this. Sometimes they argue but he feels more informed about her drug use while Sylvia understands that her father loves her and wants to help.
- Malcolm has attended a support group and found it helpful. He has also been to see a local alcohol advice centre and hopes that his wife will go with him for some counselling.
- It is early days yet but Malcolm is hopeful that the situation will continue to get better and that Sylvia will soon stop taking drugs altogether.

Case Study 3: Sunil and Rekha

Sunil is 53 and lives with his wife, Rekha. Their children Usha (21) and Ashok (19) have left home for work and university respectively. Sunil's Dad, Ramesh, is 82 and has recently had a fall which resulted in a hospital admission. On his discharge from hospital, he moved into Sunil and Rekha's home as he was not able to look after himself. Ramesh is an independent person and is quite resentful of having to be 'looked after' by someone else. Since living with them, Sunil is now more aware that his father has been drinking quite a lot. The hospital implied that the fall was caused because Ramesh was drunk and they advised Sunil and his wife to get Ramesh some help in regard to his drinking.

Sunil mentioned this when he took his father to his GP for a check-up and to get some more painkillers. The GP was unsure how to respond in terms of getting Ramesh some help as Ramesh himself was adamant that he did not have a 'drink problem' and does not want to talk about it with either Sunil or the GP. As Ramesh cannot get out of the house very well Sunil and Rekha buy alcohol for him. Sunil has tried to 'cut down' the amount that his father drinks by buying less but Ramesh was quite abusive when Sunil tried to do this. This upset Sunil as he felt he was trying to 'control' his father who was already feeling really stressed because he did not like being looked after and he was drinking to help him deal with this. However, Ramesh's drinking and behaviour is also causing rows between Sunil and Rekha.

Rekha is feeling the strain of looking after her father-in-law who is very demanding. She has very little space to herself as he is constantly calling for her before she goes to work and as soon as she gets home. She is feeling tired and rundown and has begun to suffer regular headaches. Ramesh has also become increasingly aggressive towards her. Recently on helping him prepare for bed she tried to tell him that she was getting looks when they went to buy his alcohol in the local shops. She told him she had heard people whispering that it was Sunil that was drinking too much. Ramesh was verbally abusive to Rekha then slapped her causing her to fall over and hit her head on the bedside table. On finding out Sunil had words with his father and told Rekha that he was sure his father didn't mean it and she shouldn't have raised his drinking again after last time. Rekha's injuries resulted in a black eye and she had to take a few days off work because of her injuries. The neighbours have commented on it and on the rows that have happened in the house. Rekha is angry with Sunil for his lack of support and their relationship has started to deteriorate. When they talk together about the problem, they end up rowing. Rekha is starting to stay later at work and is trying to be out of the house as much as possible after dinner. She has been able to talk to Usha on the phone but she feels disloyal doing so. She has decided to have as little to do with her father-in-law as possible but she believes that he will never leave and the problem will never get any better.

Sunil is torn between helping his Dad and asking him to leave because of the impact it is having on his relationship and home life. He believes his Dad isn't trying to be awkward, but he doesn't realise the impact his behaviour is having on everyone. Sunil doesn't feel able to talk about what is happening to anyone. Sunil and Rekha have tried to talk to Ramesh, to get him to see how the whole community is talking about them but he says that if he wasn't living with them and having to cope with the humiliation of being looked after he would not need to drink.

Sunil makes excuses for his Dad but he has pleaded with his Dad to drink less. Rekha has decided to have as little to do with her father-in-law as possible but she believes that he will never leave and the problem will never get any better.

Sunil and Rekha: Applying the intervention

Step 1 - Getting to know the family member(s) and the problem

In this situation you may be able to see Sunil and Rekha together or perhaps your contact is with only one of them. In the latter case you may want to encourage the person attending to talk to their partner about joining at least some of the meetings. During your first meeting your main priority would be to listen carefully and to encourage open talk about the situation and the aspects of life that are particularly worrying. The more familiar you are with the handbook, the easier it will be for you to identify the main stresses.

In Sunil's case you would hope to elicit concerns regarding:

- Worry about his father's drinking and not knowing what to do.
- The tensions it is creating and the impact on his relationship with Rekha.
- Possible anger with his father for his abusive behaviour towards him and Rekha.
- Wanting to be more supportive of Rekha.
- Needing to work out a way to make things better.

In Rekha's case you may elicit concern regarding:

- Anger about the way Ramesh is treating her and Sunil.
- Feelings of hurt that Sunil is defending his father's bad behaviour rather than supporting her.
- Feelings of embarrassment at having to buy alcohol for Ramesh.
- Feeling let down and ashamed about the whole situation.
- Feeling frustrated at Sunil and the way he is handling the situation.
- Feeling that things may get worse between her and Sunil.

You need to consider that there may be an element of shame that may need to be explored further. However, the feeling of shame may also make it hard to be open about the situation and it may take some time for Sunil, Rekha or both to feel that they can talk frankly with you.

If you are seeing Sunil and Rekha together, you are likely also to hear their views on how the situation is impacting on the relationship and this is an important area to explore. Are both Sunil and Rekha feeling isolated in the face of the problem? Is there anger and resentment developing because of the problem? It may be important for them to see that some of the experiences that they are having are the result of the severe stress that they are exposed to as a family and the difficult dilemmas that they are facing.

A crucial part of this step is to explore and fully understand the episodes of violence and abuse and to identify what their needs are and whether they feel they are at risk from further abuse. We have given guidance on this throughout this handbook.

Step 2 - Providing relevant information

During this Step it would be a good idea to help the family member(s) understand more about alcohol use and problems. Some of the information at the back of the handbook may be helpful here. It may be helpful for the family member(s) that you are working with to take some information away to read, or to find further information, e.g. via the Internet. Similar to what is described in the previous case studies, you could suggest to the family member(s) that they read the information and you can discuss it at the next meeting or alternatively, you could look at the information during your meeting. You should provide the opportunity

to raise any questions or clarify anything that is not understood and this discussion will enable you to correct any misconceptions.

Some of the needs for information for Sunil may include:

- Knowing more about levels of drinking and dependence.
- Finding out about the painkillers that his father is taking and interactions with alcohol.
- What would happen if his dad stops drinking?

Some of the needs for information for Rekha may include:

- Information on domestic violence and its relationship to alcohol.
- Knowing more about the effects of alcohol and the impact on the whole family.
- Knowing that her feelings are understandable and result from the stress that the problem creates.

Step 3 - Exploring how the family member copes

During this step there are a number of possible options. If you are working with Sunil and Rekha together, in addition to exploring how each family member responds, you have the possibility to explore the views on each other's ways of responding and how these interact and impact on the relationship and the whole family. You still need to use the model of coping to explore advantages and disadvantages of each response. If you are working with only one of them, you can explore ways of coping in the way that it is described in the previous cases.

In the case of Sunil, some of the responses that could be explored may include:

- Making excuses to Rekha for his father's behaviour.
- Buying alcohol for Ramesh.

In the case of Rekha you may want to explore:

- Letting Ramesh know what is acceptable and unacceptable behaviour.
- Being able to communicate with Sunil about the problem.
- Becoming more independent.

Step 4 - Exploring and enhancing social support

During this step you can explore the social support networks of either one family member (if you are seeing them individually) or both Sunil and Rekha. The same principles apply as in the previous two cases. Drawing a network diagram should assist this process and elicit current support systems or highlight the lack of these. In this case, it is important to explore what support Sunil and Rekha can provide for each other. It may also be possible to enlist the support of another family member e.g. Rekha's sister.

Step 5 - Referring on for further specialist help

During your final session you would want to discuss further the possibility of approaching other relevant services e.g. Age UK about services for Asian elders, Women's Aid for support for Rekha. A number of national agencies are listed in the back of the handbook, which will be able to provide advice on local services. You may wish to have a discussion about the different organisations which are available and how to approach them. Rekha may also want to seek support and advice about Ramesh's violent and abusive behaviour and how to respond and deal with this. While providing useful information, be careful not to be too directive. Emphasise their choices to contact specialist agencies and seek advice and your willingness to support them if they wish.

Case study: Conclusion

If you managed to conduct a series of meetings and covered some of the areas outlined you would have improved the situation by:

- Listening to the problems and helping either the individual family member or the couple depending on who you work with to understand the stresses which they are currently experiencing.
- Identifying, assessing and responding to the risk of future violent behaviour.
- Increased awareness of alcohol use and its effects.
- Helping identify the advantages and disadvantages of different coping actions and the results of these actions for everyone in the family.
- Reviewing Ramesh's current social support (or lack of it) and discussing ways of enhancing it.
- Helping Sunil and Rekha access further information and support.

Three months later

- Sunil's dad stopped drinking but has recently relapsed. Sunil hopes that he will stop again soon and is refusing to buy alcohol like he would have done in the past.
- Sunil and Rekha spend more time together and talk more about the situation and how they can work together to deal with it as a couple.
- Rekha is still angry and frightened of her father-in-law but she has received some counselling for this and these feelings are fading.
- Rekha and Sunil have given Ramesh a clear message that if he is violent and abusive again, drinking or not, he will have to leave.

Sunil and Rekha have been referred to social services who have recently conducted an assessment to see what support they can offer to the family.

Appendix 4: Exercises for Family Member

	Exercise One		
	Think about how the behaviour of your relative affects you and your family. Think carefully about problems that are related to your relative's drinking or drug use and how this affects you. Use the table below to write down some of these problems and the impact on you and your family.		
Stressful behaviour of my relative	How I feel about this	How I think my family feel about this	
e.g. My partner does not spend time with us in the evenings e.g. My daughter steals money to fund her drug use	Angry and upset I feel that I have to give her money so that she won't steal and get caught	Neglected and abandoned Angry with her for putting me in this position, and with myself for giving her the money	

	Exercise Two		
	Think about how the behaviour of your relative affects your health and that of your family. Use the table below to write down some of these health problems and the impact on you and your family.		
Health Problems that I or my family have	How I feel about this	How I think my family feel about this	
e.g. I cannot sleep at night e.g. I have a lot of aches and pains and I'm not sure why	Exhausted. I lose my temper easily I feel confused and miserable and it's hard to do what I need to do every day	My children don't understand why I lose my temper so much I can't do as much as I want to do with my grandchildren	



Exercise Three

Think about what questions you might have that would help you increase your knowledge and understanding about what is going on. You could look back over Step 1 to help you think more about what additional information you might need. If you want, write your questions below.



Exercise Four

This exercise can help you summarise the information that you have found out, and how helpful this has been. If you find it useful, look back at the questions you wrote down in Exercise Three and see if they have been answered.

1. What have I learned?

2. Is there any information that I still need to get? How am I going to go about getting this?

3. Have I increased my knowledge and understanding?

4. How do I feel about this?

5. What did I find particularly helpful and unhelpful?

6. Do I still have some questions that I need answers to?



Exercise Five

This exercise will help you look at how you currently respond to your relative's behaviour and the alcohol or drug misuse. Think about some difficult situations that you have experienced recently and write about how you responded, and how you feel about this.

Example of a difficult situation	How I responded	How I feel about this
e.g. I knew my daughter wanted to get some drugs e.g. My partner comes home drunk	I took money from her purse so that she couldn't buy drugs I help him/her wash and get ready for bed	Relieved and guilty but worried that she would steal from someone else I am glad my partner is home safe but I feel cross and put upon and I am exhausted the next day



Exercise Six

This exercise will help you look at how you respond to your relative's behaviour and whether you are happy with your actions. Think of some recent situations and write down how you reacted. Think about what was helpful and unhelpful about your response. Are you happy with how you responded to the situation, or is there something else that you could do? If you feel that there is something else you could try next time, then write this down in the final column.

The situation	How I responded	What was helpful	What was unhelpful	What I could do next time
e.g. My son hangs around with people I don't like – I know they are taking drugs e.g. My partner becomes nasty and aggressive when drunk	I try to make my son promise not to take drugs or hang around with this group of people I make sure the house is clean and I am careful what I say to my partner	I feel that I am doing something to help my son I sometimes succeed in keeping the peace until my partner falls asleep	My son resents me for interfering and I resent him for taking drugs I know it's only a temporary fix. Not a longer term solution	Rather than order my son around I will try to talk to him about my fears and concerns I could seek advice about what to do in these situations



Exercise Seven

This exercise will help you to look at people around you who are both helpful and unhelpful. Think of key people in your life and how they are helpful and unhelpful, and how this makes you feel.

Person	How this person is helpful	How this person is unhelpful	How I feel about this person
e.g. A friend at work	She listens to me and we go out to lunch regularly	She tells me that I should leave my wife	It helps to have someone to talk to but it is frustrating that she tells me what I should do



Exercise Eight

This exercise will help you think about whether you need any more support to help you deal with your problems. Using your responses to Exercise Seven, think about what you could do to increase your support.

1. Who is helpful to me at the moment and what do they do that I find helpful? What could I do to get more help from this person?

2. Who is unhelpful to me at the moment and what do they do that I find unhelpful? Is there anything I could do to change this?

3. Who else do I need support from? What am I going to do to try and get help from them? Give examples.

4. Do I need some more positive support? Where can I go to find more people who could help me?



Exercise Nine

This exercise will help you think about whether you or your family need any further help. If you want to, you could look back over previous exercises and see if there are any issues that you still feel are unresolved and how you could get help to deal with them.

1. What further help do you think you still need?

2. What can you do to try and get this help?

4. Does my relative want any help? What am I going to do about this?

5. What kind of help would other members of my family benefit from?

6. What am I going to do about this?

Appendix 5: Stresses and strains for family members

An important aspect of your role is facilitating the identification of stressors and the ways in which stress is manifested in the family members that you are seeing. Our research has suggested certain core aspects of the experience of family members, which appear to be universal, irrespective of culture, socio-economic status, gender of the relative and how they are related to the user, or type of substance. Some of the most common stresses reported by family members were listed earlier.

One of the ways in which strain in the family manifests itself is in the form of health problems. Table 4 shows references to health made by family members, which in their view were attributable to their circumstances while living with alcohol/drug problems within the family. Research has consistently shown that family members of those people with alcohol and drug problems have levels of stress which are much higher than control groups of families who are not living with this problem, and that as a result, they make more use of medical services. The evidence that their levels of symptoms are reduced following either separation or recovery of the alcohol/drug problem user lends further support to the notion that the impact of living with another's alcohol/drug problem may be a significant cause of these symptoms.

Table 4: Family member's perceived effects on health

Sickness	Anaemia	Headaches
Neuralgia	back pain	'pains'
Hypertension	hair loss	loss of appetite
Asthma	Migraines	shortness of breath
Palpitations	Diarrhoea	weight change
'minor ailments'	Itching	'health poor'
Weakness	'in decline'	'felt ill'
'health went'	'put years on me'	'in bad health'
'felt fragile'	'neglected self'	'neglect eating'
'wake early'	Fatigue	'weary with it all'
'tired'	'use more drugs'	'smoke more'
'gall bladder troubles'	'have over-eaten under stress'	'drink more'
'lay awake the whole night'	'sometimes slept for two days'	change in bowel movements

Further evidence for such psychological and physical health problems comes from studies with children and adolescents living with alcohol problems. Reviews have concluded that young people living at home where a parent has a drinking problem, are at risk for psychological problems of various kinds including emotional problems, conduct problems and school learning difficulties.

Appendix 6: Further information on alcohol and drugs

This section will summarise some of the basic information which it is useful to know about alcohol and other drugs. It is not possible to cover everything in this section; if you want to find out more than you could look at Step 2, or at the Resources section later in this handbook. Similarly, it is not possible to update this section of the handbook every time something changes so you may want to check that the information here is up-to-date before you discuss it with a family member.

Different types of drink and drugs

Different drugs and alcohol affect people in different ways, and they are grouped according to their broad effects. The table below summarises the main types of drugs and what they are commonly called⁸. The table is not exhaustive; you can find out how to get more information when you work through Step 2, and by looking at the Resources section later in this handbook.

Drug group	Slang names	Scientific names
Alcohol	booze, drink	ethanol, ethyl alcohol
Benzodiazepines and minor tranquillisers	Benzos or Tranx - a range of slang and brand names e.g. eggs or jellies Valium Librium Ativan	temazepam diazepam chlordiazepoxide orazepam
Solvents & gases	Glue Lighter fuel Aerosols Cleaning fluid	acetone butane fluorocarbons trichloroethylene
GHB/GBL	GBH, liquid ecstasy	gammahydroxybutyrate
Opiates, opiodes & narcotic analgesics	junk, slag, smack Diamorphine Temgesic, Subutex Tramadol	diacetylmorphine heroin buprenorphine tramadol pethidine, methadone, opium, morphine, codeine
Amphetamines	uppers, speed, whizz, ice, crystal meth Ritalin Reductil	amphetamines, dexamphetamine, metamphetamine methylphenidate sibutramine
Cocaine	coke, snow crack, freebase, base, stone	cocaine hydrochloride cocaine freebase

⁸ The information in this table has been taken from Drugscope's publication 'The Essential Guide to Drugs and Alcohol' (2010, 14th Edition, particularly pages 152-161).

Drug group	Slang names	Scientific names
Caffeine	coffee, tea, cocoa, chocolate, soft drink, analgesic pills	caffeine
Tobacco	tobacco, cigarettes, fags, rollies, snuff	e.g. nicotiana tabacum
Anabolic steroids	e.g. Nadrolene, Stanozolol, Dianabol	anabolic steroids
Alkyl nitrates	poppers rush	Amyl nitrate Butyl nitrate
Hallucinogenic amphetamines	ecstasy, E	methylenedioxyamphetamine, MDA, MDMA
Khat	Kat, Khat, Qat, Quaadka	cathinone, Catha edulis
Legal highs or novel psychoactive substances (NPS)	Multiple	Multiple
Methcathinone	Mcat, Miaow	mephedrone, methedrone, methylone
LSD	acid, tabs, trips	lysergic acid diethylamine, lysergide
Hallucinogenic mushrooms	Liberty Cap, magic mushrooms	psilocybe semilanceata
Cannabis	pot, dope, blow, draw, smoke, puff grass, ganja, weed, skunk hash, hashish	cannabis sativa herbal cannabis cannabis resin cannabis oil
Ketamine	Ketamine, special K	Ketamine, Ketalar

Alcohol

There are many different types and strengths of alcohol. Alcohol is commonly measured in units. A unit is a measure of the volume of pure alcohol (or ethanol) which is in an alcoholic drink (this is 10ml or 8g of ethanol). A standard drink contains one unit of alcohol, so different drinks have different numbers of units in them. One unit of alcohol is roughly equivalent to half a pint of ordinary strength beer, or one pub measure of sherry, port or spirits. The table below gives you some idea of the strengths of different drinks⁹. There are ways in which you can calculate how much you or someone else drinks. Keeping a drink diary or using a unit calculator are common methods which are used. For example, you could look on the Drinkaware website to find out more (see <http://www.drinkaware.co.uk>).

⁹ The information in this table has been taken from Drugscope's publication 'The Essential Guide to Drugs and Alcohol (2010, 14th Edition, page 62).

Type of alcohol	Examples	Units
Beer 4% pint	Carling, Guinness	2.3
Beer 5% pint	Stella Artois, Kronenburg	2.8
Beer 5% bottle	Budweiser	1.7
Cider 4.5% pint	Strongbow, Magners	2.6
Alcopops 4% bottle	Bacardi Breezer, Smirnoff Ice, WKD	1.1
Clear spirits 37.% 25ml measure	Gordon's gin or Smirnoff vodka	0.9
Dark spirits 40% single 25ml measure	Bell's whisky, Captain Morgan rum	1.0
Wine 13% 175ml glass		2.3
Wine 13% 750ml bottle		9.8
Champagne 12% 125ml glass		1.5
Cream liqueur 17% 50ml glass	Bailey's	0.9

The advice from the UK's Chief Medical Officer (January 2016) recommends that:

- Men and women should not drink more than 14 units of alcohol in a week.
- 14 units is roughly (depending on the strength of the alcohol) equal to 6 medium (175ml) glasses of wine, 6 pints of lager/ale 5 pints of cider, or 14 standard (25ml) glasses of spirits.
- Alcohol consumption up to 14 units should be spread out across the week, to avoid 'binge drinking'.
- Women who are pregnant or trying to conceive should avoid drinking alcohol.

There are three broad categories of alcohol misuse. These are:

1. **Hazardous:** Drinking in excess of the recommended level of units, or binge-drinking. A hazardous drinker may not experience problems but is at increased risk of health and other problems such as accidents.
2. **Harmful:** Drinking in excess of the recommended level of units, and experiencing a range of health and/or other problems. It can be difficult to recognise when someone is a harmful drinker because some of the symptoms of the health problems may take a while to show.
3. **Dependent:** Being physically and/or psychologically addicted to alcohol. A dependent drinker feels that they cannot function without alcohol, they may experience moderate or severe withdrawal if they stop drinking, and they will probably have a range of health or other problems as a result of their excessive drinking.

Other definitions of such problems use different language and terminology, such as alcoholism and alcoholic. However, although many find such terms helpful we use the terms used and recognised by the World Health Organisation and other major health organisations.

Drugs and the Law¹⁰

The Misuse of Drugs Act 1971 is an Act of Parliament, which groups controlled drugs into three classes; A, B and C. Each class is enforced by a set of penalties for illegal and/or unlicensed supply and/or possession, with Class B substances enforced by stronger penalties than Class C, and Class A substances enforced by stronger penalties than Class B. A penalty can include a monetary fine or a prison sentence.

1. **Class A** includes: heroin, cocaine, crack, ecstasy, metamphetamine, LSD, methadone, magic mushrooms (containing ester of psilocin), and any Class B substance which is injected.
2. **Class B** includes: amphetamines (not metamphetamine), barbiturates, cannabis, codeine, ketamine, and all cathinone derivatives (such as mephedrone and methadrone).
3. **Class C** includes: anabolic steroids, minor tranquillisers, GBL, GHB and khat.

Novel Psychoactive Substances (NPS)¹¹

This is the correct term for a group of substances which are more commonly called 'legal highs'. They are synthetic drugs which are manufactured to replicate the effects of illegal substances. There are four main categories of NPS – cannabinoids, stimulants, tranquillisers and hallucinogens. NPS are usually bought online or in 'headshops'. They emerged on to the UK drug scene in around 2008-2009 and since then have become increasingly popular but also associated with a range of problems, usually because people simply do not know what they are taking.

It is been incredibly hard for UK law (particularly the Misuse of Drugs Act) to keep up with this new group of drugs. No sooner were new substances added to the Act then a minor tweak to the chemical formula resulted in the manufacture of a new substance which was not illegal. To respond to this problem, and the growing prevalence of NPS, the Psychoactive Substances Act came in to effect in January 2016. So, it is now a criminal offence (maximum penalty of 7 years in prison) to produce, supply, possess, import or export any substance (with some exclusions such as legitimate substances like food, alcohol, tobacco, nicotine, caffeine and medical products) which produces a psychoactive effect.

Using Drugs

Of course, it is best not to use illegal drugs at all. However, if someone is going to use drugs then, there are some guidelines to minimise some of the risks associated with taking illegal drugs.

***Mixing drugs:** It is always more risky to mix different drugs. If a person does mix drugs, it is less harmful to mix drugs from within the same group (e.g. a combination of opiates or a combination of depressants). However, taking too many drugs within the same group can be extremely dangerous, for example taking too many depressants can lead to the heart stopping or cause unconsciousness.

¹⁰ Information taken from <http://www.drugwise.org.uk/what-are-the-uk-drug-laws/> - more detail is available at this page.

¹¹ For more detail, and to keep up-to-date with this area, see www.drugwise.org.uk

***Injecting drugs:** This is a particularly risky way to take drugs. Injecting can lead to serious illnesses and conditions including blood clots, blockages at the injecting site and blood-borne viruses. Hepatitis C can be transmitted by sharing injecting equipment such as needles, water, spoons and filters. The drug reaches the brain much quicker when smoked but injecting means that all the drug is taken at once and this is far more dangerous. If a person continues to inject, tell them to get clean needles and syringes free from a needle and syringe exchange (found in most pharmacies). They will need to use their own clean water, spoons and filters.

***Hepatitis C and HIV:** These are particular problems associated with injecting illegal drugs and some of the risky behaviours associated with this, such as sharing injecting equipment or having unprotected sex. People who inject drugs should not give blood or breastfeed because of the disease risks. The local hospital or Genito Urinal Medicine (GUM) Clinic will test for these and other diseases.

Naloxone

Naloxone is a drug which is a licensed medicine and which, if administered quickly to someone who has overdosed from heroin, can temporarily reverse the effects and stop that person from dying (although other measures must still be taken such as putting the person in to the recovery position and calling the emergency services). There is growing evidence of the effectiveness of naloxone in reversing overdoses and hence reducing mortality in this group of drug users. As a result, as of 2016, there are take home naloxone programmes in Scotland, Wales and Northern Ireland. In England in 2014 the Department of Health accepted recommendations made by the Advisory Council on the Misuse of Drugs that naloxone should be made more widely available, and legislative change in 2015 now means that naloxone is being made more readily available across England (for example, it does not require a prescription). Guidelines are also available from, for example, Public Health England (PHE) and the World Health Organisation (WHO) to support such initiatives.

Families and carers are one of the groups who can have access to naloxone (and associated training in how to administer it and respond to someone who has overdosed). Your organisation may have access to naloxone and staff who are trained to show others how to use it. You may want to check out what the situation is about the provision of naloxone in your area. If appropriate, this may be something to discuss with any family members who you are working with, as they may wish to complete training and have a supply of 'take home' naloxone available to them.

There are a range of places where you can find out more about naloxone, and also to check that the information summarised here is up-to-date. For example, Drugwise, the Naloxone Action Group (<https://nagengland.wordpress.com>), and the Scottish Drugs Forum (www.naloxone.org.uk).

Appendix 7: More detailed examples of coping behaviours described by family members in the course of our research

Family members' views for and against different ways of coping with a relative's alcohol or drug misuser (FM = Family Member; R = Relative)

Specific response (category)	For	Against
Resigned, accepting (Withdrawal)	<p>May be more realistic than some other ways of coping</p> <p>May help FM become more independent</p>	<p>FM may continue to feel very unhappy with circumstances</p> <p>FM may feel nothing is being done to change the situation</p>
Sacrificing, compromising (Tolerant)	<p>Arguments are avoided and life at home may seem less stressful</p> <p>It may help create a trouble-free atmosphere for the rest of the family</p>	<p>FM may feel R is taking advantage</p> <p>FM may feel the problem is simply being kept going and not confronted</p>
Supporting the relative (Engaged)	<p>Makes FM feel that R is not being rejected</p> <p>Maybe more effective in helping R change than direct attempts at controlling drinking or drug taking</p>	<p>If R does not respond FM may feel it is a waste of time</p> <p>FM finds it difficult to know when being supportive becomes over-protective or over-tolerant</p>
Standing up to the substance misuse by confronting, being emotional (Engaged)	<p>FM is acting naturally and expressing real feelings</p> <p>It may at least temporarily relieve FM's feelings of tension and anger</p>	<p>May annoy R and contribute to escalating arguments and fights</p> <p>May upset other members of the family particularly children</p> <p>R doesn't listen to FM's arguments, and it leaves FM feeling guilty</p>
Standing up to the substance misuse by refusing, resisting and being assertive (Engaged)	<p>Gives FM the feeling that the situation is not simply being accepted and FM is not being pushed around</p> <p>May be more effective in helping R change than trying to control drinking or drug taking directly</p>	<p>R may not respond favourably</p> <p>Runs the risk of alienating R or of losing R altogether</p>
Standing up to the substance misuse by controlling, protecting self and family (Engaged)	<p>Helps FM feel something positive is being done</p> <p>May help FM feel there is some hope for change</p>	<p>May make R feel resentful and may not be effective in controlling R's drinking or drug taking</p>

Specific response (category)	For	Against
		It maybe very stressful trying to control R's behaviour, and very frustrating when attempts to control drinking or drug taking don't work
Avoiding, escaping (Withdrawal)	<p>May help FM feel less stressed</p> <p>May help FM feel more in control</p>	<p>May make R feel rejected and isolated</p> <p>Instead of helping R it could make matters worse</p> <p>It can contribute to a feeling of lack of family cohesion</p>
Not worrying, gaining independence (Withdrawal)	<p>May be helpful to FM in dealing with stress</p> <p>May prevent FM becoming over-involved in worrying about or trying to change R's drinking or drug taking</p>	<p>FM may feel that R is being excluded or rejected</p> <p>FM may feel that not all is being done to try to help R change</p>

Appendix 8: How to respond when the alcohol/drug using relative comes forward for help

If you are not already seeing the problem alcohol/drug using relative and they come forward requesting help, you will obviously need to follow the normal procedures of your service. This short section outlines a few brief points to bear in mind should you or your service work with both user and family member. You may well be familiar with most of the information contained within this section.

1. Remember that the family member with whom you have been working with is your client and ensure that this remains so, i.e. do not abandon her/him now that the user has come forward for help. You are likely to find that often and for understandable reasons, the family member will feel relief if the user comes for help and this family member might be tempted to drop out from the contact with you in order to make room for your interaction with the problem user. You need to remember, however, that the fact that the user has come forward constitutes the first step and that the needs of the user may need to be met elsewhere. In addition, the situation may not change for some time and it is important that the door remains open for the family member with whom you have been working.
2. Even if the user reduces his or her consumption, or stops altogether, this does not automatically mean that the situation at home will improve. The family will have other issues to deal with and it is important that you are still able to offer help to the family.
3. The fact that the user has come forward should be seen as very positively. This ought to be communicated to all family members and the user in a clear and supportive way.
4. As far as possible, encourage open communication between family member and user.
5. Be aware of other sources of help and referral procedures and if necessary refer on for further help promptly.

Remember:

- Keep focused and know what you want to gain from the meeting.
- Arrange a further meeting if necessary.
- Do not feel that you have to come up with all the answers.
- Give yourself time to think and discuss the case with members of the project.

Appendix 9: National agencies and helplines

This handbook has been prepared for practitioners based in the UK, and hence most of the organisations listed below are UK-based. There are versions of the handbook used for training practitioners in the Republic of Ireland, Hong Kong, Goa (India), and other countries, and these have lists of organisations which are relevant to those countries.

There are a large number of organisations, websites and other resources which could provide further help for the family member in relation to the issues covered in this handbook. We are not able to give details of all of these organisations/websites but the following pages provide details of some of the key agencies across the United Kingdom which may be able to offer help and information¹². The majority of the organisations listed are national. Some may suggest local services, but a piece of work for you and your team/organisation after having completed the 5-Step Method training should be to build up a clear picture of what services are available locally for families. Some of the websites and organisations will give details of how you can find them on social networking sites such as Facebook or Twitter.

There are a number of excellent websites which provide information and advice on alcohol and drugs.

- Adfam: www.adfam.org.uk/find_a_local_support_group A list of useful organisations to help families.
- Alcohol Concern: www.alcoholconcern.org.uk The national charity working to reduce alcohol harm in the UK. *(due to merge with Alcohol Research UK in April 2017)*
- Alcohol Learning Centre: www.alcohollearningcentre.org.uk Providing online resources and learning for commissioners, planners and practitioners working to reduce alcohol-related harm.
- Drinkaware: www.drinkaware.co.uk Independent alcohol advice, information and tools to help people make better choices about their drinking.
- Drugwise: www.drugwise.org Providing evidence based information on drugs, alcohol and tobacco.
- Frank: www.talktofrank.com A to Z list of substances explains appearance and use, effects, chances of getting hooked, health risks and UK law.
- NHS Choices: www.nhs.choices.co.uk The UK's biggest health website.

¹² At the time of publication all details contained in this section were up-to-date.

Help for Families and Carers

Organisation	Description	Contact
Services in England/UK		
Adfam	National organisation working in a range of ways to support families. Includes details of groups and services for families across England.	http://www.adfam.org.uk Tel: 020 7553 7640
Al-Anon Family Groups	International organisation which supports families dealing with alcohol misuse. Runs support groups across the UK.	http://www.al-anonuk.org.uk Tel: 020 7403 0888
Carers Trust	National organisation which aims to offer action, advice and support for carers across the UK.	http://www.carers.org Tel: 0844 800 4361
Carers UK	National organisation which supports carers – run by carers for carers.	http://www.carersuk.org Tel: 020 7378 4999
Cruse Bereavement Care See also Cruse Bereavement Care Scotland	Leading national charity for bereaved people in England, Wales and Northern Ireland. There is a page on their website about bereavement through alcohol/drugs. See also www.bath.ac.uk/cdas	http://www.cruse.org.uk Tel: 0808 808 1677 http://www.crusescotland.org.uk Tel: 0845 600 2227
DrugFam	National organisation supporting families and others affected by drug misuse. Includes a range of support for those bereaved through substance use.	http://www.drugfam.co.uk Tel: 0300 888 3853
Families Anonymous	International organisation which supports families dealing with drug misuse. Runs support groups across the country.	http://www.famanon.org.uk Tel: 0845 1200 660 (helpline)
Family Lives	A national charity which offers helps and support about all aspects of family life. Action for Prisoners and Offenders' Families is now part of Family Lives.	http://www.familylives.org.uk Tel: 0808 800 2222 (helpline) Tel: 0808 808 2003 (National Offenders' Families Helpline)
Grandparents Plus (now incorporates the Grandparents Association)	National organisation which support grandparents and the wider family, including when they take on the care of grandchildren.	http://www.grandparentsplus.org.uk Tel: 0300 123 7015
Icarus Trust	A range of supports across the UK for families affected by addiction. Includes a network of Family Friends who are trained to provide support.	http://www.icarustrust.co.uk
Relate	The UKs largest provider of relationship support.	http://www.relate.org.uk Tel: 0300 100 1234
Services in Northern Ireland		
ASCERT	Provides services across Northern Ireland for those affected by alcohol/drug problems, including families, young people and children.	http://www.ascert.biz Tel: 028 9260 4422 or 0800 2545 (Head Office)
Services in Scotland		
SFAD (Scottish Families Affected by Drugs)	National organisation working in a range of ways to support families. Website includes details of other services across Scotland.	http://www.sfad.org.uk Tel: 0808 010 1011
Parentline Scotland	A free helpline, and other resources, for parents in Scotland who are concerned about children.	http://www.children1st.org.uk/parentline-scotland Tel: 08000 28 22 33

Help for Children and Young People

Organisation	Description	Contact
Alateen	Part of Al-anon- a national organisation which supports teenage relatives & friends of those with alcohol problems.	http://www.al-anonuk.org.uk/public/what-alateen Tel: 020 7403 0888
Carers Trust – support for young carers	Offers a range of advice and information to young carers about all sorts of issues. Helps young people find out about young carers projects in their area.	https://carers.org/about-us/about-young-carers
ChildLine	Free & confidential helpline for children & young adults in the UK. Also runs other forms of online support.	http://www.childline.org.uk Tel: 0800 1111
COAP (Children of Addicted Parents and People) Now part of Nacoa (see below)	Website for young people. Includes online forums, message boards and online counselling.	http://www.coap.org.uk
NACOA	National Association for the Children of Alcoholics. Provides information, advice & support for anyone affected by parental drinking.	http://www.nacoa.org.uk Tel: 0800 358 3456
Ormiston Trust	National charity to support the lives of children and young people.	http://www.ormistontrust.org
Steps to Cope	An adapted version of the adult 5-Step Method for children and young people. Primarily available in Northern Ireland but keep an eye on the website for developments.	http://www.stepstocope.co.uk

Help about Domestic Violence and Abuse Issues

Organisation	Description	Contact
Against Violence and Abuse (AVA) Project	Leading UK charity which aims to end violence to women and girls.	http://www.avaproject.org.uk
National Centre for Domestic Violence	Emergency injunction support for anyone regardless of financial circumstances, race, gender or sexual orientation.	http://www.ncdv.org.uk Tel: 0800 970 2070
NSPCC	Offers advice and information on domestic abuse and taking care of children.	http://www.nspcc.org.uk
Refuge	For women & children affected by domestic violence, Refuge runs a network of safe houses for those who need emergency accommodation.	http://www.refuge.org.uk Tel: 0808 2000 247

Organisation	Description	Contact
Respect	A UK organisation which runs perpetrator programmes and other services and also support for the male victims of violence and abuse.	http://www.respect.uk.net Respect phoneline: 0808 802 4040 Men's advice line: 0808 801 0327
The Hideout	Website developed by Women's Aid for young people living with domestic abuse.	http://www.thehideout.org.uk
The Samaritans	Confidential emotional support for people who are experiencing feelings of distress or despair including those which may lead to suicide. Includes free 24 hr helpline.	http://www.samaritans.org Tel: 116 123 (UK)
Women's Aid	Main national organisation supporting victims of domestic violence. Provides a wide range of information and services. Includes free 24hr confidential DV helpline and services for children.	http://www.womensaid.org.uk Tel: 0808 2000 247

Help about Problem Gambling

Organisation	Description	Contact
GamCare	National UK charity offering telephone counselling and face-to-face counselling in a number of locations around the country, including help for affected family members; as well as advice for professionals.	http://www.gamcare.org.uk Tel: 0808 8020 133
National Problem Gambling Clinic, London	A specialist NHS clinic serving the whole of the UK, including help for affected family members.	http://www.cnwl.nhs.uk/cnwl-national-problem-gambling-clinic Tel: 020 7381 7722

Appendix 10: Further Reading

There are a lot of reading materials on the subject of addiction, and on the ways in which families can be affected. It is not possible to give a comprehensive list here, but details are given in the following pages of things that you might find most helpful, most of which should be quite widely available. Bookshops, libraries or online retailers such as Amazon should be able to give you more details of these and other reading materials.

How alcohol and drug misuse can affect families

This list contains both academic texts and books which have been written by family members as a result of their experiences.

1. Barnard M (2007). *Drug Addiction and Families*. Jessica Kingsley.
2. Burton-Phillips E (2007). *Mum, can you lend me twenty quid*. Portrait Books.
3. Gorin S (2004). *Understanding what children say: children's experiences of domestic violence, parental substance misuse and parental health problems*. NSPCC and National Children's Bureau.
4. Harris P (2010). *The Concerned Other: How to Change Problematic Drug and Alcohol Users Through Their Family Members: A Complete Manual*. Russell House Publishing Ltd. (note that Part 1 of this manual, which covers the academic literature, is available separately).
5. Kroll B & Taylor A (2003). *Parental Substance Misuse and Child Welfare*. Jessica Kingsley Publishers.
6. Lawson S (1995). *Everything Parents Should Know About Drugs*. Sheldon Press.
7. Mullender A et al. (2002). *Children's Perspectives on Domestic Violence*. Sage Publications.
8. Orford J (2011). *Addiction Dilemmas: Family Experiences from Literature and Research and Their Lessons for Practice*. Wiley Blackwell.
9. Orford J et al. (2005). *Coping with Alcohol and Drug Problems: The Experiences of Family Members in Three Contrasting Cultures*. Routledge.
10. Trimmingham T (2009). *Not My Family, Never My Child: What do to if someone you love is a drug user*. Allen & Unwin.
11. Velleman R, Copello A & Maslin J (1998, reissued 2007). *Living with Drink: Women who live with problem drinkers*. Longman.
12. Velleman R & Orford J (1999). *Risk and Resilience: Adults who were the Children of Problem Drinkers*. Harwood Academic.
13. Ward M (2003, 2nd Edition). *Caring for someone with an alcohol problem*. Age Concern Books.
14. Yelland D (2010). *The Truth About Leo*. Penguin Books.

Addiction

1. Barber J (2002, 2nd Edition). *Social Work with Addictions*. Palgrave Macmillan (Practical Social Work Series).
2. Barry K, Oslin D & Blow F (2001). *Alcohol Problems in Older Adults: Prevention and Management*. Springer.
3. Booth Davies J (1997, 2nd Edition). *The Myth of Addiction*. Harwood Academic.
4. Bowden-Jones O (2016). *The Drug Conversation: How to talk to your children about drugs*. Royal College of Psychiatrists.
5. Chick J (2006, 2nd Edition). *Understanding Alcohol and Drinking Problems*. Family Doctor Publications Ltd.
6. Galvani S (2011). *Supporting People with Alcohol and Drug Problems: Making a Difference (Social Work in Practice)*. Policy Press.

7. Gossop M (2007, 6th Edition). *Living with Drugs*. Ashgate Publishing Limited.
8. Heather N & Robertson I (1997, 3rd Edition). *Problem Drinking: the New Approach*. Oxford University Press.
9. Heyman G (2009). *Addiction: A Disorder of Choice*. Harvard University Press.
10. Orford J (2001, 2nd Edition). *Excessive Appetites: A Psychological View of Addictions*. John Wiley & Sons.
11. Orford J (2013). *Power, Powerlessness and Addiction*. Cambridge University Press.
12. Petersen T & McBride A (2002). *Working with Substance Misusers: A Guide to Theory and Practice*. Routledge.
13. Shapiro H (2010, 14th Edition). *The Essential Guide to Drugs and Alcohol*. Drugscope.
14. Spada M (2006). *Overcoming Problem Drinking*. Robinson Publishing.
15. Stewart T (1996). *Heroin Users*. Pandora.
16. Tirbutt E & Tirbutt H (2008). *Beat the Booze: A Comprehensive Guide to Combating Drink Problems in All Walks of Life*. Harriman House Publishing.
17. Velleman R (2011, 3rd Edition). *Counselling for Alcohol Problems. (Counselling in Practice Series)*. Sage Publications Limited.
18. West R (2006). *Theory of Addiction*. Addiction Press (Blackwell Publishing).
19. Tyler A (1995, 2nd Edition). *Street Drugs: The facts explained, The myths exploded*. Coronet.

The 5-Step Method

All of the published material about the 5-Step Method is in academic papers, in books or journals. These publications are less widely available, but they should be accessible via many public or academic libraries (e.g. at colleges or Universities). You will have been given some of these papers as part of your 5-Step Method training. The list below summarises some of the main publications about the 5-Step Method. A more comprehensive list can be found on the AFINet website.

1. ADF Group: Copello A, Ibanga A, Orford J, Templeton L & Velleman R (2010). The 5-Step Method: A Research Based Programme of Work to Help Family Members Affected by a Relative's Alcohol or Drug Misuse. A Special Supplement of the academic Journal *Drugs: Education, Prevention and Policy*; Volume 17, Supplement 1, pages 1-210.

This special supplement was issued at the end of 2010, given over entirely to the *stress-strain-coping-support* model and the 5-Step method. The papers in it provide a good overview of the 5-Step Method and its research background.

In addition, there are the following publications

1. Copello A, Templeton L, Orford J, Velleman R, Patel A, Moore L, MacLeod J & Godfrey C (2009). The relative efficacy of two levels of a primary care intervention for family members affected by the addiction problem of a close relative: a randomised trial. *Addiction*, 104(1), 49-58.
2. Orford J, Velleman R, Natera G, Templeton L & Copello A (2013). Addiction in the family is a major but neglected contributor to the global burden of adult ill-health. *Social Science & Medicine*, 78, 70-77.
3. Orford J, Templeton L, Copello A, Velleman R, Ibanga A & Binnie C (2009). Increasing the involvement of family members in alcohol and drug treatment services: the results of an action research project in two specialist agencies. *Drugs: Education, Prevention and Policy*, 16(5), 379-408.
4. Orford J, Templeton L, Patel A, Copello A & Velleman R (2007). Qualitative study of a controlled family intervention trial in primary care: I The views of family members. *Drugs: Education, Prevention and Policy*, 14(1), 29-47.
5. Orford J, Templeton L, Patel A, Velleman R & Copello A (2007). Qualitative study of a controlled family intervention trial in primary care: II The views of primary health care professionals. *Drugs: Education, Prevention and Policy*, 14(2), 117-135.

6. Templeton L & Sipler E (2014). Helping children with the *Steps to Cope* intervention. *Drugs and Alcohol Today*, 14(3), 126-136.
7. Templeton L, Zohhadi S & Velleman R (2007). Working with Family Members in Specialist Drug and Alcohol Services: Findings from a Feasibility Study. *Drugs: Education, Prevention and Policy*, 14(2), 137-150.
8. Velleman R, Orford J, Templeton L, Copello A, Patel A, Moore L, Macleod J & Godfrey C (2011). 12-month follow-up after brief interventions in primary care for family members affected by the substance misuse problem of a close relative. *Addiction Research & Theory*, 19(4), 362-374.

How gambling can affect families

This list again contains both academic texts and books which have been written by family members as a result of their experiences.

Gambling

1. Velleman R, Cousins J & Orford J (2015). Effects of gambling on the family. In: H Bowden-Jones & S George (eds.), *A Clinician's Guide to Working with Problem Gamblers*, London: Routledge, 90-103.
2. George S & and Bowden-Jones H (2015) Family interventions in gambling. In: H Bowden-Jones & S George (eds.), *A Clinician's Guide to Working with Problem Gamblers*, London: Routledge, 163-171.
3. Krishnan M & Orford J (2002) Gambling and the family from the stress-coping-support perspective. *International Gambling Studies*, 2, 61–83.
4. Suomi A, Jackson A, Dowling N, Lavis T, Patford J, Thomas S, Harvey P, Abbott M, Bellringer M, Koziol-McLain J & Cockman S (2013) Problem gambling and family violence: family member reports of prevalence, family impacts and family coping. *Asian Journal of Gambling Issues and Public Health* 3 (13), 1-15.
5. Dowling N, Suomi A, Jackson A, Lavis T, Patford J, Cockman S, Thomas S, Bellringer M, Koziol-McLain J, Battersby M, Harvey P & Abbott M (2016) Problem gambling and intimate partner violence - a systematic review and meta-analysis. *Trauma, Violence, Abuse*, 17 (1), 43-61

Domestic Abuse

The following list summarises some materials which are freely available to access and download via the Internet. The resources section of the AVA (Against Violence and Abuse) Project may also be of relevance.

1. Living with domestic violence and substance use. Written by Sarah Galvani (2010). Available through Adfam. http://www.adfam.org.uk/docs/livingwith_dv.pdf
2. The Survivor's Handbook (available in many languages) <https://www.womensaid.org.uk/the-survivors-handbook/>