

An evaluation of the Moving Parents and Children Together (M-PACT) Programme, delivered by Ethnic Alcohol Counselling Hounslow (EACH)

Introduction

Families can be severely affected by the substance misuse of a relative, whether through alcohol or drug misuse. Within the family this can lead to disruption in family life, family routines, relationships, parenting and communication. Children can have a particularly hard time, losing confidence and self-esteem and finding it hard to trust others. However, there is growing evidence that some family members, including children, can demonstrate resilience to the problems that they are facing. There is also evidence that supporting those family members affected by the substance misuse of a relative can have positive outcomes for all in the family; yet there are few examples of services that work with parents and children/young people.

Ethnic and cultural perspectives

It is recognised that adults living in Black and minority Ethnic (BME) communities with alcohol addiction experience additional issues to those non-BME adults. Specific issues linked to the BME community are discussed below:

- Often the 1st generation are more difficult to engage with when it comes to accessing services. They may require a dialogue or language that communicates a normalising of their experience and understanding of the cultural barriers that may get in the way of seeking help (e.g. shame, values, and beliefs) or accepting that there is a problem. These challenges present stronger within the 1st generation compared to the 2nd generation who may be somewhat more integrated in western society.
- A higher degree of denial as a result of the 'taboo' and in particular within Muslim communities.
- There appears to be a stronger pattern, particularly in Asian communities, where clients are being sent by family members to seek treatment. The work presents an interesting challenge in these cases where clients focus on the needs of the family at the expense of their own needs. The behaviour in this community is consistent throughout all of the differing cultural contexts of this BME group.
- There appears to be a general lack of understanding of addiction but appears to be stronger in BME communities (especially some Asian communities e.g. Tamil, Pakistani, Somali)
- African Caribbean and Black communities may come with 'baggage' that has been carried around with them through the generations – the different historical experiences of oppression and subjugation etc. We need to be mindful of both internal and external pressures in the individual that may interfere with the working alliance or engagement in treatment when faced with a Caucasian or even Asian counsellor
- In some communities there remains a lack of understanding of therapy/support and what these services can offer.

The scale of the problem

It is estimated that there are 3.5 million children affected by parental alcohol misuse and 1 million by parental drug misuse in the United Kingdom. Until more recently there have been very few services for chil-

dren and their families in the UK to respond to the risks and harms they are likely to experience. The need to address this was highlighted with the publication of Hidden Harm.¹ The report highlighted the number of children in the UK affected; the harm this can have on their health and well-being, what support is already in existence for this group, and what else can be done. There were a total of 48 recommendations cutting across a broad range of service areas (statutory, voluntary etc). A further report looking at what developments there had been three years on was published in 2007. This report looked at what progress had been made in implementing the 48 recommendations across the UK, to provide examples of practice initiatives that could be developed in other areas and to identify the needs of the workforce in the future to strengthen ongoing implementation of those 48 recommendations.

The M-PACT programme

Moving Parents and Children Together (M-PACT) is a brief intervention to help children aged 8-17 whose parents have drug and/or alcohol problems. Children, young people and their parents or adults (who have loco-parentis responsibility for the child) work together in a friendly safe environment with a team of four highly skilled professional facilitators who help them find ways to achieve improvements in family life to the benefit of the family as a whole. Each family attends a thorough assessment to ascertain if they are able to participate safely and meaningfully. Parents whose addiction is active may attend, as may non-using parents who are or have been involved with addicted spouses or partners.

The programme itself is delivered over 8 consecutive weekly meetings with each session lasting 2.5 hours. During this time, children and parents will work both separately, together and as family units. Each week a different theme/topic is covered: (Introductions, understanding addiction, communication, self esteem, feelings, first aid kit/family toolbox, Endings) and has been identified at the beginning of the programme. The participants, including the children help to decide the focus of each week; the structure of the programme, allows for this flexibility. After the final weekly meeting each family is seen individually in order to review their situation and needs and a continuing care plan is formalised. After a further 12 weeks, all the families return for a 'Reunion' allowing the group to reconnect and share experiences of the last 12 weeks, but also to identify what additional help and support they require.

The Project

This report describes the findings from the Moving Parents and Children Together (M-PACT) programme which was delivered by Ethnic Alcohol Counselling Hounslow (EACH) in 2011. The purpose of the project was to build capacity within EACH to respond effectively to 'alcohol related' hidden harm. The training equipped staff with the knowledge, skills and confidence to deliver the M-PACT programme to families in a culturally diverse community in West London. Action on Addiction also benefitted, by improving their understanding of how to apply and adapt M-PACT to ethnically and culturally diverse populations. This led to modifications and enhancements of the programme manual. The manual is the training tool that practitioners take away with them on completion of the training to assist them with programme delivery.

M-PACT was delivered between February and August 2011. The programme involved 16 individuals, including 8 children (5 girls and 3 boys) and 8 adults (6 female and 2 males) across a range of minority ethnic

¹ Hidden Harm was first published in 2003 by the Advisory Council on the Misuse of Drugs Act (ACMD) to investigate the impact parental drug misuse has on children's lives.

groups, including white/other, Asian or Asian British, Black or Black British, or Mixed. Families were referred internally from within EACH, the statutory drug service and social services. Alcohol was the primary substance misused in all cases. After the first session, two families dropped out, resulting in four families completing the programme.

Methodology

Four professional practitioners (Family Counsellor, Counsellors and Counselling Psychologist) from EACH were selected to receive M-PACT training to enable them to deliver the M-PACT programme within EACH. The training was delivered over five consecutive days by University of Bath accredited tutors. The training content included:

- Understanding the impact that parental substance misuse has on the family, children and young people
- Reviewing the current legislation and guidance underpinning work in this area
- Developing participants knowledge of how the M-PACT programme can provide help and support to both adults, children and young people
- Providing participants with the knowledge, skills and understanding to deliver M-PACT in their own organisations
- Ensuring participants are aware of the challenges they might face when working with families affected by substance misuse

After the training a written report was completed, addressing how the student would integrate and deliver the learning into their workplace. At the end of the training participants had the requisite knowledge, skills and understanding to effectively deliver an M-PACT programme within their workplace to a variety of families.

All participants gave informed consent to take part in the evaluation, with the completion of questionnaires on three occasions; Session 1, Session 8 and the reunion. For this programme, questionnaires were completed by six participants (four children and two adults) at Session 1, five participants at Session 8 (one child and four adults), and six participants at the reunion (three children and three adults). The questionnaires include two standardised questionnaires and two brief questionnaires designed specifically for M-PACT, summarised as follows:

Family Environment Scale (FES) is a standardised measure which consists of 27 statements related to family life; the respondent ticks whether the statement is mostly true or false for their family. The FES assesses three main dimensions of family life, namely cohesion, communication and conflict. The FES is completed on all three occasions.

Strengths and Difficulties Questionnaire (SDQ) is a well established psychiatric screening tool which has been adopted nationally by Child Adolescent Mental Health Services (CAMHS) as a core outcome measure. The SDQ can be completed by young people, or by an adult about the young person. There are five dimensions to the SDQ: emotional problems, conduct problems, hyperactivity, peer problems and prosocial behaviour. The score for each dimension, as well as the total score, indicates whether the level of behaviour is normal, borderline or abnormal. The SDQ is completed on all three occasions.

A questionnaire which asks the participant to rate various elements of the M-PACT programme is completed at Session 8. A questionnaire which asks the participant to indicate to what extent they think the programme has facilitated change in specific areas of family life affected by substance misuse is completed at Session 8 and at the reunion.

Qualitative data were collected from participants after the programme. The researcher and the Chief Executive of EACH ran two focus group discussions shortly after the final session of the programme (on the same day that families had their review session). One group involved four children and the other involved five adults. The discussions focused on three areas: What did you like/not like about M-PACT? How has M-PACT helped you and your family? and What are your thoughts on how M-PACT could be improved? participants gave feedback using flip-chart paper, post-it notes and a group discussion. At the same time the children were asked if they would like to take part in a drawing exercise with the researcher². This exercise was completed individually with three children (one of whom did not want their drawings to be shared). At the reunion session individual face-to-face interviews were completed with five participants (two children and three adults, all of whom had also been involved in the earlier group discussions)³.

Qualitative data were collected from the facilitators after the programme during a group telephone call which lasted about one hour. Some additional qualitative data were collected from opportunistic conversations with some participants when they were attending for their review session and from comments given on completed questionnaires.

Findings

The families who attended M-PACT were from diverse backgrounds and primarily from second generation BME communities or mixed race. This concurs with the opening findings of engagement. The client group in this programme was more integrated into western culture and all had previously engaged in therapy at some level whether this was group or individual work. The facilitators also came from diverse cultural backgrounds and different therapeutic orientations which enhanced the therapeutic work and element of the programme. While there were differences in members presentation these were subtle, and did not raise any specific issues. Had there been a family from the first generation and/or someone who had no experience of therapy, this would have presented the team with challenges, specifically in terms of language, beliefs about speaking openly in front of children or sharing in general. This group worked well together. There appeared to be both a conscious and more unconscious level of respect and understanding of cultural differences and similarities.

Programme Aims

M-PACT was developed to support children and young people, to help them realise that they have not been forgotten, that someone recognises the problems they face and that it is ok to ask for help. Aims and

² Briefly, a young person is asked to draw two pictures; the first to show how things were for them before they did the M-PACT programme and the other to show how things are for them now. The young person then describes their pictures to the researcher, and the young person and researcher agree what to write on the paper to describe the pictures. See Wall & Templeton 2010, and Hamama & Ronen 2009, for more information.

³ These interviews took place at a 10-pin bowling alley and were not recorded because of the noise at the location.

objectives of the programme are listed below:

- To support children and young people whose parents misuse (or have misused) drugs and/or alcohol, reducing the negative impact substance misuse has on children and young people and the family.
- To raise parents' awareness about the impact that their misuse has on the whole family.
- To offer the opportunity for change that is unlikely without external help.
- To improve communication within the family.
- To strengthen protective and resilience factors.
- To provide education around substance misuse.
- To increase the range of coping strategies and to raise self esteem.
- To identify additional needs of both parents, children and young people and guide them towards further help.

Initial Findings

The findings from M-PACT delivery by EACH have continued to confirm that participants benefit in a range of ways, qualitative data suggesting that families benefit by:

- Understanding addiction and its impact on families
- Learning how to communicate about addiction
- Meeting and talking to others living in similar situations
- Improving communication and relationships in the family
- Children expressing themselves and being heard
- Adults hearing what children had to say

These key emerging themes are now discussed further with anecdotal evidence from participants. It is important to point out, that within the initial findings are all of the programme aims and objectives.

1. The opportunity to meet other people.

Many participants were able to state how much they valued being given the opportunity to meet others in the same situation as them. The use of the venue in providing a safe and non-judgemental environment proved very powerful and enabled all family members present to discuss some of the issues and difficulties they were experiencing.

'It's nice to go somewhere and not be judged....you don't have to be scared to ask for help'

'It was a safe place to express our feelings and listen to others in our family'



2. Involving children

The comments from the adults indicated that they specifically benefited from the involvement of children in the programme, through the children being able to express themselves, and the parents hearing what the children had to say. Many of the adults commented that a key reason for them agreeing to attend M-PACT was that it involved their children and brought an opportunity for a family to seek help as a unit. Some parents stated that they had received other support for their substance misuse, but that M-PACT brought an added dimension to 'treatment' because it directly involved children.

The facilitators also commented that M-PACT gave the children a voice. Moreover, the facilitators also felt that it was important for the children to understand that the addiction was not their fault.

'Thank you. It was a safe place to express and understand the impact of our abuse, being able to speak openly, and take children's feelings into account and make changes'

There was also an understanding from some of the participants that M-PACT had helped them better understand how addiction affects others in the family, particularly children.

'I could instantly see the benefits....it was a no-brainer [for us to take part].....we've grown from the experience, I feel really blessed'

3. Other changes and more cohesive families

Overall, the families and the facilitators felt that all relationships in the family had improved and that there was more cohesiveness.

'[M-PACT] reminded us what life's like.....it brought us closer as a family....I'm really grateful'

'...[they] left with a much closer sense of family'

4. Improved Communication and greater understanding

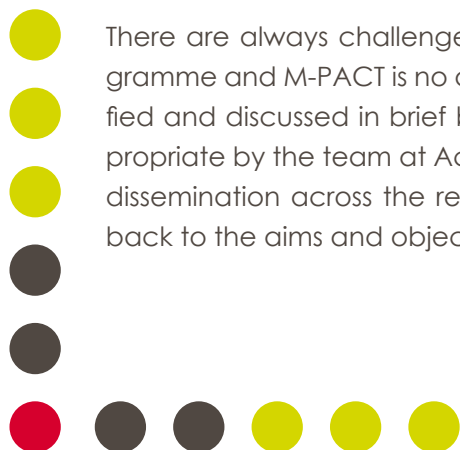
Families talked about how their communication had improved. They were more open in discussing addiction. One family said that there was more openness in talking about the past.

'Our communication has changed....we respect each other....it's much healthier'

'That's what opened my eyes....[my child] did feel it.....it humbled me to realise that I wasn't there emotionally'

Future Development

There are always challenges and potential development opportunities when implementing a new programme and M-PACT is no different. The challenges associated with this particular programme are identified and discussed in brief below. These will now need to be discussed and worked through where appropriate by the team at Action on Addiction, incorporating and updating the M-PACT manual to ensure dissemination across the rest of the M-PACT (UK) trained practitioners. In some cases these also relate back to the aims and objectives of the programme, which were mentioned earlier:



Engagement of families

There were three issues which were highlighted.

1. The benefit of having support around the 'practical' issues of attending the programme, e.g. (not paying for transport, something that was regarded as extremely valuable).
2. Information provided to the families before the start of the programme, specifically relating to the need for more information on the content to reduce anxiety.
3. Regarding the age of children, this was the first programme delivered to a child under the 'normal' age range, this child was aged 6. The team had to be flexible in the structure to ensure that engagement was possible, but including this child with the whole family was important and there was the opinion that the family had benefited by involving the child in the sessions.

The Programme itself

Comments from practitioners suggested that the training should focus on the actual delivery. Facilitators felt that without dedicated administrative and volunteer support during the course of the programme they would have struggled to have undertaken all the key tasks. Children did express that more activities would be beneficial and that the programme should incorporate more for the families to do together.

Time, additional support and aftercare

The time required to source referrals and engage with families is a common theme emerging in most other programmes across the UK, with referrals taking place in the days immediately before the programme is due to start.

Facilitators also felt that the programme could be delivered over a 12 week period, bringing it in line with other programmes they deliver in their organisation. Family members did however discuss the need for additional support during programme sessions, something they felt would have been a huge benefit for them, as the programme opened up a lot of 'old wounds' they would have liked to discuss and work through, as well as the need to have an after-care package in place post M-PACT. It was suggested that the introduction of a mid-programme review might be helpful, allowing them to offer the additional support, but also, as already discussed, allowing for more flexibility within the programme structure (i.e. more activities).

Working with diversity

Given the experience of the practitioners in working with a range of cultural groups on a daily basis, they found it hard to comment on this topic believing it was managed in a subtle and unconscious way. It was felt that it should not be assumed in other programmes across the UK that facilitators will have the knowledge and experience to work in the same sensitive way with diversity. The M-PACT practitioner network would be one way of offering support to facilitators to strengthen practice. The need to include statements about diversity and the importance of respecting diversity and different views and opinions should be included in the group rules that are established at the beginning of the programme.

It is noted that there will be a need to tailor language that might be more acceptable to BME communities in terms of cultural beliefs and values of what is acceptable. This however is something that would need to be considered across the spectrum of client groups to include gender, race and specific presenting issues.

Conclusion

M-PACT has continued to engage a diverse group of families, and maintain that engagement for eight sessions. The themes emerging are similar to those from other UK delivered M-PACT programmes, there were no specific issues arising or marked differences in how these families benefitted from the programme. Interviews conducted at the reunion provided an insight into how change can be maintained, families reporting that relationships and communication were improved and that addiction was openly discussed. There are areas of learning which help with the ongoing roll-out of M-PACT across the UK.

M-PACT has continued to demonstrate itself as an intervention of benefit to parents, children and families, filling a major gap in service delivery.

Researcher

Lorna Templeton – Independent Research Consultant

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The Final Report

