Evaluation of CASA Family Service

Final Report

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Acknowledgements

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Executive Summary

Section 1 – Setting the Scene

The CASA Family Service (CFS) was set up in 2006 to respond to increasing political concerns over the health and well-being of children of parents with alcohol and other drug problems. Current and previous national drug strategies for England have recognised families as being affected by an individual’s substance use and also having a role to play in supporting individuals to change their substance using behaviours (Home Office 2008, H.M. Government 2010). CASA Family Service has not been formally evaluated to date and it is therefore timely to evaluate the impact of the Service, particularly in the current funding climate where efficiency savings are sought and value for money prioritised within the public sector. In particular CFS seeks to evaluate its work in relation to domestic abuse and multi-agency working and to hear from a range of service users and partner agencies to inform the evaluation.

Section 2 – Methodology

The aims of the evaluation were to:
1. Define and describe the therapeutic model of intervention practised by CFS
2. Evaluate key elements of the model in relation to the existing evidence base.
3. Evaluate the extent to which the model addresses harm relating to substance use
4. Evaluate the extent to which the model addresses the overlapping issues of substance use and domestic abuse.
5. Explore the contribution of multi-agency and partnership working to the practise of the model.

This was achieved in three distinct stages:
- Stage 1 addressed the first two aims of the research through collation and review of agency documentation, interviews with all CFS staff, managers and an external consultant, and a review of the evidence in relation to the key elements of the model.
- Stage 2 addressed aims three and four and involved semi-structured interviews with adults who were attending CFS or had previously attended CFS in the last 12 months, as well as children and young people who currently, or previously, attended the service.
- Stage 3 addressed the aim five. This involved telephone interviews with key agency partners.

Finally, CFS asked the research team to advise them on any relevant outcome measures that could be used in the development of its work.

To analyse the interview data a grounded approach to thematic analysis was used (Strauss 1987). The computer-based qualitative data analysis software NVivo was used in stage 2 and 3 of the evaluation to code the interview data into detailed and then broader themes.

Section 3 – Findings and Discussion

3.1 CASA Family Service Model
The CASA Family Service model comprises two core components:

1. The systems and processes within which the service is delivered
2. The therapeutic service as provided to the families.
The following elements emerged from the data collection as being central to the development of a nurturing and respectful service, suitable for families with substance problems and other complex needs, and supportive of staff working with them:

- **Strong leadership** including a responsive and reflective management style that fosters respect and co working.
- **Recruitment of experienced and qualified personnel** that reflects the skill mix required to work with the service user group.
- **An emphasis on staff support**, from induction to in-house training and development.
- **Good supervision**, including both internal and external supervision that moves beyond reviewing caseloads to broader issues of the service's approach and “thinking space”.
- **Limited caseloads**, allowing for a better quality of service.

The CFS therapeutic model, known as the Child Focused Family Intervention for Substance Misuse (Robinson 2010), underpins CFS’ mission to work with the whole family while prioritising the needs of the child. It comprises four main stages (see appendix 10):

1. **Engagement** – implementing an assertive engagement process designed to establish a positive therapeutic relationship with service users early in the process
2. **Assessment** – adopting an holistic, strengths-based approach with service users and involving close collaborative working with other agencies as appropriate
3. **Intervention** – using a range of methods and approaches including those with a strong evidence base such as motivational interviewing and, where appropriate, cognitive behavioural interventions. The emphasis on building resilience and protective factors for children is also highlighted in the literature as important in supporting children whose parents have alcohol or drug problems.
4. **Disengagement** - reducing the frequency of the sessions, emphasising achievements, discussing longer term goals and offering support when needed, including telephone follow up approximately three months after the family have left the service.

### 3.2 Partner agency interviews

A total of nine staff from partner agencies that work with CASA Family Service took part in structured telephone interviews. The partner agencies held CFS in high regard and were extremely positive about their joint work. Particular strengths highlighted by the interviewees included the service’s approach to practice, the staff’s qualities, knowledge and skills, and the strong management of the staff and service. Other strengths included the importance of the positive working relationship respondents felt they had with CFS, their ability to work together and conduct mutually beneficial case work. Most interviewees believed CASA Family Service to be a unique service compared to other services supporting vulnerable families in the Borough. Although outcomes of multi-agency working were not officially measured, all interviewees believed their joint work led to positive outcomes for their clients, and provided numerous examples of service user success stories. In sum, partner agency staff valued the CASA Family Service and the joint work they carried out together.

### 3.3 Service user interviews

A total of 13 current or former service users of CASA Family Service participated in semi-structured interviews. The service users in general spoke very positively about CASA Family Service and felt the support and service they had received had enabled them to make positive changes which had improved their relationships with their children and other loved ones. The interviewees felt CFS was a very good service, with excellent staff that had created a safe space for them to talk about sensitive issues that, at times, had not been properly heard or addressed by other services. The ability of CFS staff to communicate well was a key feature of the service that they valued. Alcohol use was a major issue for all those interviewed, be it their own or a loved one’s use. Apart from one individual, all had made
steps towards changing their use because of the services they had accessed. Domestic violence in some form was present in all of the interviewees’ lives, and CFS had varying involvement in supporting the clients with it. The two young people interviewed liked the service and the adult service users reported changes for the better in their children’s behaviour. There were some specific areas in which some clients felt CFS could improve, however these overwhelmingly referred to CFS expanding its reach or services. Overall the interviewees said they and their children had benefited from meeting with the service.

Section 4 – Measuring outcomes

CASA Family Service has four clear broad outcomes
1. Reducing substance misuse related harm to children
2. Increasing protective parenting
3. Increasing resilience in children
4. Reducing parental substance misuse

It has recently added a fifth outcome on ‘reducing harm to children and adults from domestic abuse’. The first four outcomes have been broken down into a number of related sub outcomes which reflect the purpose and aims for the service. Currently CFS measures such outcomes qualitatively through discussions with staff, service users and other professionals and records these in progress and clinical supervision notes and review minutes. This information is collated for quarterly reports. However, the process of outcome monitoring could be strengthened further. Clearer evidence indicators for each outcome and improved recording systems could be adopted. Examples are given in the main body of this report.

Outcome measures need to continue to include review with service users (adults and children), staff and partner agency perspectives and include both qualitative and quantitative measures. A stepped approach to reviewing outcomes has been suggested here, however this is a process that is best completed in house and would fit seamlessly into the reflective culture and team discussion currently in place at CFS. There are many outcome measurement tools available, some of which may be suitable for use at CFS in whole or part. These will need exploring for relevance and appropriateness, alongside a consideration of what mechanisms already exist at CFS that could be modified and/or form part of an overall outcome measurement package.

Section 5 – Recommendations and Conclusion

CFS Model and practice
1. Develop a rolling programme of training related to the CFS model to ensure model adherence and to respond to staff queries.
2. Review a range of ways of bringing children into the service at an earlier stage.¹
3. Consider whether a formal, quantitative record of changes in service users’ substance use will add to the measurable evidence base for CFS. This also avoids reliance on documentation from other services as well as reflects the ongoing monitoring by CFS staff that is part and parcel of their work already.
4. Consider whether the formal 12 week reviews using the TOP form are adequate or whether more frequent reviews may be beneficial to both service user and staff in terms of measuring progress in reduction of substance use.

¹ CFS managers had recognised this need in 2010 and in November 2010 changed practice to ensure children attended with their parent/s or carer/s by the second or third session. It is included as a recommendation in this report to accurately reflect the responses of staff. However, it should be noted that staff were interviewed prior to and during this period of review and change and this may therefore not reflect current practice at the time of this final report in 2011.
5. Include routine questions on domestic violence in service user assessment documentation\(^2\). Consider whether a matrix relating to domestic abuse can be developed to complement the existing matrix format.
6. Review follow up processes to determine if more formal ‘booster’ sessions can be incorporated into the CFS model in a bid to support longer term change.
7. Consider whether information sharing arrangements with partner agencies are adequate and whether new ones could and should be developed.
8. Retain the focus on the structure and systems required to deliver the service. In particular the following key elements are at the core of the service delivery: strong leadership, regular and informed supervision, quality staff with appropriate attitudes and skill mix, an open and transparent working culture and reflective working practices.

**Measuring outcomes**

1. Revisit outcomes in order to review:
   a) what evidence indicators are needed alongside each one to demonstrate they are being met,
   b) how they are currently being measured and recorded,
   c) whether quantitative measures or validated tools could add value to evidence of outcomes, and the extent to which they are adequately broken down for measurement purposes.
2. Establish most appropriate time intervals for formal application of outcome measures. These timescales may differ according to what is being measured. Consider the use of likert-type scales for selected outcomes to evidence progress over time.
3. Follow the stepped approach to deciding outcome measures appropriate for CFS. Consider developing outcome measures with partner agencies for joint work.
4. Establish what process and monitoring data is currently recorded for specific CFS outcomes and whether there are any gaps in data collection. Review what outcome measures are available and appropriate for the nature of the work and desired specific outcomes.

\(^2\) This recommendation is based on the CASA documentation received to date.
Section 1 – Setting the scene

1.1 Introduction

Alcohol or other drug use\(^3\) by parents does not automatically lead to concerns over the well-being of children. However there is evidence of the negative impact of parental substance use on children both in utero and after birth, through their youth and teenage years and into adulthood. It can lead to a range of harms including developmental delay, cognitive impairment, disruption in family celebrations or routines, conflict, tensions and violence within family relationships, disruption of roles, poor communication, problematic finances and social isolation (Bancroft et al. 2004, Velleman and Templeton 2007). As a result the outcomes for children living with such negative family environments can result in their own delayed development, intellectual and emotional difficulties or, alternately, premature maturation and caring responsibilities.

The number of children and family members negatively affected by parental alcohol and drug problems is not known. A recent UK study exploring the number of children living with parental substance use suggests that this could be far higher than previous estimates suggest particularly if binge drinking and any illicit drug use are considered. Manning et al. (2009) report that nearly 30% of children under 16 yrs of age could be living with a binge drinking parent, although this reduces to 22% if “hazardous drinking”\(^4\) only is considered. For illicit drug use the figures show that approximately 8% of children live in a household where a parent has used illicit drugs in the past year, reducing to 2.8% of children living with a “dependent drug user” (Manning et al 2009). While these figures do not indicate actual harm, it is clear that the risks to children are likely to increase alongside increasing levels of parental substance use. In addition other family members are also negatively affected by problematic substance use. Some academics have estimated that for every person with a substance problem, two other people are negatively affected (Copello et al. 2000). Such combined estimates suggest that all family members will, at best, be concerned about a loved one’s substance problem and, at worst, be harmed by it.

Evidence also shows a far higher rate of domestic violence and abuse in families affected by the problematic substance use of one or both parents (see Galvani 2010 for an evidence review). Indeed the evidence suggests it is more common than not for domestic violence and abuse to co-exist with problematic substance use. Research evidence and reviews of deaths or serious injury to children have repeatedly shown the overlapping issues of domestic abuse, parental substance use and parental mental ill health as being overlooked by all services involved in the child’s care (Ofsted 2008). Subsequent reports on improving the child protection

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\(^3\) Alcohol and other drug use is referred to throughout by the combined term of ‘substance use’ unless alcohol or other drugs are specifically referred to by interviewees or reference sources

\(^4\) “drinking between 22 and 50 units per week for men and between 15 and 35 units per week for women” (Drummond et al. 2004: 9)
system in the UK have reiterated the risks domestic abuse and parental substance use can pose (Laming 2009).

It is within this context and as a response to the evidence base that the CASA Family Service was established.

1.2 CASA Family Service

CASA is a voluntary organisation for people with problematic substance use based in the London Borough of Islington. It has been delivering services for over 30 years. In 2006 the CASA Family Service (CFS) was set up, commissioned by the Safer Islington Partnership. It works closely with Islington Parental Substance Misuse Service and Islington Young People’s Drug and Alcohol Service. Its purpose is to offer a co-ordinated response to the impact of parental substance problems (‘hidden harm’) across the borough by working with families to:

- Strengthen protective parenting
- Strengthen resilience in children and young people
- Strengthen relationships between parents and children
- Reduce parental substance misuse

It does this through a range of services including structured therapeutic interventions with families (involving direct work with children and parents), group work, and outreach work in a variety of settings. CFS also offers advice and information to family members and professionals, and provides training and consultancy work to professionals across the Borough of Islington. Further, it has developed particularly close working arrangements with a number of key practice partners.

Parental substance use and the potential for harm to children and families has been high on the political agenda since the publication of Hidden Harm (ACMD 2003). The current and previous national drug strategies for England have recognised families as being affected by an individual’s substance use and also having a role to play in supporting individuals to change their substance using behaviours (Home Office 2008, H.M. Government 2010). It is therefore timely to evaluate the impact of the CASA Family Service, particularly in the current funding climate where efficiency savings are sought and value for money prioritised within the public sector.

CASA Family Service has not been formally evaluated to date and sought a project evaluation to review its practice and highlight areas for development. In particular it sought to evaluate its work in relation to domestic abuse and multi-agency working and to hear from a range of service users and partner agencies to inform the evaluation.

The Tilda Goldberg Centre for Social Work and Social Care at the University of Bedfordshire was commissioned to conduct the evaluation over a six month period from mid September 2010 to mid March 2011.

This is the final report of the evaluation. It summarises the CFS model, presents findings from the interviews with partner agencies and service users, offers an
approach to measuring outcomes and concludes with recommendations as they emerge from this evaluation process.
Section 2 – Methodology

2.1 Aims

There are many components to the service delivered by the CASA Family Service. As outlined above, while the core of its work is direct therapeutic work with individuals and families, further work is carried out in partnership with other agencies, including educational and therapeutic group work for adults and young people, consultancy work and training activities. Time and resource constraints meant that it was not possible to evaluate all aspects of CFS’ work fully. Discussions with CFS resulted in the following aims for this evaluation:

1. Define and describe the therapeutic model of intervention practised by CASA Family Service.
2. Evaluate key elements of the model in relation to the existing evidence base.
3. Evaluate the extent to which the model addresses harm relating to substance misuse.
4. Evaluate the extent to which the model addresses the overlapping issues of substance use and domestic abuse.
5. Explore the contribution of multi-agency and partnership working to the practise of the model.

In particular CFS was keen to ensure that service users’ and partner agencies’ views were a key part of the evaluation process.

2.2 Data collection

The evaluation had three overlapping but distinct stages. The methods for each stage are described below:

Stage 1

The first stage addressed the first two aims of the research, that is, to define and describe the model in use at CFS and review the key elements against the existing evidence base. The methods used in Stage 1 were:

1. Collation of agency documentation and literature relating to the development of the practice model.
2. Contact with other key people involved in the development of the model and the service, e.g. CASA director, external consultants.
3. Semi-structured interviews with all Family Service staff to explore their understanding of the model, their application of it, the skills and knowledge required to use it, and their views on its strengths and weaknesses (see appendix 1).
4. A literature review of the evidence base relating to the key elements of the model.

Stage 2

The second stage addressed aims three and four – evaluating harm to children from parental substance use and the extent to which the CFS model addressed the overlapping issues of substance use and domestic abuse. A qualitative research
design was needed as time did not allow for a study using before and after measures. The methods being used to collect Stage 2 data were:

1. Semi-structured interviews with adults who are parents or carers attending CFS (either in person or telephone) (appendix 2)
2. Semi-structured interviews with adults who have previously attended the service (either in person or telephone) (appendix 2)
3. Loosely structured interviews with children and young people who are attending CFS (using a toolkit of methods as appropriate - appendix 3)
4. Loosely structured interviews with children and young people who previously attended CFS (using a toolkit of methods as appropriate – appendix 3)

Stage 3
The third stage sought to address the final aim of exploring multi-agency working and collaboration between CFS and other services. This involved telephone interviews with key agency partners (appendix 4) Finally, CFS asked the research team to advise on any relevant outcome measures that could be used in the development of its work.

2.3 Sample selection
Given the aims of the research a purposive sample was required. Due to data protection considerations CFS staff were asked to draw up an anonymised list of families that met the following criteria:

- Families where there are known or suspected domestic violence and abuse issues
- Parents/carers attending CFS who have had at least six sessions (and are therefore at the end of the assessment phase and have established a relationship with CFS on which to base their responses)
- Families who have completed their work with CFS in the previous 12 months
- Children and young people over the age of 8yrs old who have attended individual sessions or CFS groups aimed at children and young people

From this list the research team selected every second family and these were contacted to take part in the evaluation. This resulted in a sample of nine families who had completed their work with CFS and seven families currently still attending. In terms of individuals this included 21 adults (mother/father/grandparent/aunt but not adult children) and nine children and young people.

The families were initially contacted by CFS staff in order to protect confidentiality. Only when they agreed to take part and had given their verbal and/or written consent did the CFS team pass on their names and contact details to the research team (if needed). Interviews were held either at the CFS offices, at the homes of the respondents or via telephone, whichever they preferred. The timing of the interviews was as flexible as possible and evening or after school times were offered when needed. Both adults and children were compensated for their time with a £15 or £5 voucher respectively. This was to thank them for their time rather than act as an incentive payment and participants were unaware of the payment until the end of the interview. The research team felt incentive payments were neither appropriate nor ethical for a service evaluation.
2.4 Analysis
To analyse the interview data a grounded approach to thematic analysis was used (Strauss 1987). This allows themes to emerge from the data rather than attempting to collate the data into pre-set categories or codes. Commonalities and differences identified in the individual interview responses are highlighted and then developed into broader thematic domains. These broad themes are then cross checked with the original data to ensure they remained grounded in the data rather than become too removed or abstract. The computer based qualitative data analysis software NVivo was used in stage 2 and 3 of the evaluation to code the interview data into detailed and then broader themes. Two of the research team conducted analysis on different sets of the qualitative data and then independently analysed a subset of each other’s data as a quality control measure. This ensured consistency in approach and accuracy in interpretation of the data. For the purposes of this evaluation, additional data which did not relate to the evaluation of CFS was discarded.

2.5 Ethical approval
All empirical social research requires ethical approval, however where children and vulnerable adults are involved ethical considerations need to be most stringent. Given the research aims and the involvement of children and adult service users in the data collection, extreme care was needed to ensure the evaluation methods were both sensitive and safety focussed. Interviewing service users in particular requires a number of considerations to be addressed including:

- the potential for child protection concerns to be raised during interviews with parents/carers/children
- the possibility that interview questions may cause distress (in spite of careful construction of interview tools)
- the need for support mechanisms to be in place for service users during and post interviews
- the need to ensure the interview environment was as safe as possible, that is, couples not interviewed together, children interviewed separately from parents (with permission)
- the need to ensure the researchers’ safety during the course of the evaluation,

Ethical approval was sought through the Institute of Applied Social Research Ethics Committee at the University of Bedfordshire and through the University level committee. Due to the sensitive nature of this research the Ethics Committees were particularly rigorous and approval was given. CASA Family Service did not require additional ethical approval processes to be completed.

Consent forms were drawn up for all participants with age appropriate forms designed for children and young people. In addition there was a parental consent form that needed to be signed before any child or young person could take part (see appendices 5-9).
Section 3 – Findings and Discussion

The findings and discussion chapter has three clear strands. First a summary of the CASA Family Service Model will be presented alongside the evidence base for it. A fuller report on the model accompanies this report including interviews with CFS staff (Wadd et al. 2011). The second section will focus on the interviews with the partner agencies, the third on service user responses. Each section will include a separate discussion of the findings.

3.1 CASA Family Service Model

Stage one of the evaluation was to clearly describe and define the CASA Family Service model using both agency documentation and supporting evidence from managers and staff. The following is a summary of the key elements of the model and the evidence base that underpins them.

The CASA Family Service model comprises two core components:

1. The systems and processes within which the service is delivered
2. The therapeutic service as provided to the families.

3.1.1 Systems and processes

The following elements emerged from the data collection as being central to the development of a nurturing and respectful service, suitable for families with substance problems and other complex needs, and supportive of staff working with them:

- Strong leadership including a responsive and reflective management style that fosters respect and co working.
- Recruitment of experienced and qualified personnel that reflects the skill mix required to work with the service user group.
- An emphasis on staff support, from induction to in-house training and development.
- Good supervision, including both internal and external supervision that moves beyond reviewing caseloads to broader issues of the service’s approach and “thinking space”.
- Limited caseloads, allowing for a better quality of service.

In 1986 a study by Lightfoot and Orford exploring the attitudes of social workers and community psychiatric nurses towards service users with alcohol problems highlighted how ‘situational constraints’ limited the professionals’ abilities to adopt positive therapeutic relationships with service users. It also demonstrated the importance of staff being supported by supervisors to do the work and ensuring that staff felt adequately equipped to do it. CASA Family Service’s determination to provide strong leadership, good supervision arrangements and time for critical reflection of what they do and how they do it, demonstrate its commitment to eliminating such situational constraints.

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5 A more detailed report of the model description, including data from interviews with CFS staff, is available as a supplementary report from CASA Family Service or the authors of this report.
Since the Lightfoot and Orford study, there have been many studies highlighting the importance of strong leadership, good supervision and a supportive and collaborative working environment (Frost and Robinson 2007, Husbands 2007, Scragg 2006), particularly in relation to interdisciplinary or interagency working. For CFS, the mix of staff from different professional backgrounds as well as their work with external partner agencies, appears to work well as a result of the attention given to support, supervision and “thinking space”. The importance of these elements in creating a working environment conducive to quality practice is often underestimated and/or subsumed in increasing bureaucracy, the demand for higher caseloads and doing more with less. The evidence suggests that CFS is right to focus on the quality of what they do.

Evidence also shows that service development is helped by good quality working relationships and an egalitarian culture (Hudson 2007, Katz and Hetherington 2006) both of which were highlighted as positive features of CFS by its staff. The importance of the work environment and organisational culture was highlighted in a study by Glisson and Hemmelgarn (1998) which explored the outcomes for children of an interagency coordination team designed to place young people in the care system in the USA. One of their main findings was that the strongest influence on the outcomes for children was the climate of the organisation. Offices characterised by low conflict, cooperation, high role clarity and support for workers produced better outcomes for children. Again these are features of the CASA Family Service team.

CFS also appears to invest in staff training and support starting with a lengthy induction process and ongoing in-house training. In a review of drug treatment effectiveness, Heather et al. (2006a) highlighted the importance of staff training and support to ensure adherence to the intervention adopted, stating:

> Interventions of all kinds are only effective if delivered in accordance with their current descriptions of best practice and carried out by a competent practitioner (Heather et al. 2006a: 3).

In other words a practitioner who is not competent in the intervention is likely to limit its subsequent effectiveness. Thus the internal systems within agencies that assess, monitor and support staff competence in delivering specific interventions need to be in place to maximise effectiveness. CFS’s attention to staff support and training is vital to ensure its staff deliver effective interventions. This training and support contributes to what is known as the ‘therapist variable’ for which there is a strong evidence base (Gossop 2006).

CFS’s commitment to limited caseloads per worker is also supported by a growing evidence base, particularly in relation to intensive family support work and interventions in substance use field such as case management, which often combine therapeutic input and care coordination (Braucht et al. 2005, Calsyn et al. 2005, Gorey et al. 1998, Ryan et al. 2006, 2008, Sells et al. 2006). In general, interventions with higher caseloads demonstrate far less effectiveness than those with limited caseloads.
3.1.2 The therapeutic service provided to families

The CFS therapeutic model, known as the Child Focused Family Intervention for Substance Misuse (Robinson 2010), underpins CFS mission to work with the whole family while prioritising the needs of the child. It comprises four main stages set within a family centred and family focussed framework (see appendix 10):

1. Engagement
2. Assessment
3. Intervention
4. Disengagement

Within each stage are key features which are fundamental to the CFS service model

Engagement

The first stage of engagement emerged very clearly in the discussions with CFS managers and staff as being of crucial importance to the CFS service model. In particular, the adoption of an assertive engagement processes, with the goal of engagement being to establish a therapeutic relationship. Families with substance problems and other overlapping needs can be a difficult group to access therefore effective engagement is a vital step.

Wadd et al. (2011: 15) outline the process of engagement at CFS:

Following referral and an in-depth discussion with the referrer, the assigned keyworker will telephone parents to introduce themselves, describe the nature of the service and begin the process of establishing a therapeutic alliance with the client. If the parents do not consent to a meeting, the initial referrer will be informed. If the parent consents to follow up telephone calls rather than a meeting, telephone contact will be maintained. If the parents consent to a meeting, wherever possible it will be arranged to accommodate parents’ wishes. For example, they may choose to have a known keyworker present or request that this meeting is held in a familiar place such as a children’s centre. If the client does not attend the initial meeting, follow up telephone calls will be made to maintain contact and encourage attendance at a subsequent appointment. Attempts are made to maintain engagement by placing a premium on establishing sufficient rapport in the initial sessions and encouraging non-substance using family members to attend. If clients miss sessions for any length of time, assertive efforts are made to re-engage them, for example by telephoning them, sending them text messages or letters, or offering them home visits. The initial referrer is informed of progress.

The focus on engagement in CFS’ approach is supported by the evidence base including a study by Meier et al. (2005: 304) which found that the “early therapeutic alliance appears to be a consistent predictor of engagement and retention in drug treatment”. Taylor et al. (2006) also emphasised the importance of skilled and creative strategies for engagement in their review of families that had dropped out of another London-based Family Alcohol Service.
Establishing trusting relationships is key to the engagement process. The quality of relationships between service users and staff has been identified in a number of studies into the effectiveness of interventions with people who have substance problems and other overlapping needs (Hall et al. 2009, McLellan et al. 1999, Morgenstern et al. 2008, Rogers et al. 2008). One study which explored the impact of assertive engagement by providing enhanced practical support to women seeking help for substance problems found the practical support made no difference (Comfort et al. 2000). They concluded that the most important factor was the relationship-based elements of engagement rather than practical support alone. This evidence is further strengthened by Heather et al.’s (2006b) review of the evidence on the effectiveness of treatment approaches. They stated the evidence shows that therapist alliance is highly important and, in the evidence reviewed, accounts for up to 50% of the variance in treatment outcomes. The CFS emphasis on engagement and building relationships is therefore a vitally important element of its approach.

**Assessment**

The second stage of the CFS service for families is assessment. Within CFS assessment is undertaken in greater depth and with greater thoroughness than is common in many social care agencies.

While substance use *per se* does not automatically put children at risk of harm, the fact these families were engaged with CFS indicates some concerns relating to a parent’s or carer’s substance use. Currently substance use is assessed in a range of ways by different agencies depending on the needs of the individual service user. For example, *those receiving support from an adult treatment agency* at the point of referral to CFS have a full substance use assessment by the adult treatment agency concerned and the paperwork is then forwarded to CFS on request. However as there is some delay in paperwork arriving CFS staff conduct some assessment based partially on questions in matrix 1 and partly on questions included in guidance notes to referral and assessment forms. The adult treatment agency is also asked to forward the Treatment Outcome Profile form following a 12 weekly review - this includes a review of the individual’s substance use in the previous four weeks among other qualitative outcomes (although CFS often has to request the TOP form rather than receiving it automatically).

For *adult service users not in touch with adult treatment services*, CFS complete a full assessment of the person’s substance use using the same forms as adult treatment services (standard forms for the Borough’s services), including the TOP reviews at the 12 week point as well as the questions on the matrix 1 form and others from the guidance notes for referrers. It is worthy of note that none of the Borough’s standard forms make specific reference to domestic abuse. ‘Risk of violence to others’ is included on the triage form but this appears to refer to physical threats and violence only and is far too broad a category to distinguish stranger or acquaintance violence from the perpetration of domestic abuse towards family members, in all its various forms.

The goals of assessment include establishing the extent to which parents are managing their parenting responsibilities, identifying goals for both the family unit and in response to the needs of the child, and identifying any risks to adults as well as the children. Risk assessments are initially conducted using two matrices
developed to explore the impact of parental substance use on the child and other factors that might affect the child’s safety. A further risk assessment tool is used to establish any additional risks to self or others. Importantly, however, the assessment process focuses as much as possible on family values and adopts a strengths based perspective to working with parents and carers rather than a formulaic procedural model of assessment.

Assessment is an ongoing process at CFS although the initial assessment can take approximately six sessions and is designed to be holistic. Where possible, assessment involves all members of the family as individuals and as a whole family. This often results in staff making supported referrals to other agencies with whom they work jointly as needed. CFS managers state that the development of close collaborative working arrangements with other agencies and professionals are vital to their ability to respond to the range of needs service users present with, particularly in relation to domestic violence and abuse.

This more holistic view of an individual’s needs ties in well with the shift in national alcohol and drug strategies towards a more recovery oriented approach to working with people with substance problems (Scottish Government 2008, H.M. Government 2010). The recovery approach seeks to ensure service providers look beyond the narrow focus of the person’s substance use and engage with other aspects of their lives. Families and carers are recognised as important both in terms of their support of their substance using relative but also in terms of their own needs, particularly the needs of any children. Thus CFS’s focus on holistic assessment is both politically timely and recognised as good practice in supporting people on their recovery journey.

The importance of working with people in the context of their broader social situation has also demonstrated effectiveness in intervention studies. Two American studies by Bouis et al. (2007) and Whetten et al. (2006) report on a comprehensive drug and alcohol intervention for people with a HIV, mental ill health and substance use. It combined attention to establishing a therapeutic relationship using motivational interviewing principles with working with the individual and their broader social context including other support services such as housing. There are obvious parallels between this intervention and the service at CFS. CFS is also working with people with complex needs, focusing on building a therapeutic relationship through the application of motivational interviewing techniques (among others) and are often working with people who are initially resistant to attending its services.

As stated, the assessment process at CFS seeks to identify a range of overlapping needs, in particular domestic violence and abuse. This is important as evidence shows the presence of domestic abuse can affect the engagement and retention of women in substance treatment services, particularly women with children (Galvani 2006, Heather et al. 2006a). It is also important as domestic violence is often not identified by social workers working with families affected by substance problems in spite of the high risks of harm it presents to children (Forrester and Harwin 2008). Further, a study by Choi and Ryan (2007) found that the presence of domestic abuse negatively affected family reunification where previously families had been separated. Reunification rates were lower for parents living with domestic abuse than for parents who did not. Given the potential harm to children of living with domestic
violence and abuse, the large numbers of women who have histories of child and adult abuse presenting to substance use services, and the links between suffering child abuse and domestic abuse as an adult, this is clearly an important factor to identify in supporting both parent and child. A sensitive and safe response is therefore vital for adult and child victims of abuse to avoid exacerbating further harm or increasing risks to their safety. CFS is sensitive to the issue and recognition of it is included in different ways on many of its assessment forms (see appendix 11). CFS also appears sensitive to the need for family work that does not increase risks, for example, by not working with perpetrator and victims together, and reports good working relationships with local domestic violence services.

Finally the adoption of a strengths-based approach is designed to increase self-efficacy of the parent or carer and enable people to make the desired changes required in their substance use or parenting skills. Orford et al. (2006) reviewed the accounts of people who took part in the UK’s Alcohol Treatment Trial and how they explained their changes in alcohol consumption. They did not believe it was just the intervention that accounted for their behaviour change, rather they stated that it was a combination of their own determination and self-realization that led to their reported change in drinking behaviour. Based on this evidence, CFS’s emphasis on supporting people to recognise their strengths and values is therefore as important as the method of intervention that is delivered.

**Intervention**
The third stage of the CFS service for families is the intervention. For CFS this includes methods such as Motivational Interviewing, Narrative Therapy, Cognitive Behavioural Therapy, Person Centred Counselling, Child Centred Play Therapy and Group Work.

Within the field of treatment for substance problems there is very strong evidence for the effectiveness of motivational interviewing (MI) and cognitive behavioural therapy (CBT) interventions. In an in-depth, scientific review of the effectiveness of treatment for alcohol problems, Heather et al. (2006a: 9) concluded there was good evidence of effectiveness for CBT, particularly in an intensive form for women with “mild to moderate dependence”. They also concluded MI was not only a principled approach given its non-confrontational style but was also helpful for enhancing other approaches and cost effective. Cognitive behavioural approaches were also found to be useful for couples but only when the relationship was “relatively intact” (p.10) which, for relationships affected by domestic abuse, would not be the case, nor would it be advisable for safety reasons. The review also stated that there was some effectiveness for client centred counselling although this was not as strong as more structured approaches (Heather et al. 2006b).

Wadd et al. (2011:19) describe the monitoring of service users’ progress by staff during the intervention process:

> “Throughout the intervention, project workers seek to measure progress towards reducing hidden harm by talking to and observing interactions between the adults and children and obtaining feedback from the professional network around the family. JC [the manager] holds a review
meeting with the keyworker(s) and family each quarter... which [reviews] to what extent goals have been met."

Further the goals of the interventions at CFS include highlighting resilience in children (and adults) and building protective factors through attention to parenting skills and reducing risk factors. The importance of working with resilience and protective factors has been consistently highlighted in the literature as important when working with families affected by parental substance use (Velleman and Templeton 2007). It is clear from research that some children are more resilient than others to the negative impact of parental substance use and has led to an exploration of protective factors for these children. Protective factors which have been identified include high self-esteem and confidence, self-efficacy, an ability to deal with change, a good range of problem solving skills, positive family functioning, a close positive bond with at least one adult in a caring role, and a good support network beyond the family (Velleman et al. 2003). It follows that the goals of the CASA Family Service; reducing parental substance misuse, strengthening family relationships and functioning, improving parenting capacity and strengthening resilience in children, are likely to improve outcomes for these children. In support of this, a qualitative evaluation of the Family Alcohol Service (FAS) in Camden, which shares these goals, found that the intervention led to children generally becoming less anxious, some were able to express and resolve long standing negative feelings about their situation, school attendance and achievement improved in some instances and changes were made to Care and Supervision Orders and Child Protection Registration (Velleman et al. 2003).

**Disengagement**
The final stage of the model is disengagement. CFS build in the disengagement process by reducing the frequency of the sessions, emphasising achievements, discussing longer term goals and offering support when needed. Staff contact service users by telephone approximately three months after the family have left the service providing they have given consent to do so.

Evaluative evidence from similar services have highlighted how follow up services can help some, but not all, families maintain their changes and longer term goals. An evaluation of a Cardiff based intensive family service, Option 2, showed that some families with “complex and long standing difficulties” were unable to maintain changes and wanted more input from the service (Forrester et al. 2008).

The evidence of effectiveness for the treatment for alcohol problems suggests that booster sessions may be required to sustain cognitive behavioural changes in the longer term, particularly if interventions have been brief (Heather et al. 2006a). Addressing this follow up through telephone calls (as happens currently at CFS) appears to be the first small step in supporting people to make longer term changes. However greater consideration could be given to enhancing the follow up process at CFS.

**3.1.3 Challenges**
The management and administrative processes in place at CASA Family Service incorporate many elements that have a strong evidence base. So too does its therapeutic model, the Child Focused Family Intervention for Substance Misuse. The
success of it appears to rely on three key elements: first is the need for excellent communication of the therapeutic model, second, is the need for ongoing supervision of its application, third is the importance of ensuring staff are sufficiently skilled and knowledgeable to be able to apply a model that may be quite different to models they’ve used previously – a model that avoids a formulaic, one size fits all approach. However some CFS staff identified a perceived lack of clarity about how to deliver the model which they reflected on as stemming from a number of sources including: their experience of more prescriptive models of practice, the “elasticity” and flexibility of the model (which they also acknowledged was a positive), and the feeling that the application of the model had moved somewhat from what was originally intended (Wadd et al. 2011). It is beyond the remit of this evaluation to determine which of the three key elements is responsible for the perceived lack of clarity, if indeed that were possible, however the openness and reflexivity of the entire staff team means such concerns have been aired openly and are already being addressed. Further training and discussion of the model has been implemented at CFS and plans are underway to see whether some aspects of it can be more formalized without stifling its flexibility and the ability of the model to allow staff to be responsive to the different needs of families and individuals within its application.

Other challenges were more client related and included the challenge of building trusting relationships with families affected by substance problems, the willingness of some parents to take part in family work and bring their children into the service, and people who were perceived as simply not ready to change their substance use. The issue of engaging children in the service earlier in the process is currently being reviewed by CFS staff.

3.1.4 Conclusion
The model used by CASA Family Service in its work with parents, carers, children and families affected by parental substance problems is well situated in the evidence base for treatment effectiveness. It combines its core therapeutic work with the necessary systems and processes, culture and ethos which are more likely to provide positive outcomes for family members. As Wadd et al. (2011: 35) conclude:

“...[the] evidence presented here suggest that the complexities and challenges of systemic work with families affected by substance misuse, the responsibilities of child protection and the sheer tenacity required to hold onto parents who are often reluctant to accept help, requires the extensive supervision, small caseloads and co-working which are a distinctive feature of this service. ...This mix of practices, systems, processes, cultures and ethos together with the evidence-based strategy and approach to the therapeutic work defines the CASA Service and give it its inherent strength.”
3.2 Partner agency interviews

A total of nine staff from partner agencies that work with CASA Family Service took part in structured telephone interviews. Three of the sample were managers and six were front line practitioners, working in either the voluntary or statutory sectors. The agencies included an alcohol treatment service, a drug and alcohol service, Solace Women’s Aid, Islington Children’s Social Care, The Annexe Young People’s Drug and Alcohol Service, a Family Drug and Alcohol Court Team, and Moreland and King Square Children’s Centre6.

Most interviewees said that they were in contact with CFS as needed. This was usually determined by whether or not they had service users that required both services. When they had joint clients with CFS they were in contact on a regular basis, approximately once a week to fortnightly. However, when they were not joint-working their contact was less frequent, between once and twice a month.

“It hasn’t been constant as cases change so much and you know I pick up cases and then, either you know they might let them go or I might close them or the needs change. But while there has been that need... I kept in good contact with the workers at CASA and they with me. So I was speaking to them, I mean when I have been working with them I’ve been speaking to them probably about once a week.” (Agency 3)

Partner agency staff were asked about the nature of their contact with CASA Family Service and they responded by outlining a wide range of joint work that they jointly carried out. These tasks ranged from co-working training sessions on hidden harm to jointly delivering intervention programmes such as the Strengthening Families 10-14 programme. Interviewees also said that ‘referral’ and ‘consultation’ were two other ways in which they often worked with CASA Family Service.

Other ways in which partner agency staff were involved with CFS included providing and receiving advice, joint assessments, involvement in commissioning CFS, jointly determining hidden harm strategy and enabling outreach and engagement with shared clients.

All participants were asked 14 questions from the same interview schedule (see appendix 4). A number of key themes emerged regarding the partnership work with CASA Family Service.

3.2.1 Nature of relationship and work with CFS

The importance of their relationship with CFS and the opportunity to work together stood out in the interviewees’ responses as a frequently discussed strength of CFS. Many respondents said that they had good and effective working relationships with CFS staff, and that they admired the partnerships CFS staff had built with clients. Some interviewees felt their relationship with CFS was easy to maintain because of the qualities of the staff and managers and their openness to working together.

6 Where permission has been granted, partner agencies have been named.
There was a clear sense of mutual partnership and that the work benefitted both agencies, with open sharing of information:

“...they can use us for advice if they need to, advice in reverse, I think it’s complimentary in both ways really.” (Agency 2)

“...it’s a directly mutual, but beneficial, relationship…it necessarily works in a positive way together.” (Agency 1)

Some interviewees said that they had a long and successful working relationship with CFS and would like to see this carry on. Another positive element of their joint work was the similarity between the aims of partner agencies and CFS, which enabled them to joint work more effectively. One interviewee spoke about a “commonality of purpose” which facilitated closer joint working.

In contrast, some respondents felt that they did not share the same aims as CFS due to different foci and approaches to client groups, but that that CFS’ work did in fact complement their service by meeting needs that the partner agency did not have the remit to address.

“...I mean they’re extremely useful in the sense that they provide interventions that we probably wouldn’t, i.e. working...directly with parents and children...” (Agency 6)

Furthermore, when CFS and the partner agencies did conflict on plans for the family members due to their different agency foci, such as different timescales for child and parent interventions and substance use treatment, most interviewees felt that they were easily able to overcome these disagreements because of their ability to work so well together. One interviewee felt this conflict was entirely appropriate for the area they were working in, and expected CFS to disagree with their plans for family members.

“So there might be conflict at times between our different aims if you like... and you deal with that by... regular liaison and by talking to each other regularly and trying to understand the other person’s point of view.” (Agency 9)

“...they may have a different view to ourselves around advocacy, around timescales and in terms of what’s a fair chance and I think again, although that’s caused some tensions in terms of the network, it’s been entirely appropriate. And that’s how you work through difference. I think I’d be really concerned if they agreed with everything [my agency] said and did because in that sense then they wouldn’t actually be advocating or looking specifically at the needs of these families...” (Agency 4)

Participants emphasised their positive regard for the work they carried out with CASA Family Service, feeling they were able to work alongside each other, support and understand each other in what can often be a very difficult area to work in, and this was seen as a strength of their joint work.
Most participants felt there was a great deal of mutual learning being achieved in their work with CASA Family Service. They felt CFS was able to learn about their agency’s requirements and processes and their agency was able to learn about the aspects of CFS’s work that they did not have much awareness of or training in, for example, substance use knowledge.

**Information sharing**
Whilst some interviewees felt they had clear practice guidance in place between their agency and CFS, others felt that they did not but had informally discussed how to work together.

“...there’s like a Borough wide confidentiality policy and so forth, that sort of works out how we can work with each other...” (Agency 2)

“I don’t think we’ve got anything in writing about how we work together but we have had several conversations about how we think would be best to work together...” (Agency 5)

CFS was deemed proficient at information sharing and it was felt that staff were keenly aware of confidentiality issues, particularly CFS’ manager. Most interviewees said that they and CFS gained consent from parents in families they worked with prior to sharing information between their agencies.

“I think CASA are generally very good at seeking the permission of the parent to share concerns before they share them with me...” (Agency 1)

“...they are very very clear and they do abide very strictly by confidentiality...” (Agency 7)

Interviewees overwhelmingly felt that CFS had many strengths and spoke very highly of the Service throughout their interviews. One participant felt that this evaluation would highlight CFS’s value as a service and that their work should be maintained.

“...my feeling is that in terms of the work that you’re doing it will actually demonstrate that the work they do is meaningful and purposeful and should actually continue.” (Agency 4)

**CFS is unique and goes beyond its remit**
All respondents felt CFS was an invaluable service and the staff and managers provided a unique service that went beyond its remit. Participants spoke of their innovation in practice and how impressive their work was. One interviewee said that CFS’s work had been recognised locally and nationally.

Two areas in which interviewees felt CFS excelled were their availability for meetings and having enough time for consultations, even when they were not currently joint-working with clients. Other areas in which respondents felt CFS had strengths were its contribution to the wider agenda of substance use and its impact on families and children. Also CFS was seen as maintaining a broad focus on the issues affecting their clients, something that was frequently discussed as setting CFS apart from
other agencies in the field. Other agencies were said to have a more narrow focus, making joint work difficult. Interviewees said they felt CFS had an ‘open door’ and this was a strength:

“...you know when we’ve tried to schedule meetings in getting professionals all together I think that...they make themselves available...” (Agency 8)

“I think the work that...they kind of widen their lens quite a lot, they do work with couples, parents, children and families of the problem person as well.” (Agency 6)

“...when you think of contacting them it’s not ‘oh my god I’m going to have to really work on this really hard’, it’s not like that. There’s an open door there.” (Agency 7)

One interviewee felt that without CASA Family Service the London Borough of Islington would be providing a diminished service in tackling hidden harm. Others felt relieved to know CFS was involved with their clients and felt that without the involvement of CFS in joint work, there was potential for reduced positive outcomes for their service users.

“We feel that without them we would be a lesser service and that the Borough would have a lesser service.” (Agency 7)

“...I felt quite relieved once I knew that they were meeting with the children, so they could hear what the children had to say...So that for me...reduced my anxiety about the family, so that I knew if needs be...somebody was taking into account the needs of the children and weighing up whether they were suffering or not.” (Agency 9)

“So yeh the outcome was a very positive outcome, where if they hadn’t have been involved with us...then I wonder if it would have...” (Agency 2)

A common theme from the partner agency interviews was that the CASA Family Service was different to other services in terms of their approach to its work, its attitude towards families, and its ability to meet the needs of their clients. Most interviewees felt CFS met needs that other agencies could not. CFS was commended by interviewees for their awareness of children’s needs and their broad focus on the whole of the family:

“...they’ve been really so great compared to other [agencies], I mean we work with many different agencies in the community and they’ve always really stood out to me... [they] just seem to really do a lot of good work.” (Agency 8)

“...offers support to the whole family unit...” (Agency 1)

“...really genuinely addressing the way that substance misuse can impact on children...” (Agency 5)
Two interviewees felt that having CFS situated within the wider CASA organisation allowed for improved joint working as they had excellent links to other relevant agencies, such as the Day Centre.

“...I think we’ve found that really helpful that they also have that link, you know they do this family work but then...they also have this other service that’s just more one to one alcohol counselling and the staff who can also assist in more intensive support and linking parents into rehab, kind of inpatient or outpatient rehab facilities. So I think that’s really useful because it kind of covers quite a number of bases in terms of families that we work with where there are substance misuse issues.”

(Agency 8)

### 3.2.2 The CFS approach to practice

The respondents highlighted a number of strengths in CASA Family Service’s approach to practice. The strengths most frequently centred on meeting the individual needs of both parents and children, and the flexible and non-judgemental approach that they use with their clients.

“...so it’s offering ongoing support in a different way and also offering the stuff that they do for children through the FAB Group and other bits that they do for the kids. Being able to go round and pick them up from their home and take them back. And they seem to be able to offer a lot more one-to-one support when the client needs it. Sometimes clients have to fit into very much a structure of an organisation where, if it was at CASA will bend them if they need to see someone, more often than they will see that person to give that person more support.” (Agency 2)

“Yeh to work with the... family as a whole, to tackle the stigma that the children and or the family may be feeling... as I say to work on a strengths based way, to work towards positive changes for the whole family unit.” (Agency 1)

Other approaches seen as part of CASA Family Service’s strengths included having clear boundaries for clients, employing underlying theory in their work, engaging vulnerable and hard to reach families and holding such families needs within a holistic framework. Many interviewees talked positively about CFS, framing their work around family strengths and utilising a systemic approach to practice.

“I think...the use of the pictorial assessment ... is a really good piece of work. I think the fact that they have a very clear theory underlying in terms of their systemic approach is another great strength, and I think their ability to engage and retain families in that process.” (Agency 4)

“...to work on a strengths based way to work towards positive changes for the whole family unit...” (Agency 1)

### 3.2.3 Staffing
The staff team was frequently praised by interviewees who universally thought the staff were one of CFS’ strengths.

Staff qualities were discussed by all interviewees, who highlighted their devotion, enthusiasm and friendliness as qualities that supported their joint work. Interviewees also felt the staff had created a ‘culture of pleasantness’ and were a good team who were enjoyable to work with. Interviewees frequently expressed their admiration for the staff’s openness, insight into the work, reliability, professionalism and helpful approach to joint work.

“They have really excellent [staff], who are open to discussion and who are very very much into co-working, they don’t actually think that they’re the ones who’ve got the only views on things...” (Agency 7)

The skills of the staff were also commented on. Many interviewees said staff were good at listening to them as well as to their clients and had an ability to reflect on their work. Interviewees said staff were positive, proactive and supportive of clients and their joint work. In terms of work with the clients, the partner agency staff praised the staff’s skills in addressing substance misuse issues, engaging families, being thoughtful of client’s needs and overcoming any resistance from clients. Their ability to communicate well was highly rated:

“...my impression has been that they’re quite pro-active in communicating with us...” (Agency 8)

“...supportive in very challenging circumstances...” (Agency 5)

“...they’re impressive at being able to engage difficult to engage people...” (Agency 7)

The wide range of specialist knowledge that staff had was also seen as a strength of the service and they appreciated the advice that was given. Interviewees said that CFS staff had a good idea of thresholds relating to harm and risk and a great awareness of the issues affecting families with ‘hidden harm’ problems.

3.2.4 Strong management and leadership
Management of the service was frequently deemed to be one of CFS’ greatest attributes. Interviewees felt they had a good working relationship with the team manager and that she was supportive and willing to contribute to case work on behalf of other CFS staff when required. One interviewee said they particularly thought the manager’s confidence and comfort in raising difficult issues within joint work was a real strength of hers and of the service. She was also reported to be helpful and work with her was deemed effortless.

“...[team manager] strikes me as being quite hands on, I’ve noticed that she is seen as quite happy to pick things up when other staff members are away... when someone’s not been in and she’s just picked up their work and just to make sure things get done, so I think she’s really quite happy to step in as a manager to have direct contact with families herself
and kind of manage certain tasks on those cases when the workers themselves aren’t around for whatever reason.” (Agency 8)

“...the manager there ...I find her...a particularly easy person to work with, very helpful, very good at her job, very supportive of the joint work we need to do together. Yeh I generally would say she’s one of the...best professionals I work with in my job, and I work with a lot of different professionals in my job.” (Agency 1)

One interviewee commented that the longevity of CASA’s Chief Executive had allowed CFS to tackle the hidden harm agenda effectively and also to appoint excellent staff who were able to carry out this vision.

“...their Chief Executive ... has been there for a long time and...I actually think that in this instance it’s a very good thing because he knows the agenda completely and it shows and he knows the sort of people who should be delivering the type of vision that he’s had for the service.” (Agency 7)

3.2.5 Challenges and Weaknesses
When interviewees were asked about any challenges they had encountered working with CFS or weaknesses in their joint work, all respondents were unable to think of any. Any disagreements as a result of conflicting interests were always resolved, and this was not seen as a weakness in their joint work with CASA Family Service, more as something to be expected from the field they worked in.

“I think in some respects the key challenge is sometimes around advocacy. I think that they advocate very meaningfully on behalf of their families and sometimes I think that that can lead to disagreement or conflict between statutory services and a provider service, but I think we overcome those difficulties through discussion and kind of working forward.” (Agency 4)

Some interviewees discussed aspects they would like to see change in the service; however these issues were highlighted as personal to them, and not a fault with how the service operated in general. Such issues included bringing children into the work earlier, achieving best value with their work in terms of how long they support families, the availability of their referrals (limited to Islington) and the appropriateness of harm reduction for all.

“Personally, this is just my personal feeling... I think harm reduction only goes so far, I think for some people who are addicted it’s either all or nothing and encouraging people to slowly reduce does not necessarily lead them to a manageable way of using in the long run. It works for some people but I don’t think it works for everybody and I think sometimes it can do somebody more harm than good. Again that’s just a really personal opinion.” (Agency 5)

Capacity was a theme that was raised in a few interviewees’ responses to the challenges of working with CASA Family Service. Some interviewees said they
wished CFS had the capacity to work with more families, whilst others thought CFS should be reducing their client list to concentrate on a smaller number of families. In addition, many interviewees felt CFS’ funding could be a potential weakness of the service, especially in the current economic climate with (at the time of interview) London Borough of Islington cuts looming.

“I suppose its maybe that they try and do too much? ... I think there maybe some capacity issues there although I’m not aware of a waiting list at this moment in time.” (Agency 4)

“I think the key challenge for both of us at the moment that we face is funding...We are quite fearful that gains made may be hard to maintain if funding... doesn’t actually stay as it was and if that resource isn’t maintained.” (Agency 7)

Overwhelmingly, interviewees felt that any issues they had encountered whilst working with CASA Family Service were the result of the type of work in general, and common to all joint work within other agencies in the Borough, not specific to CFS. Examples of such issues included working with clients with complex needs and their apprehension about involving their children in working with services.

3.2.6 Outcomes
The interviewees were asked whether they measured the outcomes of their work with CFS and the general response was that they did not. One respondent thought some measures were recorded and fed back to commissioners and another thought that the FAB group’s outcomes were measured, but most did not know of any requirement to document outcome measures.

“...we know there’s really good outcomes but no unfortunately they’re not being measured.” (Agency 2)

One children’s agency felt that it would be difficult to measure the outcomes of their joint work as their clients were very reluctant to disclose an alcohol or drug problem in the presence of children centre staff. While they displayed information and leaflets on CFS for their service users to access they would be unaware of their client’s direct uptake of the CFS.

Another interviewee felt that formal outcome measures would be useful:

“...it’s a shame because it would be nice to be able to show the engagements between the two agencies and what positive outcomes or more positive outcomes there have been for clients.” (Agency 2)

In spite of the lack of formal outcome measures, all respondents talked at length about experiences of positive client outcomes from the joint work they had undertaken with CASA Family Service.

“So in that case that joined up working and the services offered to that family made an absolutely tremendous difference...” (Agency 5)
“And their work in the outcomes around DV as well are extremely impressive.” (Agency 4)

“...parents who have engaged with them have felt really safe engaging with them, and really committed to the process”. (Agency 5)

Furthermore, one interviewee believed that CFS’s work has positive impacts on the Borough’s budget.

“...the impact and the outcomes are that it actually saves Islington money because fewer people, fewer families will be needing more complex help from Children’s Services than if CASA didn’t exist”. (Agency 7)

An overwhelming number of successful joint work examples were provided, detailing difficult case work with vulnerable clients in complex situations.

“...so there was a discussion between our two agencies and it could have gone where... our client may have been really furious that the mother had sort of told them and then they, CASA, had then told us. But actually because of the working and because of CASA themselves and because we then sat down with the mother and the daughter, it was able to be a really positive outcome...So yeh the outcome was a very positive outcome, where if they hadn’t have been involved with us, we may not have had such a good relationship...” (Agency 2)

When asked none of the respondents were able to provide any examples of unsuccessful joint work.

3.2.7 Discussion

The representatives interviewed from the key partner agencies were overwhelmingly positive, both about their joint work with CFS and the work that CFS does. The people interviewed were identified by CFS as its key partners and it is possible that different findings would have emerged with a wider and larger sample. However, it was important methodologically that the partner agencies approached had regular contact with CFS on which to base their interview responses. Combined with the findings of the service user interviews (section 3.3 below), there is a consistency to the themes emerging from both sets of interviews that add credence to the experiences reported by CFS’ partner agencies.

What is clear is that the success of the partnership working reported by agencies is primarily due to staff qualities and skills. Staff were highly valued for their openness and accessibility and their willingness to listen to partner agencies and offer advice as needed. This raises important implications for staff recruitment in the future and for other agencies seeking to replicate the work of CFS. In determining the CFS model (see s.3.1) the mix of staff experience and the reflective approach to staff development and management emerged as an important element of the model. The weight given to this aspect of the model appears to have been justified in terms of the external perceptions of CFS and their ability to build relationships with a range of partner agencies. Sections 3.1 and 3.2 above have already highlighted the evidence
that supports good staff training and the importance of agency culture and environment to delivering a good service.

It is also clear is that the management and leadership of CFS is valued highly and is important to the partner agencies. There is the sense that through the strong leadership at CFS, the ethos and values of the service are embedded in the work of the agency. This appears to have been enabled by the longevity of the management team and the stability this has brought to the relationships with partner agencies and service users. A review of literature exploring the key features of successful inter-agency and integrated working found that the following features were essential:

1. **Strong leadership with a shared and agreed vision.** Managers need to have a clear vision of the nature of the service, its goals and the contribution that integrated working can make to achieving those goals. This vision needs to be understood and shared at every level of the organisation.

2. **High quality staff.** For service users their overwhelming experience of the service is the professionals they meet. The quality of the staff is to all intents and purposes the quality of the integrated service.

3. **Good communication.** Creating integrated teams does not automatically ensure good inter-professional communication. Successful integration pays attention to communication across boundaries and between levels within the organisation.

4. **Time.** Developing integrated services takes time. Successful services are allowed to spend time developing shared understandings and working arrangements.

   (Galvani and Forrester 2010: 2)

It appears that CFS has a commitment to adhering to each of these key features and this is reflected in the views of their partner agencies. Further a recent systematic review of the effectiveness of social care interventions with people with alcohol and drug problems found that staff supervision was a key feature of a number of studies (Galvani et al. 2011). This was either noted because of its absence or, among those that had better outcomes, because there was regular and informed supervision including supervision and monitoring of staff skills. It also found evidence to support the importance of communication and relationship building skills in effective interventions – qualities that have been commented on by partner agency representatives.

What the CFS approach also appears to have achieved is overcoming the classic stumbling block to joint working, that is, information sharing. While formal information sharing policies were not in place with a number of key partners all felt that information sharing was discussed and clarified and that CFS was clear on its confidentiality boundaries. Galvani and Forrester’s review (2010) found evidence that good inter-agency working was achieved through both parties gaining clear understandings of the other agency’s roles and responsibilities and having confidence in information sharing procedures.

The partner agencies believed that CFS was doing work that was not being done elsewhere in the Borough. Working with individual parents, children, and the whole
family unit was seen as important to addressing the Hidden Harm agenda, in collaboration with other agencies. Whole family interventions where there are substance problems have been increasingly identified as important at a national strategic level. Recent national alcohol and drug strategies have been reflecting the importance of families and communities in supporting people's efforts to change their substance use as well as the need to support children and family members affected by an individual's use. It seems therefore that the work of CFS is politically timely offering a tried and tested service at a time when the Government is said to be seeking greater support for families affected by a loved one's substance use (H.M. Government 2010).

The key challenge identified by both CFS staff and some partner agencies was engaging the children earlier in the therapeutic process. As discussed in s. 3.1.1, CFS is currently reviewing its assessment processes to address this issue. The second area that offers an area for development is measuring outcomes with partner agencies. This will be discussed further in section 4.

3.2.8 Conclusion
To conclude, interviewees from CASA Family Service’s partner agencies held the service in high regard and were extremely positive in talking about their joint work. Particular strengths highlighted by the interviewees included the service's approach to practice, the staff’s qualities, knowledge and skills and management of the staff and service. Other key strengths discussed were the importance of the relationship respondents felt they had with CFS, their ability to work together and conduct mutually beneficial case work. Most interviewees believed CASA Family Service to be a unique service compared to other services supporting vulnerable families in the Borough, and that it was also a service that went beyond its remit in the service provision it offered to clients. Although outcomes were not officially measured, all interviewees believed their joint work led to positive outcomes for their clients, and were able to provide ample examples of service user success stories. In sum, partner agency staff valued the CASA Family Service and the joint work they carried out together.
3.3 Service user interviews

A total of 13 current or former service users of CASA Family Service participated in semi-structured interviews. Nine were current service users and four were former service users (‘completers’). The sample was made up of 11 females and two males, 11 were adults and two were young people. Ten of the adults were parents, one was a grandparent. Eight of the interviews were conducted face-to-face at the CASA Family Service, three interviews were conducted over the telephone and two took place at the service user’s home. Among the parents/carers that took part in the study, there were a total of twenty children (younger and adult); including two young people interviewed as part of the study sample. The findings from the shorter interviews with the two young people have been included in the findings below.

At the time of interviews (December 2010/January 2011), the current service users had been attending CFS for between five years and six months. Most met with their worker on a weekly basis whilst others said they met approximately every couple of months. Most of the interviewees said they attended sessions alone although sometimes their children came with them. Two interviewees came with their partner to sessions. The completers had stopped attending CFS approximately one to two years previously. Their attendance had ranged from daily phone calls and weekly attendance to fortnightly, monthly or ‘occasional’ sessions. As with the current service users the completers had attended some sessions alone, others included a partner or child or family. This changed according to need and availability.

The CFS building was said to be the main location in which their sessions took place, with a small number of sessions taking place at service users’ homes, children’s centres and nurseries. All but two of the adults interviewed were the person with the substance problem; the remaining adult members included one grandparent carer and the partner of the individual with the substance use problem.

When asked how they first found out about the CASA Family Service, responses included a recommendation from a friend, referrals from social services, GPs and a children’s centre.

A number of key themes emerged from the interviews conducted with the service users and these are reported below.

3.3.1 Life before CFS
A number of topics fell into this broader theme. These were alcohol and drug use, domestic violence and abuse, and relationships with children, family and friends.

Alcohol and Drug Use
When asked about their alcohol and drug use prior to attending CFS most interviewees felt that their or their partner’s use was excessive, resulting in negative consequences for themselves and their family. Prior to attending CFS, all of the

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7 This does not include information on the young people interviewed as they would only be attending if their parent/carer was attending - also the majority of work was carried out with the parent/carer.
participants reported problematic alcohol use at some point in their lives, and most used to drink heavily, sometimes throughout the day. All but two of the interviewees said that they did not use any drugs; alcohol was the main substance used by the people interviewed.

Before using CFS, a few interviewees described how they felt ‘alcoholics’ were people different to themselves, and they did not class themselves as being alcohol dependent.

“now I look back and I [had] trouble identifying myself as an alcoholic because I just presumed that these people you know are drinking on park benches and they’re not like me.” (Interviewee 11)

Most interviewees were conscious of the negative consequences of problematic drinking and the effect it had on them, their relationships and family. For example, one interviewee felt that previously alcohol was his main focus in life, whilst another knew she became selfish and stated her personality changed whilst drinking. Another spoke at length about the effect her partner’s problematic alcohol use had on their relationship, disclosing how they could never make plans and never talked about issues that came up in their relationship.

The physical and health effects of heavy drinking were also discussed:

“Yeh physically... I wasn’t really...looking after myself properly because every time I used to go out on a binge you know, it would take me like about 3 days to recover... And in them three days I would hardly eat, just drink juices and fluids and that kind of affects your health and you know physical being. (Interviewee 1)”

However, one person felt that alcohol was not an issue for her and was reluctant to place herself on the drinking scale despite disclosing she drank throughout the day (scale of 1-10, with 1 being no alcohol use and 10 being heavy alcohol use).

“It depends what you class as heavy. For me it was quite all right really but it depends what you mean by the heavy style of it, 2 bottles - 3? I don’t know where to put myself.” (Interviewee 8)

Some interviewees talked about their motivations for drinking, describing how it was a calming influence or an escape that they used as a relief to other problems in their lives:

“...it was to make me actually switch off from everything else, like normal you know, everyday life and things that I was going through, it ended up being my escape.” (Interviewee 11)

Some people found it very hard to give up alcohol but were also aware that something had to be done even before they were referred to CFS. One interviewee had already stopped using alcohol for 18 months prior to working with CFS and no longer felt alcohol was an issue for her.
Domestic violence and abuse

Most of the interviewees did not talk about the relationships they had been in prior to attending CFS apart from in the context of domestic violence. When asked about their experiences of domestic violence before they had been referred to CFS, many of the interviewees talked openly about the abuse they had suffered. A few people were reluctant to discuss the issue and were not questioned further. One interviewee was not asked about domestic violence due to the potential safety risks to his partner who was also being interviewed. Of those who discussed their experiences, they had, or were, experiencing physical, emotional, verbal and psychological abuse.

“I think [partner] never hits me, never. But abusing me, swearing at me, calling me names and...like I’m rubbish on the floor and sort of saying things that he’s having an affair...” (Interviewee 2)

“Yeh recently it did explode into violence and I had to call the Police.” (Interviewee 6)

“My parenting went downhill because I was more worried about what was going to happen next at home rather than, how do I put it without sounding like a bad mother? I was focusing on keeping things nice indoors.” (Interviewee 10)

One interviewee had to relocate because of the domestic violence she had experienced. Another reported the violence and abuse of her loved one had resulted in his attending a perpetrator programme.

For most interviewees, alcohol was involved in the domestic violence in some way. This ranged from violent partners drinking prior to a domestic violence incident to one interviewee who felt her alcohol use was to blame, to people thinking that their mutual alcohol consumption escalated the domestic violence:

“...no I’m not going to talk about it because I think I’m to blame. Because of the drinking I wasn’t thinking you know...” (Interviewee 4)

“...if you [are] both drinking at the same time...that’s a recipe for disaster.” (Interviewee 3)

“I suppose it is because you’re more likely to say stuff that you don’t, that you’d probably be more measured about saying if you hadn’t had a drink, suppose even 1 or 2 drinks loosens your tongue doesn’t it? … So yeh it’s hard, it would be hard to qualify or quantify what was my drinking and what was his drinking role, if that makes sense?” (Interviewee 9)

“Well we was involved in domestic violence. I’m not with him anymore, he’s my ex now. Thank god (laughs). But yeh it was domestic violence involved, I was drinking too much, he was drinking too heavy and there was police always being called.” (Interviewee 6)

Interviewees not only talked about the impact their experiences of violence and
abuse had on themselves, but also how their children had been affected, particularly by witnessing incidents. They described their child’s reaction to their father’s verbal abuse:

“... when he sees [father] doing that, he starts punching him and kicking him...” (Interviewee 2)

“I didn’t realise my [child] was there and we ended up having a little bit of a fight but I didn’t realise [child] was there, so it did affect [child]” (Interviewee 3)

“The children were in bed and they didn’t hear the argument but they heard the police coming in because their, our house, the bedrooms are downstairs and their bedrooms are near the front door. So thankfully they didn’t hear the argument or see the argument or you know, but they did still, you know my little one got woken up.” (Interviewee 9)

One interviewee whose son perpetrated domestic abuse against his partner described how her grandson behaved similarly towards her when she was caring for him while his dad attended a perpetrator programme:

“I got to in the end that [child] was so abusive to me… he was just giving me a life of hell. As I says to [worker] and that, ‘I feel as though I’m being abused by an 8 year old you know?’ When it was time for bed he would be throwing all the clothing over here and you know it was horrible. … I mean 8 years of age, swearing at me and everything you know? Which he’s probably heard off his dad, mum, whoever you know?” (Interviewee 5)

One interviewee described the combined impact on the children of her and her partner’s substance use and the domestic violence and abuse:

“… he used to soil himself and stuff like that, that was his insecurities. He doesn’t do that now. So obviously it did affect them, I didn’t realise how much it did affect them until they actually my son … [said] how he felt about alcohol and he just doesn’t like it at all. He doesn’t like people arguing and shouting so it affected him yeh. (Interviewee 6)

In contrast, one participant felt that the domestic violence she had experienced had not affected her children because they were too young at the time to know what was going on.

Relationships with children, family and friends
Most interviewees felt that either their own or their partner’s alcohol use had negatively affected their relationships with their friends and family. Some interviewees had a good support network around them and their families had raised their alcohol use with them. However, other participants felt they either had no support to turn to or felt unsupported by their networks.

“...I wasn’t getting no help you know...” (Interviewee 4)
“...they couldn’t see what my worry was, they couldn’t see anything...”
(Interviewee 2)

The impact of their substance use on their parenting and relationship with the children was frequently mentioned during the interviews. Children were aware of their substance use and most of the interviewees talked about the negative experiences and behaviour of their children and, in hindsight, how this was the result of their drinking and its impact on their parenting. The interviewees talked about how their own drinking, or that of their partner, had reduced their ability to parent effectively and how relationships with their children had been negatively affected. One interviewee said that before she came to CFS she had no routines in place for her young children. Others reflected on the lack of time and quality of relationship with their child:

“[Alcohol] makes me more temperamental, less patient with my [child]...”
(Interviewee 3)

“...before I didn’t have enough time for them to be honest... I wouldn’t see [child] or have...quality time with [child] for days...we wasn’t really bonding to be honest...” (Interviewee 1)

Participants talked about how the substance use in their family affected their children’s behaviour and feelings. Interviewees spoke about their children acting out or being reluctant to speak with them. One interviewee spoke in detail about the physical symptoms her child was showing as a result of the anxiety they felt from their father’s drinking, as well as the tantrums her child used to have prior to attending CFS.

“...it upset [child] a great deal because I wasn’t the person...that [child] knows.” (Interviewee 11)

“...the first time he came he misbehaved a little bit but then once he got to know [the staff] he adjusted to it and we found out that he did actually blame himself for mum and dad drinking... (Interviewee 6)

“I don’t think [child] likes talking about it, [child would] rather keep it to [himself].” (Interviewee 4)

Interviewees discussed how their children often took on extra responsibilities to help or care for their parents or siblings before they started seeing CFS.

“...they do tend to take on a role where they feel responsible for you.”
(Interviewee 11)

“...the only person that could look after my [youngest child] while I went in to Detox was my [oldest child]...” (Interviewee 4)

One interviewee felt her drinking had little effect on her children, believing that because she still functioned as a parent her drinking was not a problem.
“I still function, I still have got on with things, with my responsibilities, tidied up the house, done the shopping, collect the kids, cooking, I still functioned. So I didn’t find that there was any negative impact so to speak.” (Interviewee 8)

3.3.2 Life after CFS
Almost all of the interviewees spoke at length about the positive changes that had occurred in their lives since they had been attending CFS. These changes occurred in many areas of the service users' lives including changes in themselves and in their family lives.

Personal changes
On a personal level service users talked of feeling more confident and happier since they had been accessing CFS, as well as feeling like their worries had been alleviated. Interviewees said they felt stronger and much more able to cope in stressful situations. Other positive personal changes included looking for employment, taking greater care of themselves and eating more.

“I’m still going through this stuff that I went through when I drank but I know that I don’t need...anything to get by it. Obviously I’m in a better place but when I do have problems that come up now I deal with it.” (Interviewee 11)

“I wasn’t car[ing] about myself...but now I’m more conscious, now I’ve started taking care of myself” (Interviewee 4)

“I’ve changed in myself, I’m not running away from feelings or emotions any more. I’m confronting them and being honest, talking about how I feel .... I’m going to college next year, I’m furthering my career. I’m setting an example to them as well ....” (Interviewee 6)

Changes in parenting and child-parent relationships
Interviewees talked a lot about positive changes in their parenting. Some said that their children and family were their focus now and one interviewee said social services had now closed their case as a result of the positive change that had taken place. Most interviewees stated their parenting had changed for the better. Interviewees talked about taking more responsibility for their children and one felt that now he was a good role model. Other participants had introduced routines, were taking the children out more, and spending more time with them.

“I think basically most changes have been in the...home...like we have proper routine for the kids, certain...timetable, time to eat, time to sleep, time to have a bath, you know everything is broken down and we stick to it.” (Interviewee 1)

“What’s changed now is the fact that I’m not selfish...It’s all about them now.” (Interviewee 11)

“... taking them out places as well which we never used to do.” (Interviewee 2)
“Oh I learnt to listen to my daughter, I learnt to be the parent and not her friend. … and I learnt quite a lot in how to structure her every day, how to be there for her without being neurotic and trying to hide. …it’s brilliant now.” (Interviewee 10)

“One of the main things that really helped me that I was looking for was how to have a conversation about my drinking with my eldest … it sort of dawned on me that actually he’s going to know that what I’m doing isn’t good for me and it’s frightening and they helped me with all that side of things. To actually be able to be open with my children and talk to them”. (Interviewee 9)

One of the young people said that now he liked being able to have more things to do and have more friends round to his house.

“I’ve been having a…lot more friends because I only had one or two coming, now I’ve got lots.” (Interviewee 7)

The interviewees also discussed the positive change that had occurred in their relationships with their children.

“...I didn’t feel bonded with [child] but I now feel like we’re getting somewhere...” (Interviewee 2)

“I’m a mum and I love it and we’re all very close so I suppose [we’re] closer now because I’m a stronger person.” (Interviewee 11)

**Changes in their children**

A change for the better in their children’s feelings and behaviour was also commonly discussed. Interviewees had noticed their children’s behaviour had improved and that they seemed to be happier. They said their children were more open and willing to talk with them and that they seemed to feel more secure. Most interviewees said their children were aware of the changes that had happened at home.

“... he’s more open now, he talks you know, if there’s something bothering him you know, he’s very open and he talks, whereas before he... just used to keep quiet...but now the communicating is very open...” (Interviewee 1)

“She’s noticed a lot of changes, since I’ve been coming here. She doesn’t see me drinking, she doesn’t see anything else you know, she’s quite happy with that.” (Interviewee 4)

“He used to have big big tantrums and...I would feel really embarrassed just going to the shop...but now that’s sort of changed...” (Interviewee 2)

“Before I used to get problems with her schooling and used to be a nightmare. She’s happy to go to school. She’s just a different child altogether. She’s more confident. She’s more outgoing. She’s more
academical. She goes to school every day without a problem.” (Interviewee 10)

“His confidence is growing and growing. He still, he can be a little bit of a handful but he’s just a normal 8 ½ year old boy. They just test your boundaries. … Apart from that he’s a lovely little boy. He’s very loving and caring, from what he’s been through he’s still standing strong.” (Interviewee 6)

One of the young people interviewed said that since their family had been coming to CASA Family Service he no longer felt lonely, never had any arguments with his mum or said upsetting things and never talked about sad feelings as he only had positive things to say. The young person said he felt happier now.

**Change in alcohol and drug use**

Current service users reported positive changes in their alcohol and drug use. All but one of the current service users felt their or their partner's alcohol and drug use had reduced since attending CFS. Interviewees said their awareness of the impact of alcohol was now much greater and they also felt able to cope without alcohol.

“… [partner will] only have the odd can…and [partner] will stop at that, which is a big big change.” (Interviewee 2)

“I know exactly what I’m doing. I know how to control it now as well, I do know what’s good and what’s not.” (Interviewee 3)

“I know why I drink. There were reasons, I didn’t really know then but I do now.” (Interviewee 11)

Some of the interviewees were still drinking and using drugs, but they said that they had cut down from their previous use. Current drinking scores on the 1-10 scale (with 1 being no alcohol use and 10 being heavy alcohol use) ranged from 1 to 3. However it was clear that some people were still drinking at high levels in spite of reporting reduced use:

“With the alcohol...I’m really good actually...well at one point before I got to the stage where I was up to like 2 to 3 litres of cider again, but now I’m back to about 1 again. Doing good.” (Interviewee 3)

Changes in alcohol and drug use among the service users who had completed their work with CFS were a little more difficult to determine. For two of the completers the problematic use was by a loved one – one respondent did not want to discuss it, the other appeared to minimise her loved one’s use and vacillated between stating it was a problem and it wasn’t. However her work with CFS around the impact of his substance use had a knock on effect in terms of her own alcohol use:

“Because when the children were here I could have no alcohol. I used to like a glass of wine or a Bacardi, well I’d have no drink in here whatsoever. .. and now I’ve got my life back but to go and sit and have quite a bit to drink, it has just done something to me. I don’t know. It’s just, it isn’t the
same. Before … I could sit and have a Bacardi and coke and a chat with my friends and now, I don’t know, I just didn’t want it, that’s right, I didn’t want it. It put me off … Not that I’m a drinker - I’m a social drinker - but it has just done something to me.” (Interviewee 5)

The remaining two completers reported changes in their substance use post CFS, with both rating their former problematic drinking at 5 on the 1-10 scale. One stated she was no longer drinking, rating herself as 0 on the scale, but as 2-3 on the drug use scale, the other had reduced her alcohol use to one bottle of wine per night and placed herself as “2-3” on the scale.

Domestic violence and abuse
Some of the participants discussed the impact of attending CFS on the domestic violence they were experiencing in their lives. Two people said the ‘arguments’ they previously experienced no longer took place and that they did not want violence around their children.

Other service users said they felt they now had the strength to cope with domestic violence and their attitude towards their (ex) partners had changed for the better. In addition, it was felt by one of the interviewees that the verbal domestic violence she had been experiencing decreased due to her partner’s reduction in drinking and this was as a result of CFS’ intervention:

“…now we don’t have any arguments…it’s just been the one can, he’s not abusive with one can…” (Interviewee 2)

“Whenever my ex has acted in a certain way and he’ll tell me what I’m doing to him…whatever he said to me I believed, it was quite a stressful thing but now I can deal with him.” (Interviewee 11)

“…it’s not good for me and my kids and stuff so, I don’t want violence around them.” (Interviewee 3)

Some interviewees also spoke about the improvement in their romantic and familial relationships since they had been attending CASA Family Service. They felt they were more open with, and closer to, their partners and subsequently spent more time together.

“…we’re spending more time me and my [partner] together now, and that kind of brung us back together again, like when we first met.” (Interviewee 1)

“…once we came here and we spoke everything out and got all the support and stuff we’ve started working together as [partners], rather than just arguing and bickering and stuff, so we’re working together as a team, working with the children and everything’s just coming together.” (Interviewee 2)
Reasons for change
Most service users acknowledged a range of areas of support that had enabled them to change. Three areas were identified as responsible for the positive changes in people’s lives: meeting with CFS, their own self motivation, and motivation they took from their families.

The participants talked a lot about how CFS had helped them to change by giving them useful skills and enabling them to cope with situations. A few of the service users felt their current life would not have been the same if they had not been supported by CFS, and would have in fact been much worse.

“...if it wasn’t for [worker] I would just, I won’t be around, not at all, not at all.” (Interviewee 4)

“...I think they’ve helped me so much that I don’t know whether I’ll be the person that I am today without their [support].” (Interviewee 11)

“... if we didn’t have this support, there would be nothing, we would have collapsed, you know, [partner] would be in [another country] now and I’d be on my own with two kids so I thank CASA for us, making us strong as a family again.” (Interviewee 2)

Many of the interviewees felt their own motivation to change had enabled them to seek help and improve their lives, as well as the help they had received from CFS and other support services.

“I acknowledge the fact that I had a problem and I started looking out for help, so it’s down to my willingness to change basically.” (Interviewee 1)

“Obviously I’ve put a lot of work into it as well...” (Interviewee 11)

The support from those around them was also a motivation to change. One interviewee said they had remained sober for 18 months because they had accessed and received help from Alcoholics Anonymous, in addition to the help they had received at CFS and support from their family. One service user attributed her reduced drinking to her children who she felt had motivated her to change

“And also from my family because they really were suffering with me and they gave me support, a lot of support up...I think it was their influence as well as my willingness to change yeh.” (Interviewee 1)

“My family and obviously my meetings [with AA], when I went in the beginning, have helped me to live a life without alcohol to blot stuff out, so I’m in a good place now.” (Interviewee 11)

No change and reasons for it
For some of the service users interviewed, they felt that some areas of their lives had not changed. One service user felt she always had a great relationship with her children so change in that area of her life was unlikely.
For two interviewees certain situations in their lives had not changed for the better, but they felt CASA Family Service had done enough to support them through the situations. They felt either that they did not expect CFS to be able to do much about the situations or knew there was further work to be done with the service to work towards positive change.

One interviewee said CFS had not helped her to reduce her drinking because her alcohol use was not actually much of a problem. However this person continued to drink throughout the day and felt CFS had not helped her to address her physical needs, but had only helped with enabling her to talk about issues she faced:

“...I'm still the same person as I was before I met them...I don't think it's changed anything...I don't think it stopped me doing my drink...But the thing is I'm not comatose when I do drink because I'm still functioning you know? So I'm not...just drunk dead asleep, no, no. So for me I feel like I haven’t got a problem because when I think of alcoholics, you know the ones that sit on the street, the dirty ones, toothless ones...Because I still get on with my responsibilities, my kids don't go hungry, I do shopping, I do cooking but say in the daytime I could be drinking bit by bit...you know I don’t get drunk.” (Interviewee 8)

### 3.3.3 Experience of CFS

A number of themes emerged regarding how people experienced CFS from the start of the contact through to their ongoing or previous work with them.

When asked about their first visit to CASA Family Service and how they felt about attending, most interviewees reported mixed feelings; they were apprehensive and confused about what the service would be like but at the same time wanted help and looked forward to finding out what CFS had to offer.

“When [I] first came to CFS [I] was worried because [I] didn’t know what to expect...” (Interviewee 12)

“I had sort of mixed feelings because I wasn't sure what it was all about...but I just thought they're going to try and help us so let’s go.” (Interviewee 2)

“Well I felt nervous because it was something new and I didn’t know what to expect.” (Interviewee 9)

“A bit apprehensive, as I said I’m a private person and stuff that was going on in my home I didn’t really want to share...” (Interviewee 10)

Some interviewees were worried about being judged by staff and felt embarrassed to talk about their substance use. Others said they felt calm and comfortable at the first meeting with the service. After having met with the staff at CFS for the first time, interviewees said they felt fine, which they attributed to the nice staff that had helped them to settle into the service. Participants said they no longer felt embarrassed after meeting with staff and that they wanted to attend the service once it was explained to them. All participants said there was nothing more or less CFS could have done at
their first meeting to make them feel more likely to attend for further sessions.

“... it was fine after [I] came as they were nice.” (Interviewee 12)

“The CASA staff are very friendly and they make you feel welcome you know...they put you at ease...” (Interviewee 1)

They’re just so, their whole manner is just so sort of warm and welcoming, non-judgemental and supportive that it just, I just thought ‘yeh I can come back here’. Definitely. …They’ve been incredibly, incredibly amazing. (Interviewee 9)

In relation to ongoing work the interviewees continued to speak very highly of the workers at CFS and said they were friendly and welcoming. The parents said they liked the staff, with one interviewee seeing her worker more as a friend. Another highlighted how much their child was fond of the staff:

The consistency of having one worker, often for long periods of time, was identified as a strength. For some this enabled trust to be built up which, in turn, allowed them to be more open in sessions:

“I feel good that...there’s been one person because a lot of these services you use...it’s just getting to know somebody all the time and you know, them getting to know you is like going through your whole life again all the time and its really good the fact that I’ve known [worker] for that long...” (Interviewee 3)

“I got closer and closer and closer to her yeh, more, I built up more of a trust. Because it takes me a while to trust people so, trying to study people out beforehand but she supported me in every possible way like with social workers, you know she was very supportive.” (Agency 6)

A few of the interviewees thought their workers had good knowledge and experience. Others commended the staff’s excellent level of understanding and the effort they made to help them and their families.

“... [worker] could understand the situation I’m in.” (Interviewee 4)

“It’s amazing how they have really kind of cared for us and you know...” (Interviewee 1)

“...because they worked with other families and other children, so they know all about it...if there’s something they don’t agree with they’ll just say it in a way which will show us actually they’re right what they’re saying, which really helps us...” (Interviewee 2)

“Because they were very good at what they done. They didn’t, they don’t judge you. They help you. They help you an awful lot.” (Interviewee 10)
Particular to the completers was a sense that they could contact CFS whenever they needed to although they were no longer formally engaged with the service. There was a clear sense that they had moved on with their lives but also a clear sense that they could call CFS or go back to the service if they needed it again in the future.

**CFS vs other services**

Most of the service users had been involved with other services and it is in this context that their views were sought on CFS and the impact it had on different aspects of their lives. In comparison with other services CFS was viewed very positively. In particular the one-to-one work at CFS was preferred over group sessions as they had their own time to talk, did not absorb other people’s problems and did not feel like they had to make friends with peers.

“...they speak one to one rather than having other parents around me. I don’t like other parents around me.” (Interviewee 4)

“I think I found the group meetings a bit draining after a while because I end up...taking on board everybody else’s problems...” (Interviewee 3)

In addition, one interviewee appreciated the fact that it was not an abstinence only service and that she was able to call her worker on the day of her session and tell her she had had a drink.

The majority of interviewees felt CFS was different to other services in that CFS helped when other services could not. Participants felt that they were not supported at other services compared to CFS.

“I don’t want to go elsewhere and you know, I’m happy coming here. I feel like we get what we need from here...I just think we’re getting all the support that we can...” (Interviewee 2)

“The other services did not work because they don’t understand it. It’s always talking about children, you know, they’re not talking about the alcohol, they leave that one behind, talking about the whole thing, ... my alcohol, my children, you know I need help with all of it. I need all that,[with other services] it’s just one and I think that’s not helpful just one. I just want the whole thing.” (Interviewee 4)

“[Social services]… frightened my daughter because every time she would do something wrong, I felt scared, not now, but I felt frightened to chastise her because I was frightened that I’d get reprisals from them, so their services did more harm than good.” (Interviewee 10)

Service users preferred the approach that workers used with them, noting CFS staff were not forceful. They were encouraging in their approach and interviewees, including one of the young people interviewed, felt able to talk about issues they wanted to talk about.

“With here they give a lot of information, they’re not forcing you, they’re just giving you, I feel more comfortable. “ (Interviewee 4)
“[I] didn’t feel pressured to talk about certain things if [I] didn’t want to.” (Interviewee 13)

“Encouragement you know … I didn’t want to go back to the alcohol services because I felt a bit let down by them and then I sort of just wasn’t in the right space so I just basically started drinking 15 minutes later each night and it was, and I was talking to [staff member] once a week as well. That’s what I did.” (Interviewee 9)

Of the other services people were accessing, most were accessing services that CFS had either referred them to or had direct links with, including the CASA Day Centre, CASA Families, Partners and Friends Service, Solace Women’s Aid, Social Services, mental health services (child and adult), Coram Parenting and adult drug and alcohol services.

Some of the interviewees could not remember if they had accessed other services or if CFS had referred them to services, whilst some said that they had not attended the services they had been referred to.

All of the interviewees agreed that the CASA Family Service was a good service that they found useful. Most of the interviewee’s explicitly said they liked the service and some said they enjoyed going to CFS. A few of the participants said they liked the atmosphere of the service.

The two young people said they both liked the rooms they met in (particularly the bigger one). One of the young people said he liked the journey to CFS as he got to spend time with his mum; the other liked the routine of going to the service every week.

The CFS approach
There were many ways in which CFS had supported service users and worked with them to improve the outlook for their family. One interviewee mentioned her family had participated in the card sort exercise, which her son had enjoyed, and that they often played it in sessions when her children were present.

“...we played with some cards and [child] had to pick cards and I had to pick cards and [partner] had to pick...what was important to us, like being happy, having food, TV, you know all different kinds of things and [child] enjoyed that, [child] wanted to come again...” (Interviewee 2)

One of the most frequently occurring themes was that of being able to talk and open up to the staff at CFS and how this had been hugely beneficial to the interviewees. They said it was nice to talk and they felt it was soothing and therapeutic because it enabled them to ‘get it all out’. The service users valued their sessions as a safe space to talk about issues that they perhaps could not to talk to other professionals or family members about without feeling judged. They also felt staff were good at listening to them and this emerged as being a key element of what helped.
“…they listened to what I had to say you know, not many people had listened to me before but they did listen and understood what I was talking about and they supported me.” (Interviewee 6)

“...I realised now that it gave me the opportunity...to get things off my chest and talk about things.” (Interviewee 11)

“...this one is just one room, nobody else there. And you can talk, free, you can talk about your alcohol, you can talk about other things.” (Interviewee 4)

“If I’ve got stress or a problem I’d rather come here and talk about it rather than go to someone at home...I feel more happy coming here.” (Interviewee 2)

Another common theme was the interviewees felt that they had learned new ideas and skills from CFS – often around communication and resolving problems. People stated felt that they had learnt to talk and be open with their partners. Interviewees also described how staff had helped them with their parenting and their relationships with their children.

“And when [her worker] told me how to do it, how to talk to [him], I talked to [him] or sometimes she will say ‘if [he] doesn’t want to talk, try and sit down and leave it’...” (Interviewee 4)

“...it’s good you know...they show us different views...maybe we’re thinking something really bad about something and then they say ‘well no actually, if you look at it from this way’...then we think ‘oh yeh’, we feel better.” (Interviewee 2)

Many of the interviewees felt the support they had received at CASA Family Service was excellent and felt there was nothing more they could do to help them. Service users discussed the different ways in which they felt they had been supported, ranging from learning about the impact of alcohol on them and their families to relapse prevention to support for parenting and stressful situations and going the extra mile to give them confidence by involving them in agency recruitment:

“…it’s nice to know that people have got that confidence in you. It all helps, along your recovery. Because you need as much support you know along the way because it is hard.” (interviewee 6)

All of the participants described positively the approach that staff took with them and their families and the flexibility they offered. One interviewee recalled how her youngest child did not feel comfortable with a lot of adults in the sessions, including the workers, her parent and older siblings, so staff changed to one-to-one work with the child rather than family sessions. This flexibility to meet the individual needs of clients and families and tailor their approach to those needs shone through in all the interviews. Another interviewee liked that the fact that the service was flexible in arranging appointments – allowing appointments to be made at convenient times.
One service user commended the service’s ability to address all of the issues she needed help with, not just her drinking or help with her children.

**Domestic Violence**

When the interviewees were asked about how CASA Family Service had approached the issue of domestic violence with them there was a mixed response. Some of the participants said they had discussions with staff about their domestic violence experience and that these had been separate to their partner if they were still in a relationship. Several participants talked about how CFS had helped support them through their experience of domestic violence.

“And they did give me generally lots of advice about how to react to him, how to be, what to do and my strength has grown because I used to carry a lot of guilt because of the relationship.” (Interviewee 11)

“...I went through them, and I ended it anyway. Yeh I speak about everything you know, I spoke to [worker] about how I felt about the relationships and the ups and downs...” (Interviewee 3)

[They provided] someone to talk to and support with anything and information if things were going on for me and the children. I think one point she did send me to Solace Women’s Aid, which was good for the kids as well. Do the art therapy and stuff don’t they? Yeh she just advised us where to go and just support really, she was there. (Interviewee 6)

Two interviewees said they had not spoken about domestic violence with their worker, one of which thought CFS probably knew about her experience but that they had not really gone into much depth during sessions, but she said she would be happy to talk about it:

“...we didn’t really explore that side of things but they are aware why I have moved here without my partner knowing. But no we didn’t delve into that side of things.” (Interviewee 8)

However, another interviewee felt very strongly that she did not want to discuss domestic violence with CFS stating she would rather not have to think about it:

“She’s asking me about my abuse and things, I refused to talk about it...I just want to blank that one out, if that comes up it will make me more angry and I won’t bring that up. I know she’s trying to help me but I won’t bring it up.” (Interviewee 4)

One interviewee said she had not experienced domestic violence.

### 3.3.4 Challenges and Improvements

When asked if the service users had faced any challenges whilst attending the CASA Family Service or if they felt there were any areas CFS needed to change, the overwhelming response was that everything CFS had done was fine and they had not found any weaknesses or challenges in the support they had received.
Two people made suggestions on how to reach out to more people and another said that she had initially found sessions draining. However, in general service users liked the service and were grateful for the support they had received. One of the young people said that there was “nothing to improve” at CFS.

A few interviewees said they would recommend the service to someone who was in a similar situation to themselves and one interviewee said she had mentioned the service to a local MP who was involved in commissioning in Islington.

“I’ve put big words in for the services so you know I felt they were good, because they have helped.” (Interviewee 4)

“I like to do anything that helps because you know I like to give back because I’ve been helped...” (Interviewee 11)

One interviewee disclosed a challenging situation she had faced involving her worker at CFS, where a referral to another service was made resulting in the service user feeling very hurt and confused. The situation was however quickly resolved and the interviewee said she was able to maintain the excellent relationship she had previously had with her worker and that she continued to access the service. This service user was clear that she held CFS in high regard, but was worried that in a similar situation someone else would not have taken it so well and dropped out of the service.

A few of the interviewees suggested some ways in which the CASA Family Service could be improved, which included taking more of a preventative approach and doing outreach in secondary schools and having more advertising in places people frequently access, like pubs and GP surgeries. One interviewee was concerned for CFS’s funding as she knew most services were underfunded. Another client felt links to a hypnotist may improve CFS’s ability to help individuals with alcohol problems.

### 3.3.5 Moving Forward

When asked what they hoped to gain from working with CASA Family Service from that point onwards, most interviewees said they wanted to continue to make improvements in their lives and lead a normal life with their children. One interviewee was anxious about what she felt was the precarious nature of reducing alcohol use but hoped to see more certainty in the future. Others realised there were still changes that needed to be made.

“I think the main challenge that we have is [partner] not drink[ing], we don’t want [partner] to drink again, so that’s the main thing...” (Interviewee 2)

“...it’s still work in progress, and I’m not there yet, so I’m still depending on the help and advice...I want to...just be free of alcohol...I want to be at a level whereby I’m not at risk anymore you know.” (Interviewee 1)

### 3.3.6 Discussion

The interviews with former and current service users were designed to explore the extent to which the CFS model in practice addressed harm relating to parental
substance use, and the extent to which it addressed the overlapping issues of substance use and domestic abuse.

What is clear from the current and former service user interviews is that prior to CFS involvement their level of substance use, or that of their loved one, was extremely high and that all reported positive changes in their own or a loved one’s substance use. It cannot be guaranteed that these changes were purely the result of CFS intervention, as people were in touch with other services and also identified a range of internal and external motivating factors. However, the service users were, overall, extremely positive about the support they received from CFS, how they were treated by staff and what they were learning or had learned about the impact of substance use on their children. Both current and former service users reported their present level of substance use as being significantly lower than before they started work with CFS although only one current service user reported abstinence. It was apparent that some people were still drinking and using substances at relatively high levels even though they reported reducing their use considerably. This is not to imply that people were not telling the truth as a change from very high to relatively high levels of use can still be a tremendous achievement and significant reduction in use. It could however indicate a lack of awareness of the risks that remained in the current levels of use. This could only be judged through further assessment and discussion.

What was very positive was the extent to which the majority of former and current service users felt their work with CFS had initiated personal changes for them as individuals but most importantly in terms of their parenting and their relationships with their children/grandchildren. Of particular importance is the topic of improved communication skills which was a thread that ran through all the interviews. Whether this was being able to talk about their own stresses and pressures without feeling judged, or how they had improved communication with partners and children in particular, this is clearly an area of CFS’ work that is an important and successful one for service users. From engagement at the initial meeting or point of contact to ongoing work within and outside sessions, the service users reported extremely positively about the approach and manner of CFS staff.

What this approach also does is model a way of communicating, even about difficult and sensitive issues, and this appears to have had an impact on the service users. Importantly parents reported positive changes in their children’s feelings and behaviours and seemed to be aware that this was a result of the changes they had made. What would strengthen subsequent evaluations, be they external or internal to CFS, is mechanisms to ensure greater feedback from children and young people and other agencies involved in the care of the children where appropriate. This would allow the positive reports from parents and carers to be corroborated.

The level of co-existing domestic abuse and substance use, primarily alcohol, appeared high among those who disclosed domestic abuse and were willing to discuss it. CFS’ response in general appeared to be positive and there were clear examples of how CFS staff had offered support and discussed the options available for specialist support. For some parents and children, referrals to specialist domestic violence services had been made and accepted. Some service users said that domestic abuse had not been addressed and this raises questions as to whether routine questions about domestic violence are being asked as part of the
assessment processes or whether the service users interviewed had simply forgotten.

Appendix 11 includes a table of the key assessment documents currently known to be in use at CFS, cross referenced with the four key areas of practice that are at the core of CFS work. Domestic violence appears to be well considered in the current assessment processes at CFS however what is not evident from the assessment forms is the extent to which all staff are routinely questioning service users and how this is being done, that is, what questions are being asked. Clearly the CAADA DASH form is used where there is a positive response to the Yes/No question about domestic violence on the risk assessment forms but its length and purpose are not necessarily appropriate for inclusion at initial assessment. As the table shows, most of the assessment forms contain prompts about domestic violence or use domestic violence as an example of additional information in a particular section but only the referral form guidance notes list some questions that people could ask and it is not known to what extent the questions on the referral form guidance notes are being asked by all staff in the assessment process. It may be that questions on domestic violence are so automatic and so embedded in the assessment process that CFS staff feel questions do not need writing down. However for consistency, monitoring and measuring purposes it might be advisable to include routine questions on domestic abuse on the forms used with service users as opposed to those geared towards referrers. Indeed domestic violence questions could be integrated into current or new matrix forms given the high rate of overlap with substance problems and the combined negative impact on children’s safety. An example of one matrix style domestic violence assessment has been appended to this report (appendix 12).

3.3.7 Conclusion
To conclude, the service users in general spoke very positively about CASA Family Service and felt the support and service they had received had enabled them to make positive changes which had improved their relationships with their children and other loved ones. Alcohol use was a major issue for all those interviewed, be it their own or a loved one’s use. Apart from one individual, all had made steps towards changing their use because of the services they had accessed. Domestic violence in some form was present in all of the interviewees’ lives, and CFS had varying involvement in supporting the clients with it.

The interviewees felt CFS was a very good service, with excellent staff that had created a safe space for them to talk about sensitive issues that at times had not been properly heard or addressed by other services. The two young people interviewed liked the service and the adult service users had noticed a change for the better in their children’s behaviour. There were some specific areas in which some clients felt CFS could improve, but overall the interviewees said they and their children had benefited from meeting with the service.
3.4 Strengths and limitations of the research

Asking people about their substance problems and experiences of domestic violence and abuse are highly sensitive topics to research. The construction and design of the research must prioritise safety (both emotional and physical) and sensitivity. Recruitment to research of this kind can therefore be challenging. One of the strengths of this evaluation was that initial contact was made by CFS staff. Where a relationship is established and positive this is likely to help recruit service users to the research. Similarly where regular contact already exists, as with current service users attending the service, there were regular opportunities to ask people to take part. However this strength could also be a weakness. Where relationships with CFS staff have not gone well people may decline to take part. Alternately where their experience of CFS has not been what they wanted or expected this may also affect recruitment. Researchers are often seen as neutral in these situations whereas CFS staff are understandably linked with concerns over child welfare and parenting abilities.

This evaluation has resulted in a large amount of valuable data. However the sample size represents only a proportion of CFS service users and is very limited in terms of children and young people recruited to the study. In spite of CFS’ best efforts only two young people agreed, or were able, to be interviewed. The circumstances surrounding one of these also led to a curtailed interview. In spite of the willingness of both parent and child to take part, meeting at CFS was their first contact for some time and emotions were high. It felt inappropriate to use the limited time they had together to conduct a fuller research interview. Also, at the request of the young person, the parent was in the room at the time which may have influenced what the child said and did not say. This lack of feedback from young people is a limitation of the research and no conclusions can be drawn relating to their experience of it. Tying the evaluation to a group work session with children and young people attending a group at CFS was suggested however no groups were running at the time of the evaluation. Future monitoring and evaluation of the CASA Family Service should consider the best ways to maximise involvement of young people attending the service.

The findings are also likely to reflect more positive views of CFS as it would be reasonable to assume that people who may have been unhappy with the service would be less willing to discuss their experiences of it. Conversely, those who agreed to take part may well be those that are happier with the service and therefore willing to spend extra time discussing it or making the effort to meet with the research team.

Finally, given the timeframe of this evaluation it was not possible to use methods that would offer a more objective measure of individual and family change relating to the aims of the CFS intervention. In addition to the qualitative data, quantitative data would present a fuller evaluation. Future evaluations should be conducted over a longer time period and include before and after measures at several time intervals to attempt to assess the ongoing impact of CFS’ interventions. They might also consider including independent data on each family’s progress from agencies with whom CFS is joint working.
Section 4 – Measuring outcomes

4.1 Overview
This section will summarise the complexities of outcome measurement, identify the key considerations for CFS in deciding which outcome measures it needs, make recommendations for how to go about developing outcome measures and highlight a number of sources that could be consulted in the review and development of such measures. Unfortunately, it is beyond the remit of this evaluation to clarify or review specific outcomes for CFS as this is a task that needs to take place in-house. There are very many potential outcome measures that may be appropriate for CFS but these would need to be reviewed in light of agreed CFS outcomes.

There are many uses of the term ‘outcomes’. The DCSF (2008: 7) defined outcomes as “end results”; the result of the actions that precede them. The outcomes for children and young people introduced in the Every Child Matters policy framework and cemented in law by The Children Act 2004, required the “whole system of children’s services” (H.M. Government 2004: 4) to work towards five broad outcomes for children:

1. Be healthy
2. Stay safe
3. Enjoy and achieve
4. Make a positive contribution
5. Achieve economic wellbeing

The organisations and services that make up the “whole system” have been tasked with adopting a focus on outcomes in their service delivery, in ensuring outcomes accountability and commissioning, and through service evaluation. The language of outcomes and outcome monitoring now dominates the funding and political agendas.

In order to effectively measure such broad outcomes they need to be broken down into service relevant outcomes and they need to be meaningful, achievable and be able to track change over time. In the Every Child Matters Outcomes Framework (DCSF 2008) each of the five broad outcomes have been broken down further. For example, ‘be healthy’ is broken into “physical health”, “mental and emotional health”, “sexual health”, “healthy lifestyles” and “choose not to take illegal drugs”. By breaking down the broader outcomes, outcome measures can then be sought which focus on each of these specific areas.

4.2 CASA Family Service Outcomes
The same principles apply to the outcomes for CASA Family Service. For CFS its broad outcomes and indicators are:

5. Reducing substance misuse related harm to children
   a. Reduction in substance misuse taking place in the presence of children; children no longer exposed to methadone etc, children no longer exposed to inappropriate substance misusing adults
b. Positive change in family status in relation to child protection issues, eg. removed from register

c. Engagement in adult treatment services, reduction in substance use

d. Increased engagement in professional and community support networks as appropriate.

6. Increasing protective parenting

a. Time and positive attention for children from parents/carers

b. Children seeing parents/carers being united and caring. This includes consistency of approach between parents/carers and reduction in parental conflict

c. Routines and special occasions being maintained consistently for children

d. Supporting children to show and talk about feelings and to have positive view of themselves

e. Involvement of other appropriate supportive adults and external activities for children

f. Deliberate planning for the future

g. Improvement in family functioning – established routines, boundaries in parenting/children’s behaviour, joint children and parent/carer activities, meals eaten together, better communication between the adult and child(ren)

h. Improvement in the adults’ self-esteem and confidence around parenting skills

i. Increase in appropriate, encouraging, non critical feedback to child

7. Increasing resilience in children

a. Children understanding and expressing feelings

b. Having own abilities and interests

c. Children engaged with people and activities outside the family/wider support networks

d. Being able to problem solve and have coping strategies

e. Able to ask for help

f. Seeing self as separate from family problems

g. Having own plans for the future

h. Being given age appropriate information about adult problems

i. Better school attendance/improved engagement in school work

j. Improvement in presenting difficulties or behaviours

k. Increase in confidence and socialising

l. Regaining status as a child as opposed to role as young carer for parent/carer and, in some cases, younger siblings.

8. Reducing parental substance misuse

a. Abstinence

b. Near abstinence with occasional lapse

c. Controlled use

d. Reduction in quantity

e. Reduction in frequency

f. Reduction in harmful practices, eg. sharing needles; putting self in dangerous situations
g. Engagement in treatment for substance misuse.

In addition a broad outcome relating to domestic abuse was considered for this evaluation:

9. Reduce domestic violence-related harm to adults, children and young people

CFS has clearly begun the process of breaking down broad outcomes into related outcomes or indicators. It is extremely positive that these go far beyond the outcomes specified in other attempts at outcome measurement, for example the Treatment Outcome Profile form, and they are relevant and useful given the purpose and aims of the CASA Family Service. Currently these qualitative outcomes are monitored on an ongoing basis through feedback from staff, service users and professionals with whom CFS works. They are recorded in progress notes, clinical supervision notes and review minutes, and are collated by CFS’ manager every quarter for reporting purposes.

However while the outcomes are all relevant and can be measured qualitatively they could be strengthened in the following ways:

1. Each specific desired outcome measure needs to be set alongside tangible indicators that clarify how it will be evidenced. For example, 1b – ‘Positive change in family status in relation to child protection issues’ - is clearly measurable; the evidence is removal from child protection register which is verifiable. Similarly 3i - ‘better school attendance’ - can be verified by school registers/partnership work with the school. However others are not as clear and these could be strengthened. For example, 1d – ‘Increased engagement in professional and community support networks as appropriate’- what is it that will indicate that the person has achieved this indicator? Would this be involvement in self-help meetings, or recommencing involvement in a church group, or attending a Zumba class in the community centre? All outcomes need to be evidenced and achievable. CFS would benefit from reviewing all its broad and specific outcomes and ensuring that it is clear what evidence they are seeking for each one.

2. The development of an outcome measure form for recording progress could be devised and placed on each person’s file thus facilitating easier completion on a regular basis by all staff as well as providing a tool on which to base quarterly reports or for reference by funders and evaluators. It could also note the source of the information, be it staff, adult or child service user, family member or other professionals.

3. CFS could consider whether more objective or quantitative measures could be included and/or whether validated tools, for example the strength and difficulties questionnaire, would add value to existing data or cover a number of its indicators.

**Recommendation 1** – Revisit outcomes in order to review a) what evidence indicators are needed alongside each one to demonstrate they are being met, b) how they are currently being measured and recorded, c) whether quantitative measures or validated tools could add value to evidence of outcomes, and the extent to which they are adequately broken down for measurement purposes.

**4.3 Measuring change**
Measurement over time is also a key part of assessing change and movement towards outcomes. Measures need to be administered at baseline, during and after work has been delivered. This is also politically expedient at a time when longer term recovery from alcohol and drug problems appears to be at the core the Government’s alcohol and drug strategy (H.M. Government 2010). Repeating measures at set times will evidence progress and changes, or lack thereof, and provides not only a formal evaluation tool for the purposes of outcomes accountability but also a way of more formally assessing practice and, where necessary, establishing the need for a practice review.

The appropriate timeframe will vary depending on the issue being measured and level of associated risk. For example, measuring the substance use at regular intervals during the therapeutic process provides a clear indication to both staff and service users about the degree of change in their substance use. CFS staff report regular monitoring of individual’s substance use during the course of their ongoing work with them and this is recorded in their meeting notes on individual files. However there may be advantages to a) recording this more formally and quantitatively to evidence changes in substance use without needing to sort through service users’ notes, and b) considering whether the formal 12 week reviews using the TOP form are adequate or whether more frequent reviews may be beneficial to both service user and staff in terms of measuring progress in reduction of substance use. Every 12 weeks may suffice where a child is not at risk – where a child is at risk from the behaviour of a parent with substance problems a review of levels of substance use may need to occur earlier than 12 weeks. Similarly if average length of stay in the service is less than three months, outcome measures would need to be applied sooner.

Common practice in outcome measurement is measuring at baseline then at intervals approximately three months apart. Given the six session assessment process at CFS, it may be opportune to measure at baseline and then shortly after the assessment process when service users have had both the six session assessment period and a chance to establish ongoing therapeutic work. Subsequently regular reviews should be planned although any significant changes in the lives of individuals may prompt measurement before the next formal outcome review occurs. Consideration could also be given to following up those who have left the service at 3, 6 and 12 month periods.

Woolfall and Sumnall (2010: 333) advise using likert-style scales “in order to enable progressive assessment of outcomes over time” rather than yes/no responses. Likert-type scales include a scale along which people choose a response, for example, strongly agree, agree, neither agree nor disagree, disagree, strongly disagree. Numbers could also be used as could other statements that can be placed along a scale. This type of scale is currently in use by CFS in its assessment matrices and also in its work with service users. Therefore inclusion of this type of scale to demonstrate selected outcomes would fit well with CFS’ current practice.

Recommendation 2 – Establish most appropriate time intervals for formal application of outcome measures. These may differ according to what is being measured. Consider the use of likert-type scales for selected outcomes.
4.4 Stepped approach to outcome development

The following is a summary of the key steps to deciding outcome measures:

1. Convert broad outcomes to specific outcomes: what is it you actually want to measure? Are there several specific indicators within one outcome? What counts as evidence that the indicator or outcome has been met?

2. Establish whose perspective you want on each outcome: for example, CFS managers and staff, adult and child service users, external agencies?

3. Decide whether other considerations will affect what you do and how you do it – for example, for service user outcome measures what age group/s need to be considered? Are there other factors such as literacy or visual impairment that need to be considered?

4. Decide how you want the outcome measures to be administered and recorded? For example, do you want self completion measures or those that can be completed between staff and service users? Is there a specific form to use and be placed on people’s files?

5. Decide how often you want to measure the outcomes? This may vary depending on the outcomes being measured.

6. Explore the outcome measures available that fit the focus, perspective and administration route required. These could be qualitative and quantitative.

7. Pilot the measures selected.

Discussions with commissioners about their expectations of the agency’s outcome measures could be an important starting point. Where relevant validated outcome measures are not available it may necessitate the development of new outcome measures.

Recommendation 3 – follow the stepped approach above to deciding outcome measures appropriate for CFS. Consider developing outcome measures with partner agencies for joint work.

4.5 Monitoring and recording

What is essential is that outcome measures are not used independently of ongoing monitoring and recording practice within CFS. In their review of 53 outcome measures for evaluating UK-based interventions for children whose parents have substance problems, Woolfall and Sumnall (2010) concluded:

...outcome measures should not be used in isolation, but to compliment the use of formative process and monitoring data... [sic]

Monitoring and recording data helps to establish statistical data which provides both a quantitative analysis of for example, referrals to domestic violence services, but also provides an indication of trends across a period of time which can be used qualitatively for review of processes and practice.

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8 Woolfall and Sumnall (2010) state that in measuring child outcomes as many perspectives as possible need to be considered for example, teachers, social workers, to maximise the chances that the emotional or behavioural change that is observed (or not) is a result of the intervention and not other changes in the child’s life or circumstances.
**Recommendation 4** – Establish what process and monitoring data is currently recorded for specific CFS outcomes and whether there are any gaps in data collection.

### 4.6 Choosing outcome measures

In the course of this evaluation both CFS staff and key partner agencies have reported the desire for better outcome measures. There is no single gold standard outcome tool for measuring the broad outcomes of CASA Family Service. However there are many tools that will measure specific components of it. From what is known about CFS’ current broad outcomes there are four main areas for which measurements could be sought: substance use, domestic violence, child welfare, and family and home environment. There are many validated outcome tools in these areas, narrowing down what is appropriate for CFS depends on what exactly it is that is being measured and with whom.

The administration of outcome measures should not be a burden in practice otherwise they will be avoided. The right outcome measure, targeted to specific outcomes, should complement and enhance the practice focus and service user goals and outcomes. In the following section a number of sources of outcome measures are suggested for reference. These are not recommendations as a more in-depth review of the many available measures is warranted alongside consideration of CFS’ practice and reviewed specific outcomes. What they offer is examples of the types of measures that could be considered. The sources referenced below include outcome measures that require different levels of application and may take anything from a few minutes to much longer to complete. Some measures will be overly time consuming and therefore not wholly appropriate but reviewing such measures may be helpful in helping CFS to develop a clearer understanding of what it wants to measure and how.

Further good practice suggests that while CFS may clarify its broad and specific outcomes, service users should also be involved in setting their own outcomes of their time with CFS. These will be similar to goals but CFS may need to support service users in ensuring they are as tangible and measurable as possible. In other words, ‘communicate better with my child’ is a fine goal but would need to be more specific in terms of outcomes, for example, ‘spending at least one hour each day talking to/playing with my child’. These will not be actions unfamiliar to the practice of CFS and a scale could be developed with the parent as a stepped approach towards achieving the outcome. Wherever possible and appropriate the child’s assessment of whether these outcomes have been achieved should also be attained.

**Substance use**

One broad outcome measure for CFS currently is to reduce parental substance use, and another to reduce substance-related harm to children. CFS currently uses a number of assessment tools for this purpose including two matrices for risk assessment – one relates to the individual’s substance use, the other to the impact of substance use on parenting and child care. Both rely on a combination of professional judgement and service user responses. A number of items on both matrices could be used as outcome measures, particularly given their use of a scale of response categories. Some items would not be appropriate for ongoing use, e.g. matrix 1, question 6, how long have you been drinking, but could be replaced with more outcome focussed items. Indeed original documentation on the matrices suggests
“second and subsequent application” of the matrices (Robinson 2006). Alongside existing substance use assessment tools, clear baseline data relating to substance use is established using these combined measures. These measures could then be repeated at set intervals during and after CFS intervention and comprise the outcome measures for the reduction of substance use among CFS service users.

**Domestic violence and abuse**

The same approach is currently not possible for measuring outcomes relating to domestic violence and abuse. Currently CFS has no outcomes relating to domestic violence and abuse. The detailed risk assessment form (part 9) in use at CFS signposts staff to the CAADA DASH form that lists questions on domestic violence for the purpose of MARAC (Multi-Agency Risk Assessment Conference) referral, however the questions are necessarily very risk assessment focussed and not helpful as a therapeutic tool nor as an outcome measure. Outcome measures need to be adopted or developed for specific outcomes in this domain.

For children’s exposure to adult domestic violence there are limited tools available. Reference could be made to the *Children’s Exposure to Domestic Violence Manual* (Edleson et al. 2007) which contains a short summary of measures available and a new tool developed by the authors for measuring domestic violence exposure for children aged 10-16. There is also a compendium of tools available that provides details of 170 different tools for measuring the “serious violent and delinquent behavior, conflict resolution strategies, social and emotional competencies, peer influences, parental monitoring and supervision, family relationships, exposure to violence, collective efficacy, and neighborhood characteristics” (Dahlberg et al. 2005:1).

For adult exposure to domestic violence there are even fewer outcome measures. One assessment tool that has been used as an outcome measure is the *Domestic Violence Survivor Assessment* (Dienemann et al. 2002)⁹. Dienemann (undated) describes the tool:

> We created a grid of 12 issues across a continuum of five states based on Landenberger’s Theory of Recovery and the Transtheoretical Theory of Change. The five states are: Committed to continuing, committed but questioning, considers change: abuse and options, breaks away or partner curtails abusiveness, establishes a new life—apart or together. The relationship issues include: Triggers of abuse, managing the abuse, seeking legal sanctions for abuse, attachment to the relationship, her view of options to this relationship, and managing personal loyalty to norms and beliefs. The personal issues include: accessing help, self identity, self efficacy to be on her own, feelings, mental health, and control of money.

There is a self-completion version as well as a form for the professional to complete once they have discussed domestic violence with the service user concerned (see appendix 12). What is positive about this assessment tool is the “five states” enable

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⁹ Use of this tool is possible with permission of the authors, c/o Jackie Dienemann. Email: JADienem@uncc.edu
both service user and professional to identify any changes in the service users’ beliefs, understanding and behaviours. The 12 issues can also be revisited at agreed intervals during the course of the intervention and during follow up.

The tools above have been supplied by specialists working in the domestic violence field. However, further consultation with local domestic violence services would be advisable.

*Child Welfare*

The outcome of reducing harm to children needs to be clear, measurable, and specific. There are many tools available that measure cognitive and behavioural and emotional change. Others focus on physical or mental health, including young people’s substance use. The measures available can be completed by children of different ages, their parents, teachers and carers, a range of professionals working with them and so on. They range from questionnaires to exercises to hypothetical scenarios. Thus once CFS has agreed its evidence indicators for specific outcomes decisions can be made on the type of outcome measure to use. From a parent’s perspective the current risk assessment matrix 2 in use at CFS could also be used to trigger discussion and concrete outcomes for parents to work towards. This may already be the process for goal setting.

Woolfall and Sumnall (2010) reviewed 53 outcome measures to assess their suitability for evaluating UK-based interventions for children whose parents have a substance problem. They found 17 were most suitable for use with children and seven for use with parents. The children and young people’s measures fell into five groups, those measuring; Health, Drug and Alcohol Use, Safety, School, Child Behaviour. The parent measures also fell into five broad group; Depression, Health, Drug and Alcohol Use, Parenting, Family Life and Self-esteem. A copy of the article is submitted with this report.

Another popular measure is The Strengths and Difficulties Questionnaire (SDQ) (Goodman 1997) – primarily a *behavioural* screening tool focussed on 3-16 year olds. It can be completed by parents, teachers and young people aged 11yrs +. It can be administered by professionals in discussion with parents and children or as a self-completion tool. There are also follow up versions available to be used post intervention. All versions of the SDQ ask about positive and negative attributes. Twenty-five items are divided between emotional symptoms (5 items), conduct problems (5 items), hyperactivity/inattention (5 items), peer relationship problems (5 items) and prosocial behaviour (5 items).

Finally a relatively recent development of health related quality of life measures have been developed by a cross Europe project called Kidscreen. They have developed three versions of a questionnaire for use with children and adolescents aged 8-18 yrs. The shortest version is a 10-item questionnaire and takes 5 minutes to complete. They use likert-type scales so change can be measured at different times. The other versions are 27 and 52 item questionnaires that take between 10 and 20 minutes to complete. The full questionnaire includes items on the following areas: physical and psychological well-being, moods and emotions, self perceptions, parent relationships and home life, peer support, financial resources, school life and bullying. Further information can be found at [http://www.kidscreen.org/](http://www.kidscreen.org/).
**Family and Home Environment**

Exploring the family and home environment should include attention to domestic abuse and the impact of parental substance use as mentioned above. While some measures include parental conflict this is quite different to domestic violence and abuse as CFS is aware. A number of tools are available that assess the family and home environment specifically. Some that focus on young people’s views are included in the compendium of tools previously mentioned and may be relevant for this broad outcome area and outcomes relating to child welfare, particularly those that ask children about parenting (Dahlberg et al. 2005).

A popular measure is the Family Environment Scale (Moos and Moos 1986). It allows family members to express the real family situation, an ideal family situation and an expected family situation. It contains scales that measure relationships, personal growth and “system maintenance”. However care needs to be taken in its use as it is now dated and sections such as ‘open conflict’ need to be treated with caution given our more informed understanding of domestic violence and abuse 25 years after it was introduced.

A more recent measure highlighted by Woolfall and Sumnall’s review (2010: 339) is the Family Assessment Measure (version III) (Skinner et al. 2000). Woolfall and Sumnall suggest it is useful for “identifying strengths and weaknesses of a family unit from multiple perspectives (children aged over 10 years). Each person in the family is asked to rate their roles and responsibility within the family unit and responses can then be compared and discussed therapeutically. The authors report it is useful for monitoring progress during the intervention.\(^{10}\)

**Recommendation 5** – Review what outcome measures are available and appropriate for the nature of the work and desired specific outcomes.

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**4.7 Conclusion**

CASA Family Service has clear key outcomes and related specific outcomes and is measuring these qualitatively through discussions with staff, service users and other professionals. However, as CFS is aware, the process of outcome monitoring could be strengthened further. Clearer evidence indicators for each outcome and improved recording systems could be adopted. Outcome measures need to continue to include both service users (adults and children), staff and partner agency perspectives and include both qualitative and quantitative measures. A stepped approach has been suggested here, however this is a process that is best completed in house and would fit seamlessly into the reflective culture and team discussion currently in place at CFS. There are many outcome measurement tools available, some of which may be suitable for use at CFS in whole or part. These will need exploring for relevance and appropriateness, alongside a consideration of what mechanisms already exist at CFS that could be modified and/or form part of an overall outcome measurement package.

\(^{10}\) Information on Family Assessment Measure (FAM) can be found at: http://www.mhs.com/product.aspx?gr=edu&prod=famiii&id=overview
Section 5 – Conclusion and recommendations

5.1 Conclusion

This evaluation comprised two clear strands of work: the first was to define and review the model of practice used by CASA Family Service and the extent to which it was evidence based; the second was to research the views and experiences of those who work with CFS, namely service users, past and present, and key partner agencies.

It is without doubt that the CASA Family Service has developed both a model of practice and an application of it that is highly valued by its staff, service users and partner agencies. While standing on different sides of the service delivery fence, both service users and partner agencies were united in their praise of the CFS approach, and in particular the CFS management and staff. The qualities staff bring to the service delivery and the respect and empathy they convey clearly signalled a refreshing change for both partner agencies and service users.

However, no service is without room for improvement and CFS would be the first to admit it. With its reflective approach to management and practice, reviewing what it does and how it does it appears to be an ongoing process within CFS. The qualitative data collected from partner agencies and service users in this evaluation contained very few suggestions for improvement. It is a service that is clearly valued extremely highly by those who use it, either professionally or personally. A number of recommendations are offered below and have been drawn from all stages of the evaluation process. These include recommendations relating to outcome measurement. While a review of CFS outcome measures was not an aim of the evaluation process, it has been recognised by CFS as an area it would like to review and some preliminary recommendations have been made.

It is perhaps apposite to conclude this evaluation with the views of two former service users:

“I just think that it’s a really good service, it’s a really good service. ... I know I could phone at any time...and either somebody would speak to me or they’d get somebody to phone me back. You know I know that there’s always that, that it’s open for me to use whenever I need it.” (Interviewee 9)

“... just trust them and have faith in them and let them help you. That’s what they’re there for. And they’re great people.” (Interviewee 6)
5.2 Recommendations

CFS Model and practice

1. Develop a rolling programme of training related to the CFS model to ensure model adherence and to respond to staff queries.

2. Review a range of ways of bringing children into the service at an earlier stage\textsuperscript{11}.

3. Consider whether a formal, quantitative record of changes in service users’ substance use will add to the measurable evidence base for CFS. This also avoids reliance on documentation from other services as well as reflects the ongoing monitoring by CFS staff that is part and parcel of their work already.

4. Consider whether the formal 12 week reviews using the TOP form are adequate or whether more frequent reviews may be beneficial to both service user and staff in terms of measuring progress in reduction of substance use.

5. Include routine questions on domestic violence in service user assessment documentation\textsuperscript{12}. Consider whether a matrix relating to domestic abuse can be developed to complement the existing matrix format.

6. Review follow up processes to determine if more formal ‘booster’ sessions can be incorporated into the CFS model in a bid to support longer term change.

7. Consider whether information sharing arrangements with partner agencies are adequate and whether new ones could and should be developed.

8. Retain the focus on the structure and systems required to deliver the service. In particular the following key elements are at the core of the service delivery: strong leadership, regular and informed supervision, quality staff with appropriate attitudes and skill mix, an open and transparent working culture and reflective working practices.

Measuring outcomes

9. Revisit outcomes in order to review:
   a) what evidence indicators are needed alongside each one to demonstrate they are being met,
   b) how they are currently being measured and recorded,

\textsuperscript{11} CFS managers had recognised this need in 2010 and in November 2010 changed practice to ensure children attended with their parent/s or carer/s by the second or third session. It is included as a recommendation in this report to accurately reflect the responses of staff. However, it should be noted that staff were interviewed prior to and during this period of review and change and this may therefore not reflect current practice at the time of the final report in 2011.

\textsuperscript{12} This recommendation is based on the CASA documentation received to date.
c) whether quantitative measures or validated tools could add value to evidence of outcomes, and the extent to which they are adequately broken down for measurement purposes.

10. Establish most appropriate time intervals for the application of outcome measures. These timescales may differ according to what is being measured. Consider the use of likert-type scales for selected outcomes to evidence progress over time.

11. Follow the stepped approach to deciding outcome measures appropriate for CFS. Consider developing outcome measures with partner agencies for joint work.

12. Establish what process and monitoring data is currently recorded for specific CFS outcomes and whether there are any gaps in data collection. Review what outcome measures are available and appropriate for the nature of the work and desired specific outcomes.
Appendix 1 – Interview schedule – CFS staff

Induction and Training
1. Could you tell me very briefly what your role is here?
2. How long have you been working at the family service?
3. What was your background before that?
   a. Children, adults or a bit of both?
   b. How long doing this type of work?
4. How easy did you find adapting to working with the whole family?
5. When you started, how were any gaps in your knowledge/skills identified and addressed?
   a. Child protection training?
   b. Domestic violence training?
   c. Visiting other services?
   d. Drugs awareness training?
6. When you first started, how did you come to understand what it was you were being asked to do with families and how you were to do it?
   a. Descriptive paperwork about the model?
   b. Did anyone sit down and talk it through with you?
   c. Training day with Wendy?
   d. Co-working or observing others?
   e. Were the group meetings clinical supervision and client review meetings helpful?
7. Did you feel you had sufficient knowledge and skills when you first started working with the families?

Practice and Experience of Service Now
8. How does the CASA Family Service differ to other services you have worked at?
9. How do you keep abreast of developments in the field?
10. What would you say are the main challenges that you face in your day to day work?
   a. Working with everyone but keep the child a priority?
   b. Confidentiality issues that arise from working with whole family, not just individuals?
   c. Child protection issues – lot of responsibility?
   d. Co-working?
11. How are you supported in dealing with those?
   a. Clinical supervision meetings?
   b. Client review meetings?
   c. One-to-one meetings with the team manager?
12. How do you ensure safety for all in the way that you work with families?
13. What about domestic violence?
14. How do you know whether or not things are improving within the family?
   a. Set goals at beginning?
   b. Measures/indicators?
   c. Indicators robust enough?
15. What size is your current caseload? Is this about average?
16. Do you feel that the size of your caseload allows you to deal with the complexity of family work?
17. To what extent do you work with other agencies?
18. What do you think are the strengths of the service?
   a. Engagement process?
   b. Domestic violence?
   c. Multi-agency working?
   d. Staff feel valued?
19. If you could change anything about the service, what would it be?
20. Is there anything I haven’t asked you about that you would like to say?

Appendix 2 – Adult Interview schedules

Former Adult Service Users (‘Completers’) 
(25 Nov 2010)

Section 1 - Background
1. How did you first find out about CFS?
2. When did you first start attending CFS?
3. When did you stop attending and why?
4. How often did you meet with them?
5. Where did you usually meet them?
6. Did you meet with them on your own or did your child/ren or other adults join you?
7. Do you have any contact with them now you’ve stopped meeting formally? (If not, was additional support offered by CFS?)
8. What did you feel about meeting with CFS in the beginning?
9. At that time was there anything they did or said that made you more or less likely to meet with them?
10. How did you feel about meeting with them as time went on? (If different, ask what has changed?)

Section 2 - Alcohol and drug use and impact on children/family
11. Can you tell me a little about your/your partner’s/your son/daughter’s alcohol and other drug use prior to working with CFS?
12. On a scale of 1-10 with 1 being no alcohol use and 10 being very heavy alcohol use, where were you/they when you started working with CFS?
13. Where on the scale were you/they at the end of your time with CFS? (If there is a change, ask the reasons for the change)
14. On a scale of 1-10 with 1 being no other drug use and 10 being very heavy and problematic drug use, where were you/they when you started working with CFS?
15. Where do you think you/they are now? (If there is a change, ask the reasons for it)
   (Prompt - do you think CFS has contributed to the change? or is it other services? your own choices? or a mixture of all of them?)
16. Could CFS have offered you more support with changing your alcohol or other drug use? If so, what would you have liked that support to be?
17. How was the use of alcohol/drugs impacting on your/their parenting? (Prompt: what else?)
18. To what extent do you do things differently as a parent since you’ve been coming here?
   (Prompt: aspects of protective parenting: regaining parental authority, time spent together as a family, instilling boundaries/routines, communication)
19. What impact was your/their alcohol/drug use having on family life more generally?
20. How has this changed since coming to CFS, if at all?
21. To what extent do you think your child/ren would say things have changed at home since you’ve been coming here? If yes, would you be able to tell me what they would say has changed?
22. Would you be able to tell me about any observations you have made of any change in your children's behaviour since coming to CFS?

Section 3 - Difficult or abusive relationships (only to be asked when parent on own)
23. Most people with alcohol and drug problems experience conflict in their adult relationships with current or former partners. To what extent was/is this the case for you/your loved one?
24. This conflict can often become emotionally and mentally abusive and physically violent. What has been your/their experience?
25. Did CFS discuss this conflict/abuse with you? If so, what support were they able to provide (Prompt: a) to you, b) to your partner, c) to your children/grandchildren? If yes, explore how the support has been provided, eg. 1-1 with parent/s, 1-1 with children, couples, family work, linking with specialist referrals etc).

26. (If not discussed) Would you have minded if they’d asked you about it and asked if you wanted some support?

27. If they did not discuss it, how would you have felt about them discussing it with you?

28. Have you/they had contact with other agencies who specialise in supporting people who experience conflict, abuse or violence in their relationships? (If yes, what role did CFS have in this if any?)

29. (If involved with other agencies) To what extent did you, CFS and the other agencies meet or work together? How was this organised?

**Section 4 - Reflection**

30. Would you say your meetings with CFS changed you in any way?
   a. Way you are as a parent/grandparent/relative
   b. Your relationship with your children/grandchildren etc?
   c. Your relationship with a partner/spouse or other family member?

31. What were the challenges or difficulties of meeting with CFS? (Prompt: Did you manage to overcome these? And if so, how?)

32. To what extent did CFS help you access or refer you to any other services that you might need? (If so, which services are these?)

33. What did you hope to get out of coming to CFS? And did you achieve this?

34. Is there anything you’d like to add about CFS and your meetings with them?
Current Adult Service Users
(25 Nov 2010)

Section 1 - Background
1. How did you first find out about CFS?
2. When did you first start attending CFS?
3. When did you stop attending and why?
4. How often did you meet with them?
5. Where did you usually meet them?
6. Did you meet with them on your own or did your child/ren or other adults join you?
7. Do you have any contact with them now you’ve stopped meeting formally? (If not, was additional support offered by CFS?)
8. What did you feel about meeting with CFS in the beginning?
9. At that time was there anything they did or said that made you more or less likely to meet with them?
10. How did you feel about meeting with them as time went on? (If different, ask what has changed?)

Section 2 - Alcohol and drug use and impact on children/family
11. Can you tell me a little about your/your partner’s/your son/daughter’s alcohol and other drug use prior to working with CFS?
12. On a scale of 1-10 with 1 being no alcohol use and 10 being very heavy alcohol use, where were you/they when you started working with CFS?
13. Where on the scale were you/they at the end of your time with CFS? (If there is a change, ask the reasons for the change)
14. On a scale of 1-10 with 1 being no other drug use and 10 being very heavy and problematic drug use, where were you/they when you started working with CFS?
15. Where do you think you/they are now? (If there is a change, ask the reasons for it)
16. (Prompt - do you think CFS has contributed to the change? or is it other services? your own choices? or a mixture of all of them?)
17. Could CFS have offered you more support with changing your alcohol or other drug use? If so, what would you have liked that support to be?
18. How was the use of alcohol/drugs impacting on your/their parenting? (Prompt: what else?)
19. What impact was your/their alcohol/drug use having on family life more generally?
20. To what extent do you do things differently as a parent since you’ve been coming here? (Prompt: aspects of protective parenting- regaining parental authority, time spent together as a family, instilling boundaries/routines, communication)
21. To what extent do you think your child/ren would say things have changed at home since you’ve been coming here? If yes, would you be able to tell me what they would say has changed?
22. Would you be able to tell me about any observations you have made of any change in your children’s behaviour since coming to CFS?

Section 3 - Difficult or abusive relationships (only to be asked when parent on own)
23. Most people with alcohol and drug problems experience conflict in their adult relationships with current or former partners. To what extent was/is this the case for you/your loved one?
24. This conflict can often become emotionally and mentally abusive and physically violent. What has been your/thier experience?
25. Did CFS discuss this conflict/abuse with you? If so, what support were they able to provide (Prompt: a) to you, b) to your partner, c) to your children/grandchildren? If yes,
explore how the support has been provided, eg. 1-1 with parent/s, 1-1 with children, couples, family work, linking with specialist referrals etc).

26. (If not discussed) Would you have minded if they’d asked you about it and asked if you wanted some support?

27. If they did not discuss it, how would you have felt about them discussing it with you?

28. Have you/they had contact with other agencies who specialise in supporting people who experience conflict, abuse or violence in their relationships? (If yes, what role did CFS have in this if any?)

29. (If involved with other agencies) To what extent did you, CFS and the other agencies meet or work together? How was this organised?

Section 4 - Reflection

30. Would you say your meetings with CFS changed you in any way?
   a. Way you are as a parent/grandparent/relative
   b. Your relationship with your children/grandchildren etc?
   c. Your relationship with a partner/spouse or other family member?

31. What were the challenges or difficulties of meeting with CFS? (Prompt: Did you manage to overcome these? And if so, how?)

32. To what extent did CFS help you access or refer you to any other services that you might need? (If so, which services are these?)

33. What did you hope to get out of coming to CFS? And did you achieve this?

34. Is there anything you’d like to add about CFS and your meetings with them?
Appendix 3 – Toolkit of exercises for use with children/young people

Option 1 - Interview schedule: older children

Remember there are no right or wrong answers, and it's fine to say you’re not sure.

1. Can you tell me what was your family and home life like before you and your family started attending CFS?

2. Can you tell me what your life is like now since you have been attending CFS?

3. Would you be able to think about and tell me what you like about going to CFS?

4. Would you be able to tell me what perhaps you don’t like about going to CFS?

Prompts via category cards where appropriate (8-16 years)

The cards can be used as prompts when asking the open ended questions 3 and 4. Either verbally or visually.

- Feelings
- Journey
- Building
- People who are at CASA Family Service
- What you see
- Talking about things
- What you hear or listen to
- The time you spend here

Category Cards for Option 1

Feelings

Journey to and from CASA Family Service
Building and rooms you meet in

People who are at CASA Family Service

What you see

Talking about things

What you hear or listen to

The time you spend here
Option 2: Character game

Present them with the outline of a person on the page, and say that this is their character, and they can name and colour them in any colour they want to. Go through this with them.

You are going to ask them a few questions about [name ] and what they might think and feel. Would that be ok? They can speak, write, or draw their answers. (Picture of a house and CFS can be used as aids).

Ask them if they can tell you what does __ like to do? What makes ___ happy? Suggest: friends, sport, reading, music, school. Perhaps draw these things too. What is _____’s favourite colour?

Can you tell me what _____ wants to be when they grow up?

Ask them if they can, tell you where does ___ live, and who do they live with? Prompt: in London, live with their parents/siblings/pets/grandparents.

Ask them if they can tell you what _____’s home life is like? What do they think about that, and how that makes ____/ them feel?

If _____’s family had some problems, do you think they would like to get some help for their problems? Would they like to come to a service like CFS?

If we say that ____ did come with their family to CFS can you tell me what you think ____ might think and feel? Do you think they would like coming? What might they like if they came? What do you like about coming to CFS? (Prompt: category cards)

Can you tell me what you think ____ might not like about coming to CFS? Is there anything you don’t like about coming with your family to CFS? (Prompt: category cards)

If ____ came to CFS, do you think things at home and in their family might change? How might things be different in their family and home life if ____ came to CFS?

Have things changed for you and your family since you have been coming to CFS?

Can you tell me if there’s anything else ____ might want to say about CFS, to other children and young people in a similar situation? What might help children like ____ when they feel sad? What makes you a happier person?

Thank you, you have told me some very interesting things about ____ and what it is like to be them and you. I think I would like to be their friend.
**Option 3: Relationship Cards**

Here are some cards with things that may happen in a family or in a relationship on them.

I am going to ask you to tell me whether these things happen ‘always’, ‘sometimes’, or ‘never’.

You can tell me out loud, write what you think down or draw your answer, depending on what you feel most happy doing. If there are any things that happen in your family that aren’t on any of the cards, you or I can write them down/ draw them on the extra card here.

Are you happy to do this exercise? Does everything make sense?

So **before** you came to CFS, which of these things happened in your family? Please can you tell me whether each thing on the cards happened in your family ‘always’, ‘sometimes’ or ‘never’?

(Provide an example to make clear.)

Discuss their answers. How did these things make you feel? Are these things good or bad things to have in a relationship?

Thank you, that’s excellent. Now I’m going to ask you to do something similar.

Can you tell me, **now** that you and your family come to CFS, what things happen in your family? Please can you tell me whether each thing on the cards happens in your family ‘always’, ‘sometimes’ or ‘never’?

Discussion: I see these things that always happened before, have now changed? And this happens more now? How do these things make you feel? Are these things good or bad to have in a family? Do you think CFS has helped with these things in your family?

Thank you. You have really taught me a lot about what different things can happen in relationships and how things can make the people in the relationships feel.

Is there anything you wanted to say about relationships?
Behaviour Cards for Option 3

Saying upsetting things

Buying presents

Talking about good feelings

Talking about sad feelings

Honesty

Trust

Saying sorry

Drinking alcohol
Kissing
Feeling safe
Arguing
Feeling lonely
Hurting them
Looking after each other
Being jealous
Respect
Taking money without permission
Keeping things secret that are happening at home

Using drugs
Laughing and joking together

Doing things together
Feeling happy

Giving praise
Doing what they said they would do
Calling each other names

Supporting each other

Listening to each other

Sharing looking after the kids
Appendix 4 – Interview Schedule – partner agencies

1. Please tell me briefly about your agency and the focus of its work?

2. What is the nature your contact with CASA Family Service?

3. How frequent is your contact or work with the Family Service?

4. To what extent do you have clear guidance and procedures for working together in place with CFS?

5. What value is the Family Service to your own practice?

6. How do you measure the impact of your work with CASA Family Service on your service user’s outcomes?

7. How do you feel the CASA Family Service benefits from involvement with your agency?

8. What do you think are the key challenges of working with CFS?

9. How do you operate in terms of information sharing and confidentiality procedures with CFS?

10. From your experience, what do you think are the CASA Family Service’s strengths?

11. Can you give any examples of joint working with the Family Service that demonstrates the benefits of working with them?

12. What do you think are the CASA Family Service’s weaknesses’?

13. Can you give any examples where joint working has not been successful and why that might be?

14. Do you have anything further to add about your work with CASA Family Service or about the Family Service itself?
Appendix 5 – Information Sheet and Consent Form (CASA Family Service Staff)

You may be aware that the University of Bedfordshire has been asked to evaluate CASA’s family service. As part of this evaluation we are talking to CASA staff, other agencies and people who use CASA’s family service to find out what they think about the service they receive. The research would like to include your views and experiences working within the family service.

Before we start we would like to emphasise that:
- You don’t have to take part
- You can refuse to answer any question
- You can stop the interview at any time.

We can interview you at CASA or at another location of your choosing. The interview will take up to an hour. Anything you tell us will remain confidential – we will NOT report back anything you say. Confidentiality will only be broken if anything you tell us suggests you are at risk of harm from others or if you present a risk to children or vulnerable adults.

In our research reports we may want to use something you have told us. If we do this we will not use your name or any other identifying information. All quotations will be anonymised. The findings of the research may also be used in articles and conference presentations but again no identifying information will be used.

With your permission we would like to record the interview. If not, we will take written notes as you talk. Recordings and any notes taken during the interview will be destroyed once the final report and related publications are complete, but no later than 12 months after the end of the research project.

If you have any further questions about the research please feel free to contact the Research Coordinator, Dr Sarah Galvani on 07884 007222 or sarah.galvani@beds.ac.uk. If you are unhappy with any element of the research process you are also entitled to contact an independent person at the University of Bedfordshire. The contact is Angus Duncan at angus.duncan@beds.ac.uk or 01582 743473.

Please sign this form to show you that you have read, or I have read to you, the contents of this information sheet and consent form and that you agree to take part in the research. Alternatively you can return this form electronically with an email stating you consent to take part.

____________________________________________ (signed)
____________________________________________ (printed)
______________ (date)

Return to either: i) Georgia, the researcher, at the time of the interview  
ii) by email to the researcher, georgia.glynn@beds.ac.uk  
iii) give or send to CASA, for the attention of Georgia Glynn, Researcher, C/o CASA Family Service, 86 Durham Road, London, N7 7DT Tel: 020 75617490
Appendix 6 – Information Sheet and Consent Form (Adult service users)

CASA Family Service has asked the University of Bedfordshire to evaluate their service. This means we are talking to staff, other agencies and people who use the CASA Family Service to find out what they think about the service they receive. The research needs your views and experiences of the service and hopes to find out what you feel about the service, how it has helped you or not, what the good things are about the service and what might be improved. There are no right or wrong answers – all we want is your views and experiences. It will help CASA to know what it is doing that works and if there are aspects of their service that don’t work as well. The interview will take no more than 1 hour. If you would like to speak to anyone after the interview CASA staff will be around at the agency or by phone to offer support. If you would like to speak to someone outside of CASA, please consult the Resources Sheet given to you by the Researcher.

Before we start we would like to emphasise that:
- You don’t have to take part – it is your choice and will not affect the service you get from CASA
- You can refuse to answer any question
- You can stop the interview at any time.
- You can choose the location of the interview (unless it presents safety concerns for our researcher)

Anything you tell us will remain confidential – we will NOT report back to CASA anything you say. The only exception to this would be if anything you tell us suggests you are at risk of harm or that you present a risk to children or vulnerable adults. NB. We politely ask that all research participants are alcohol and drug free when they attend for their interview.

In our research reports we may want to use something you have told us as a quote. If we do this we will not use your name so it is not possible to tell who it came from. The findings of the research may also be used in articles and conference presentations but again no identifying information will be used. With your permission we would like to record the interview. If not we will take written notes as you talk. Recordings and any notes taken during the interview will be destroyed once the final report is complete.

If you have any further questions about the research please feel free to contact the Research Coordinator, Dr Sarah Galvani on 07884 007222 or sarah.galvani@beds.ac.uk. If you are unhappy with any element of the research process you are also entitled to contact an independent person at the University of Bedfordshire. The contact is Angus Duncan at angus.duncan@beds.ac.uk or 01582 743473.

Please sign this form to show you that you have read, or I have read to you, the contents of this information sheet and consent form and that you agree to take part in the research. Alternatively you can return this form electronically with an email stating you consent to take part.

_________________________ (signed) ____________________________ (printed)
_________________________ (date)

Return to either: i) Georgia/Sarah/ Michelle, the researcher, at the time of the interview
ii) by email to the researcher, georgia.glynn@beds.ac.uk,
iii) give or send to CASA Family Service, for the attention of Georgia Glynn, Researcher, C/o CASA Family Service, 86 Durham Road, London, N7 7DT. Tel:
0207 5617490.
Appendix 7 – Information Sheet and Consent Form (Partner agencies)

CASA Family Service has asked the University of Bedfordshire to evaluate their service. This means we are talking to staff, other agencies and people who use CASA’s Family Service to find out what they think about the service they receive. The research would like to include your views and experiences of the CASA Family Service as a partner agency, in particular what you feel are its strengths and what might be improved.

Before we start we would like to emphasise that:

- You don’t have to take part
- You can refuse to answer any question
- You can stop the interview at any time.

The interview will last up to one hour. Anything you tell us will remain confidential – we will NOT report back to CASA anything you say. Confidentiality will only be broken if anything you tell us suggests you are at risk of harm or that you have or were intending to harm children or vulnerable adults.

In our research reports we may want to use something you have told us. If we do this we will not use your name or any other identifying information about you or your agency. All quotations will be anonymised. The findings of the research may also be used in articles and conference presentations but again no identifying information will be used.

With your permission we would like to record the interview. If not we will take written notes as you talk. Recordings and any notes taken during the interview will be destroyed once the final report is complete.

If you have any further questions about the research please feel free to contact the Research Coordinator, Dr Sarah Galvani on 07884 007222 or sarah.galvani@beds.ac.uk. If you are unhappy with any element of the research process you are also entitled to contact an independent person at the University of Bedfordshire. The contact is Angus Duncan at angus.duncan@beds.ac.uk or 01582 743473.

Please sign this form to show you that you have read, or I have read to you, the contents of this information sheet and consent form and that you agree to take part in the research. Alternatively you can return this form electronically with an email stating you consent to take part.

................................................................................. (signed)
................................................................................. (printed)

_______________ (date)

Return to either: i) by email to the researcher, Georgia, at georgia.glynn@beds.ac.uk
 ii) give or send to CASA, for the attention of Georgia Glynn, Researcher, C/o CASA Family Service, 86 Durham Road, London N7 7DT Tel: 020 7561 7490
Appendix 8 – Information Sheet and Consent Form
(Children and Young People)

Hello. We are Georgia, Sarah and Michelle and we work as Researchers. This means we like to speak to people about what they think about things in their lives.

CASA Family Service has asked us to find out what people think about the family service you go to. We are going to do this by talking to people who go there and then writing a report about what we find (a bit like homework). The report will be about what parents and children think about CASA Family Service. We are asking you because we don’t know what children think about the service so we hope you will tell us. We will want to talk to you for about 30 minutes.

It’s not a like a test! There will be no right or wrong answers; we just want you to give us your views on what is good about CASA Family Service and whether you think it has helped you and your family. You can also tell us if you think there are things the service could do which they are not doing at the moment. CASA Family Service want us to find out about this too.

If, when we are talking, you want to stop talking or leave the room that’s OK. If you don’t want to answer any of the questions that’s OK too. We will keep everything private so we won’t tell anyone what you tell us. BUT if you tell us that someone is hurting you or that you might be hurting other people we might have to tell someone. We would tell you before we did this.

When we are talking we would like to put the digital recorder on so that we can remember what you said for our report. But at anytime you can tell us to turn it off and we will. When we are writing the report we may write about some of the things that you have talked about but we will not use your name. If you have any worries after we speak to you, you can come and talk to us and also the people at CASA Family Service will be able to talk to you in person (if we meet there)
or on the phone (if we meet somewhere else). Or you can talk to someone at ChildLine.

Your parent has said it’s OK for us to talk to you, but it’s your choice if you want to or not. We won’t talk to you unless you say it’s OK. You can ask us any questions you like before you agree and at any time when we meet with you.

YOUR NAME: ...............................................................
(Write your name here if you are happy to join in).
Thank you very much

<table>
<thead>
<tr>
<th>I understand that it is my choice to take part, and I can say no at any time if I don’t want to do it anymore</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>I understand that Georgia/ Sarah/ Michelle would like to speak to me for about 30 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand that there are no right or wrong answers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am happy that I can say no to any question and leave the room whenever I like</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand that what I say will not be told to anyone else but if someone is hurting me or I am hurting someone else then Georgia/ Sarah/ Michelle will have to tell someone about it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am happy for Georgia/ Sarah/ Michelle to record my voice</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 9 – Parent/Guardian Consent Form

Your child is invited to take part in a study about the family service at CASA. This will be carried out by researchers at the University of Bedfordshire.

CASA Family Service has agreed to help us access children and young people who may be willing to take part, however, we need your agreement for your child to be involved.

Below is some information on the study. Please read it carefully and if you are happy for your child to take part, sign below and return it to CASA Family Service in the envelope provided or hand it in to the agency. Without your consent we cannot involve your child, even if they want to.

The study: The research will ask children and young people about their views on what they do at CASA Family Service and how they think it has helped them and their family. It is important to find out this information so we know how best to support children and young people who may be affected by someone else’s alcohol or drug use. Unless we ask children and young people we won’t know.

How we do it: The children and young people will be interviewed in a friendly way! We will ask questions like “what is one of the reasons you like going to CASA” or “is there anything CASA does that you don’t like”? The interview will last 30 minutes max. CASA Family Service staff will be available (after the interview either at the agency if the interview is held there or on the phone if the interview is held elsewhere) to chat to you and/or your child if needed.

Risks/benefits: The only risks involved with this study involve the possibility that talking about the agency and what they do to help your child and your family could raise issues that may be considered sensitive. Georgia/ Sarah/ Michelle will be conducting the interviews and are experienced researchers and will be sensitive to how the children are feeling and offer support if necessary. Each child participating in this study will also give their own consent to take part and it will be made clear to them that they can leave the room or stop the interview at any time. They can also have you present if they wish.

Confidentiality: With your permission we would like to record the interview to help us remember what was said and ensure we don’t miss anything. The
interview data will be confidential to the researcher (Georgia/ Michelle) and the research supervisor (Sarah). The only exception to this would be if anything the children or young people said suggested they were at risk of harm from others or were causing harm to others. If this was the case we would follow CASA Family Service’s child protection policy and/or report any concerns to the appropriate authorities. Recordings and any notes taken during the interview will be destroyed once the final report and related articles are complete. This will be no more than 12 months after the end of the study. Excerpts from the interview may be made part of the final report and articles and used in conference presentations, but under no circumstances will any names be included.

**Voluntary nature/questions:** Your decision whether or not to allow your child to take part will not affect your, or your child’s, current or future relationship with CASA Family Service. If you decide to allow your child to participate, you are free to withdraw your child at any time without affecting your relationship with CASA Family Service.

If you have any further questions before you sign please contact Sarah on 07884 007222. If you are unhappy with any part of the research process you can contact an independent person at the University of Bedfordshire who will listen to you and investigate your concerns. The contact is Angus Duncan at angus.duncan@beds.ac.uk or 01582 743473

If you agree that your child can take part please write in your child’s name and sign below

Name of child __________________________________________

Signature of Parent/Guardian __________________________________________

Date ______________

Signature of Researcher __________________________________________

Date ______________
Appendix 10 – CASA Family Service Model

Engagement

- Discuss with referrer (or parent if self-referral) whether or not referral is appropriate.
- Where necessary, give advice to referrer on how to broach/discuss issue of hidden harm with family.
- Provided parents have consented to referral, phone them to introduce worker/agency, explain what will happen in first meeting.
- Arrange date for first meeting, accommodating parents wishes, e.g. having a known key worker present or have meeting in familiar place such as a children’s centre.
- If client does not attend initial appointment, follow up with phone calls to maintain contact and encourage attendance at subsequent appointment.

Assessment

- Approach to child protection, confidentiality & information sharing explain to parents. Aims of assessment are to:
  - Understand how SM affects parenting & family functioning.
  - Identify potential/actual risks to children & adults.
  - Identify immediate safety needs e.g. safety planning.
  - Identify any concerns that children or adults have.
  - Assess understanding of concerns which referring professionals have raised (adults).
  - Identify family strengths, values & priorities.
  - Identify current & past tensions/stressors in family.
  - Explore social and professional support.
  - Explore coping responses & levels of motivation to change.
  - Identify gaps between hoped for family functioning & current circumstances.
- Assessment is carried out in 4-6, hour long weekly sessions which include a combination of sessions with parents (together and individually), the whole family and each child individually. Parents and children will usually have separate key workers who co-work whole family sessions.
- Refer to other agencies e.g. adult alcohol and drug services, DV services, housing advice, where necessary
- Offer to attend with client or hold joint meetings at CFS where appropriate.
- Identify goals in terms of family’s values/ aspirations & relate to protective parenting, resilience in children & young people, family relationships & functioning, reduction in SM.
- Agree goals with family, taking into account concerns of social services if involved.

Intervention

- Work towards the goals agreed during assessment using a combination of:
  - Motivational Interviewing
  - Narrative Therapy
  - Cognitive Behavioural Therapy
  - Person Centred Counselling
  - Child Centred Play Therapy
  - Group work
  - Parenting skills support/training
  - Family communication skills
- Carry out regular reviews of progress towards goals including review of whether goals still relevant.
- Where clients miss sessions for any length of time, make assertive efforts to re-engage through variety of means including text/phone messages, letters and offers of home visits.

Disengagement

- Reduce frequency of sessions gradually over a period of months when hidden harm no longer exists or has been reduced to minimal level.
- Hold final session during which the achievements that the family have made are emphasised and long term goals agreed. Encourage parents to contact CFS at any time in the future when they feel the need to do so.
- Follow up phone call made three months after final session.

The intervention is delivered by key workers in an unlimited number of hour long sessions. In addition to working with families themselves, key workers also work with other professionals who are engaged with the families. For example they may provide information/reports to a Multi-Agency Risk Assessment Conference for DV or attend care plan review meetings with substance misuse or mental health professionals. Where families are engaged with Children’s Social Care, key workers might write reports for review meetings or attend case conferences.
## Appendix 11 – CASA Family Service Assessment Tools

<table>
<thead>
<tr>
<th></th>
<th>Substance Use</th>
<th>Domestic Violence</th>
<th>Child Welfare</th>
<th>Family and Home Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Matrix 1 – Parent’s/Carer’s Use of Alcohol and other Drugs</strong></td>
<td>✓</td>
<td></td>
<td></td>
<td>✓ One question asks about the context of the parent’s substance use</td>
</tr>
<tr>
<td></td>
<td>Focusses on the nature, extent and impact of adult’s substance use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Matrix 2 – Impact of Substance Use on Parenting and Childcare</strong></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Q.’s 3, 5, 9-10</td>
<td>One question (Q7) about coping with stress contains an example of domestic violence</td>
<td>Q.’s 1-4, 7-10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>One question (Q7) about coping with stress contains an example of domestic violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Islington Models of Care Brief Risk Assessment Form (part 4)</strong></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Two sections ask about overdose and treatment issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Islington Models of Care Detailed Risk Assessment Form (part 9)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>? X Not purpose of this form however one Q. on drug service engagement</td>
<td>One prompt question under Social Risks asking if any DV victimisation or perpetration</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes/No question on DV which, if Yes is ticked, requires completion of the CAADA DASH risk indicator form (below)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CAADA DASH Risk Indicator Checklist</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>One Q. asking about substance use or mental health issues. Substance misuse also mentioned as an example of additional risk factors.</td>
<td>Whole form is a checklist to be used when preliminary questioning leads to a positive response about suffering domestic abuse and can be used to refer individuals to MARACs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes/No question on Risk to Children. If Yes ticked, requires further assessment of parents and a Common Assessment Framework form completed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children are considered at several points in relation to risk of harm from perpetrator</td>
<td></td>
<td></td>
<td>X The checklist asks about family related issues but in the specific context of DV.</td>
</tr>
<tr>
<td><strong>Family assessment form (v. Sept 2010)</strong></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Section on Substance Use and Impact on Family Life.</td>
<td>Encourages staff to check the Referral Information form has been completed; a prompt on domestic violence is included in the final section which asks staff to provide a summary of the family’s needs and identify any unmet needs</td>
<td>Sections on parenting strengths and needs; child’s strengths and needs</td>
<td>Section on family and home situation, views of each family member and professional</td>
</tr>
<tr>
<td>Substance Use</td>
<td>Domestic Violence</td>
<td>Child Welfare</td>
<td>Family and Home Environment</td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------</td>
<td>--------------</td>
<td>-----------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| Client Risk Assessment Form (v. Nov 2009)  
NB. No longer in use | ✓ | ✓ | ✓ | ? ✓ | Two sections relate to harm to others and any risks inherent in home setting. |

- Contains sections for staff to complete on history of DV victimisation and perpetration and current risks.
- Some questions about domestic violence plus a guidance note not to ask in the presence of partners or family members. Also asks about related convictions or legal problems and steps taken to minimise risks to others from domestic violence.

Q.’s relating to harm and neglect, violent behaviour, DV victimisation and perpetration, self harm, mental or physical health problems.

Referral Information Form (v. Oct 2009) and guidance notes  
NB. While all domains are covered theoretically the information is a) second hand and b) appears to depend on whether the referrer has asked the right questions prior to referral.

- Referrer questioned about the person’s substance use, impact on family life, risks and protective factors
- Includes ‘experience of domestic violence’ on tick box checklist, (section G), with a prompt to identify details of safety concerns or risks in section H.
- Guidance notes contain a section on domestic violence including sample questions to ask referrers about domestic violence and its risks to adult, children and staff.

Section focussing on child/young people in family, incl. their view of parental substance use. Also Q.’s on health and well being concerns, education, life events, strengths, social care and other service involvement.

Includes questions on housing, mental health, legal issues, family members’ details.

Treatment Outcomes Profile  
Average amount of substances used each day in the past 4 weeks

X

X

Limited info on days in work or school, and risks to housing. Client asked to rate overall quality of life.

Part 2 MOC paperwork – Islington Alcohol Triage Form  
Primarily focussed on alcohol with one question on illicit drug use

X

One risk assessment question on ‘History of violence to others – use of weapons or threatening behaviour’. Highly unlikely to detect domestic abuse behaviours

Children’s details required and whether they live with their parent/carer and whether social care are involved.

Part 3 MOC paperwork – Referral & Triage Form – drug services (Nov 2010)  
Primarily focussed on drug use but includes one question on alcohol use.

X

Form includes question about contact with children and prompts for parenting assessment to be completed.

Question regarding accommodation needs, literacy, disabilities, others affected by their use or able to offer support, caring responsibilities, support needed, mental and physical health, criminal justice history.
## Appendix 12 - DOMESTIC VIOLENCE SURVIVOR ASSESSMENT

<table>
<thead>
<tr>
<th>Today’s Date: __________</th>
<th>Session # _____</th>
<th>COUNSELOR NAME _________________________</th>
<th>CLIENT CASE # _________</th>
</tr>
</thead>
</table>

### Issues about the relationship

**A. Triggers of abusive incidents?**

|----------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------|

**B. Managing Partner Abuse**

<table>
<thead>
<tr>
<th>The bad things are a trade off for what is good in relationship</th>
<th>Placates, feeling trapped. Asks partner to get help</th>
<th>Realizes cannot prevent partner abuse. Tries to avoid abuse by sleep, work, etc.</th>
<th>Decided abuse must end. Makes and acts on plans for own safety.</th>
<th>Learns new ways to relate to new or changed partner. If separated, continues to avoid abuser.</th>
</tr>
</thead>
</table>

**C. Seeking Legal Sanctions**

<table>
<thead>
<tr>
<th>Does not agree to call police or courts</th>
<th>May seek information. If seek sanctions, likely recant</th>
<th>Seeks sanctions, may be hoping to change relationship.</th>
<th>Seeks sanctions-consistently follows up legal processes</th>
<th>Continues to seek sanctions/harass or stalk, actively protects self.</th>
</tr>
</thead>
</table>

**D. Attachment**

<table>
<thead>
<tr>
<th>Keeps abuse secret. Hopes to give enough love to prevent violence</th>
<th>Cares &amp; “Gives 2nd Chance” Admits abuse to self, wants it to be a secret. Feels shame.</th>
<th>Ambivalent about losing sex, home, income, dreams. Acknowledges abuse &amp; own needs</th>
<th>Embarrassed that P is abuser. Realizes love is a separate issue from abuse.</th>
<th>After left, reminds self why; lets go. If remains rebuilds attachment within new rules for no abuse.</th>
</tr>
</thead>
</table>

**E. Views Relationship and Options**

<table>
<thead>
<tr>
<th>Positive overall. No need for options. Violence temporary.</th>
<th>Reflects on good and bad. Tries to change self to avoid abuse, begins to fear future.</th>
<th>Ambivalent. Wishes partner would change. Maybe try brief separation.</th>
<th>Determined abuse must end. Willing “to do what it takes” over time to become safe</th>
<th>Over time makes decisions based on her safety even if he pleads, stalks, &amp;/or harasses.</th>
</tr>
</thead>
</table>

**F. Managing loyalty to norms and own beliefs.**

<table>
<thead>
<tr>
<th>Fears stigma of failing in relationship. Loyal to norms and own beliefs.</th>
<th>Remains “for the family, or status, or children” Does not want partner humiliated.</th>
<th>Conflicted between own loyalties and rising sense of injustice. Considers options.</th>
<th>Partner does not deserve loyalty, whatever others think. May be a precipitating crisis.</th>
<th>Continues to feel leaving or require partner change is justified. Some guilt re: family response.</th>
</tr>
</thead>
</table>

**Committed to continuing (1) Committed but questioning (2) Considers change, abuse and options (3) Breaks away or partner curtails abusiveness (4) Establishes a new life – apart or together (5)**

### Today’s Date: __________ Session # _____ COUNSELOR NAME _________________________ CLIENT CASE # _________
## Issues about the individual

<table>
<thead>
<tr>
<th>G. Accessing Help</th>
<th>Does not see others as understanding.</th>
<th>Generalized mistrust &amp; fear no one can help.</th>
<th>Hints to others of abuse seek support &amp; help. Fears reprisal</th>
<th>Persistently seeks and sorts out who is and is not helpful</th>
<th>Continues help multiple sources. Uses other’s knowing to limit abuse.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Self Efficacy: be on her own</td>
<td>Cannot imagine life without partner.</td>
<td>Considers possibility and fearful about being on own.</td>
<td>Sets goals &amp; takes first steps. Reality tests separation fears.</td>
<td>Acts to meet goals. Tests tolerance: being on her own.</td>
<td>Over time increases self sufficiency and independence.</td>
</tr>
<tr>
<td>J. Feelings</td>
<td>Avoids/denies own negative feelings.</td>
<td>Avoids all feelings to protect self. Numb, overwhelmed</td>
<td>Can name feelings &amp; need for self esteem. High fear, anxiety</td>
<td>Begins to recognize anger. Channels feelings into action.</td>
<td>Continues to have negative feelings. Accepts loss &amp; uncertainty has hope</td>
</tr>
<tr>
<td>K. Mental Health</td>
<td>Stressed. Possibly depressed &amp; confused. May have PTSD.</td>
<td>Stressed/depressed etc. May dislike self &amp; other symp. If PTSD, worsens.</td>
<td>High anxiety, panic attacks. Fantasies murder. Fears is crazy. If PTSD, intolerable.</td>
<td>Senses can gain control of “out of control” feelings. If PTSD, causes higher stress</td>
<td>Continues to acknowledge &amp; cope with stress. Mental Health improves. If PTSD, symp. rise, then recede</td>
</tr>
<tr>
<td>L. Control of Money</td>
<td>Partner knows best how to take care of money. Asks what is spent.</td>
<td>Aware lack of personal money a problem. Spending is a big issue with partner.</td>
<td>Hides money or spending but sees need as unfair. Considers learn money management.</td>
<td>Money, spending and control are shared or separate. More confident can manage money.</td>
<td>Continues to knows own finances. Equal say in spending and access to money in future.</td>
</tr>
</tbody>
</table>

Committed to continuing (1)  
Committed but questioning (2)  
Considers change, abuse and options (3)  
Breaks away or partner curtails abusiveness (4)  
Establishes a new life – apart or together (5)

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References


