

**Applying psychological theory to understand the  
difficulties and supporting factors in implementing family  
based approaches in alcohol treatment services.**

**by**

**Claire Lee**

**Submitted to the University of Leicester,  
Faculty of Medicine & Biological Sciences,  
School of Psychology in partial fulfilment of the degree of  
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## Abstract

*Applying psychological theory to understand the difficulties and supporting factors in implementing family based approaches in alcohol treatment services.*

The current study investigated staff perceptions regarding whether recommendations for family based approaches to be made available in alcohol treatment services were being implemented. This included exploration of factors that staff perceive may either impede or facilitate family based work.

There were two stages of data collection. Stage 1 involved collecting demographic and descriptive information from the participating services to establish the homogeneity of the sample and whether family work was offered by each service. For Stage 2, 18 staff from seven alcohol treatment services were recruited. Semi-structured interviews were audio-taped, with interview questions based on theoretical domains which explored respondents' perceptions of the implementation of the guidelines and family based work. The interview transcripts were analysed twice, initially to give an indication of the respondent's perception of the level of success of implementation but also to identify pre-determined theoretical domains which supported and impeded implementation of family based work. The transcripts were then reanalysed to indicate relationships between domains, to provide a hierarchical framework for organising the themes and to identify other themes which may have been missed in the first analysis.

The first analysis indicated variability in the level of success of implementation across services. Further exploration indicated factors contributing to more successful implementation which included staff believing that family work was likely to lead to positive results, providing it was compatible with their skills and perceptions of their role and identity, and they were motivated to provide it. Barriers to implementation identified by staff included: 'Environmental context and resources,' (e.g. lack of funding and time, inadequate space, inaccessible working hours and staffing levels); 'social influences' (e.g. lack of support from management and the team); and 'emotions' (e.g. fear, anxiety and lack of self-confidence in doing family work).

The study also identified facilitators and barriers to family work at different levels: Staff participant; problem drinker and family; and the organisation. The results suggested that staff perceptions of family based work, the culture of working within addiction services, and perceiving the problem as within the individual problem drinker were particular barriers to family based work. The study therefore demonstrates the importance of considering the social construction of the problem and the socio-cultural context to help facilitate implementation of family based work in alcohol treatment services.

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## **Word Count**

|                              |       |
|------------------------------|-------|
| Literature review            | 5312  |
| Literature review references | 868   |
| Research Report              | 17519 |
| Critical Appraisal           | 1982  |
| References                   | 1211  |

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## **SECTION 1: LITERATURE REVIEW**

### **WHAT ARE THE PSYCHOLOGICAL FACTORS THAT UNDERPIN THE MECHANISMS OF CHANGE IN ALCOHOL TREATMENT?**

The National Treatment Agency in Substance Misuse (NTA) published a 'Review of the Effectiveness of Treatment for Alcohol Problems' in November 2006 (Raistrick, Heather, & Godfrey, 2006) which summarised the results of three systematic reviews on the effectiveness of different treatment approaches for alcohol problems. Whilst many different treatment approaches have been found to be effective for problem drinkers, the mechanisms that help promote behavioural change remain unclear. In addition, up to 80% of addiction problems get resolved without formal treatment (Annis, 1996).

Several psychological theories have attempted to explain the process of alcohol specific behaviour change. The most popular include social cognitive theory (Bandura, 1989), transtheoretical model (Prochaska & DiClemente, 1984), and theories of reasoned action and planned behaviour (Ajzen & Fishbein, 1980; Ajzen, 1991). The transtheoretical model has been particularly influential and whilst there are many other theories of addiction, PRIME theory (West, 2006) is generally regarded as the antithesis to the transtheoretical model and will therefore also be discussed.

The transtheoretical model integrated several theories to understand behaviour change and consisted of four dimensions: stages, processes, markers and contexts of change (DiClemente, 2006). In this model an individual goes through five stages (pre-contemplation, contemplation, preparation, action and maintenance) in a linear sequence, before they achieve the desired change (Prochaska & DiClemente, 1984). Internal and external experiences such as consciousness raising and supportive

relationships are processes that help facilitate the transition through the stages, with markers of change referring to decision making about the change (e.g. weighing up the pros and cons) and perceived ability to achieve the change (self-efficacy/temptation) deemed integral in this process. The context surrounding the change, which can be internal and external influences such as life situation, relationships and social systems, influence and interact with the process.

PRIME theory (West, 2009) regards intentions to change as unstable which is in opposition to the transtheoretical model. PRIME theory understands behavioural change as resulting from changes in things that influence our wants and needs, and changes in ways we respond to the environment. Different motivations can come into operation at any particular time and influence behaviour through the motivational system which consists of five levels (responses, impulses and inhibitory forces, motives, evaluations and plans), which form a hierarchical system. Higher levels can only influence behaviour through lower levels, for example, at the lowest level 'Responses' are generated, which are influenced by the next level 'impulses and inhibitory forces' which compete with each other at that specific moment in time. The impact of these different motivations on change means that change is fluid and unstable.

Social cognitive theory (Bandura, 1989) proposes that people learn their behaviour through observing other people and that people behave in a certain way to achieve a goal. Understanding the interrelationship between thoughts, behaviour, other personal factors and the environment are central to this approach. This model of reciprocal causation viewed these factors as operating and interacting with each other bi-directionally with the strength of one factor not necessarily equalling the influence of another factor.

The theory of reasoned action (Fishbein & Ajzen, 1975) understands intention and behaviour as resulting from the attitude towards performing the behaviour and subjective norms such as perceived social pressures. The theory of planned behaviour (Ajzen, 1985) added a further dimension to this theory by suggesting that perceived behaviour control such as perceptions of difficulty and control influences performing the behaviour.

An initial search of Cochrane and NHS CRD databases indicated that a review on psychological factors underpinning the mechanisms of change in alcohol treatment had not been previously published. Such a review was deemed important for both the addictions and wider psychological fields for several reasons. Understanding what underlies behavioural change in an area that had been found to be highly susceptible to relapse (Hunt et al., 1971; Lowman et al., 1996) may provide insight into general models of behaviour change. Many alcohol interventions are influenced by Prochaska and DiClemente's (1984) stage of change model, so an increased understanding of behaviour change may help clinicians to develop more effective treatment interventions. Identifying variables that influence behaviour change may facilitate this. Researchers have suggested that self-efficacy (Morgenstern et al, 1997), social support (Epstein & McCrady, 1998), social environment (Copello & Orford, 2002), motivation (DiClemente, Bellino & Neavins, 1999), readiness for change (Prochaska & DiClemente, 1984), and pre-treatment factors (Tober et al., 2000) are influential mechanisms of change in the addiction field and are the focus of the present review.

## **Method**

A literature review of English language journals was conducted using two databases (Psychinfo; Assia) with the keywords alcohol\*, treatment and change. Only

two databases were used as a means of focusing the review on the psychological and social sciences. A decision was made to not use 'maintenance' as a key word after initial scoping reviews identified mainly pharmacotherapy studies which detracted from the focus of the review and only journal articles published within the last 10 years were considered to keep the review up to date (November 1998 to November 2008). The current review identified 202 articles, which were screened using pre-defined inclusion/exclusion criteria (See Appendix 9). Only quantitative studies were considered, which were either Randomised Control Trials (RCT), Secondary data from RCTs, or those that assessed change over time as this explored the process of how problem drinkers change and move towards recovery. Finally, articles were assessed by their title and abstract to identify whether they were concerned with psychological factors that underpin mechanisms of change in alcohol treatment.

## **Results**

Inclusion and exclusion criteria resulted in 15 journal articles being selected for review which focused on the causal association between different psychological factors and change variables in alcohol treatment (see Appendix 10). Most of the studies were RCTs (six studies) or used secondary data from RCTs (four studies) that measured change variables. There was variability in the measures used to assess change processes with changes in alcohol consumption and drinking behaviour being used as outcome measures in 12 studies, however, even measures of alcohol consumption and drinking behaviour varied. The next most frequently used measures assessed self-efficacy, psychosocial functioning and relationships, stages of changes, and AA attendance. Positive outcomes over time were used to indicate change (i.e. improvements in

psychosocial functioning, reductions in alcohol consumption and alcohol related problems).

The results of the current review were organised into categories of self-efficacy, pre-treatment factors, stages of change, social support and social environment, with the relationship between these factors and the mechanisms of change underlying alcohol treatment investigated.

### ***Self-efficacy***

The concept of self-efficacy emphasised the person's sense of control over performing a specific behaviour (Bandura, 1977), and was the definition used by the studies in the current review. However, PRIME theory (West, 2009) made the distinction between self-efficacy referring to 'beliefs' about the likelihood of achieving a particular goal or referring to 'feelings' of self-confidence, with the two definitions influencing behaviour differently. For example, beliefs were part of the post behaviour evaluations whereas feelings were part of generating motives.

Alcoholism typology was found to influence self-efficacy, with less severe drinkers having greater self-efficacy and better outcomes (Bogenshutz, Tonigan & Miller, 2008). This indicated that the severity of the drinking problem influenced the change marker. However it was unclear whether the division of the sample into Type-A (e.g. later onset, less severe dependency and alcohol related problems) or Type-B Alcoholic (e.g. earlier onset, greater dependency, severity and more associated problems) produced matched demographic characteristic samples which limited the generalisability.

Alcoholics Anonymous (AA) attendance has been found to increase self-efficacy to remain abstinent (Bogenshutz et al., 2008). AA attendance increased self-efficacy in participants who attended AA for longer (McKellar et al., 2008) and predicted more stable outcomes (Moos & Moos, 2005). Further exploration of the processes and markers of change during AA that increase self-efficacy would help to understand this mechanism of change. However, the influence of social context on behaviour such as group influences on identity (social identity theory, Hogg & Abrams, 1988; self-categorization theory, Turner, 1985) and perceived social pressures (Ajzen, 1985) also suggest that social influences associated with AA may increase self-efficacy, and therefore require further exploration.

Carbonari and DiClemente (2000) examined how drinking outcomes related to self-efficacy, with a focus on confidence to resist and degree of temptation. The largest change in self-efficacy was observed in an abstinent outcome group (and not the moderate and heavier drinking outcome groups), with confidence scores for abstinence increasing and temptation scores decreasing the most in this group. This indicated that increasing self-efficacy can help to reduce drinking frequency and intensity, and that increasing confidence to abstain and reducing temptation to drink may be an important part of the change process, consistent with DiClemente's (2006) transtheoretical model.

Further support for the role of self-efficacy as a mechanism of change has been provided by McKellar et al. (2008). Several factors were found to be associated with increased self-efficacy one year after treatment: reductions in heavy drinking, alcohol related problems, avoidance coping and impulsivity; improvements in depression; social support from friends; and longer duration of attending AA. Some of these factors are consistent with the processes and contexts of change in the transtheoretical model (DiClemente, 2006) and indicate that they interact with self-efficacy to produce



behavioural change, but further exploration of how these factors may interact with each other remains unknown.

Longitudinal studies have also explored the role of self-efficacy in maintaining change in the drinking behaviour (McKellar et al., 2008; Moos & Moos, 2005). Moos and Moos (2005) found that lower self-efficacy was associated with entering treatment, whereas higher self-efficacy was associated with unassisted recovery. Irrespective of whether participants received help or not, self-efficacy increased over time as did reductions in problem drinking, which suggested that self-efficacy had a role in behaviour change which may be independent of treatment. However, high initial increases in self-efficacy were found in participants who remitted, indicating that other factors were involved in achieving stable remission. From a PRIME theory perspective, intentions to change were not stable, and identity change such as would be found with a high initial increase in self-efficacy, could drive behaviour change but self-control was needed to maintain change (West, 2009). Strength of self-efficacy at different stages, and the interaction between self-efficacy and different processes involved in maintaining change such as self-control, needs to be explored further.

McKellar et al. (2008) explored factors associated with maintaining self-efficacy and found factors that predicted improvements in self-efficacy were: being female; more educated; less change in substance use problems; and impulsivity. High initial reductions in alcohol related problems and impulsivity did not maintain self-efficacy levels 16 years later. This suggested that these processes were not predictors of stable change and that high initial improvements in these areas may be considered risk factors for a remission. This naturalistic study has potentially many uncontrolled variables which may have influenced self-efficacy ratings and limits the findings. Consistent with social cognitive theory and the transtheoretical model, McKellar et al.

(2008) highlighted different factors that interact with self-efficacy, but also indicated that certain factors have more strength in predicting long term change. Further exploration of the interrelationship between these factors is needed.

Self-efficacy can be increased by giving participants self-help material prior to treatment which emphasizes their responsibility for behaviour change and advocates problem drinking as a learned behaviour (Bamford et al., 2005). Although the leaflet suggested strategies for reducing consumption, this did not change the actual strategies used by participants, thus indicating that other factors were responsible for changing drinking behaviour. Both internal and external processes of change in the transtheoretical model (DiClemente, 2006) were likely to be needed, as when only one process was targeted, such as the self-help material focusing on internal processes, only internal changes occurred. External processes which move participants towards taking active change may require more than targeted advice in a leaflet, to achieve actual behaviour change. This indicated that the markers influencing the processes of change may be different for internal and external processes.

Self-efficacy was found to correlate with spiritual beliefs, particularly spiritual well-being (Piderman et al., 2007). This was consistent with the transtheoretical model that advocates beliefs as part of the context influencing processes of change. Spirituality and recovery were introduced during the program but were not the central focus, and were not controlled for, which limits the generalisability. Another criticism was that only a three week period was explored and previous studies have indicated that initial increases in self-efficacy may trigger later remission (Moos and Moos, 2005). It may be useful to explore the interactions between spiritual variables and self-efficacy over a longer period to help establish whether 'beliefs' per se facilitate longer term change, and if they do, how they influence change.

In summary, increasing self-efficacy can help to reduce drinking frequency and intensity, with several factors identified as interacting with self-efficacy such as self-help information, social support, beliefs and attending AA. Consistent with PRIME theory, change did not follow a particular sequence but was unstable. This may reflect the influence of wants and needs on behaviour which was dependent on the drives which are activated at the particular time. PRIME theory suggested that beliefs about ourselves can influence behavioural change when the individual becomes aware of their inner drives which are influencing their wants and needs (West, 2009). The majority of the studies however defined self-efficacy as associated with feelings of self-confidence, so it may be useful to explore the other interpretation of self-efficacy which refers to beliefs about achieving a particular goal.

### ***Pre-Treatment Factors***

Female problem drinkers have been found to reduce their drinking prior to entering treatment (Cook et al. 2005). This reduction in drinking intensity pre-treatment, which was a change in behaviour, was found to predict a reduction in drinking intensity 12 months post treatment. The stated goal of abstinence, stage of change and which interviewer was conducting the assessments, were not correlated with these changes in drinking frequency over time. Pre-treatment changes need to be explored further, as other variables may be influencing change before treatment begins, which may be missed in other research studies. This was consistent with Blomqvist (1999), who found that many problem drinkers started to reduce their drinking long before they actually reached total recovery, and indicated that change was a gradual process developed over time. From a PRIME theory perspective, behaviour change

involved forming a plan, which involves self-conscious intentions related to future actions, such as deciding to start alcohol treatment. Plans require clear boundaries to become active, which may explain why the stated goal of abstinence was not associated with reductions in drinking (Cook et al., 2005), due to the rules and boundaries not being activated.

### ***Stages of Change***

Two studies in the current review explored the relationship between stages of change and drinking outcomes (Callaghan, Taylor & Cunningham, 2007; Carbonari & DiClemente, 2000). Callaghan, Taylor and Cunningham (2007) found that participants in the pre-action stages (precontemplation, contemplation) had significant improvements in drinking related behaviours and showed improvements over time. However, no significant differences were found in drinking outcomes and different stages of change when they compared the drinking outcomes of participants who remained in the pre-action stages against participants who moved into the preparation/action stage three months later. This indicated that stage of change did not correspond directly to actual drinking behaviour and that change involves oscillating between different stages and not progressing in a fixed order towards recovery (Littell, 2002). Consistent with PRIME theory, behavioural change does not follow a particular sequence; instead what the problem drinker wants or needs most at a particular time is what influences their behaviour (West, 2009).

When the action stage was looked at in isolation, participants were more likely to remain abstinent, indicating that elements associated with it may underlie behaviour change (Carbonari & DiClemente, 2000). This effect for action may have been observed

because action was looked at in isolation, whereas when the action and preparation stages were combined, this effect was not found (Callaghan et al., 2007). The action stage involved actively changing the behaviour or the environment, so changes in those areas may be a crucial for behaviour change, however, it was unclear from Carbonari and DiClemente (2000) which elements of the action stage were critical in producing the changes observed. A criticism of these two studies was the classification of the groups: Callaghan et al. (2007) combined different stages and omitted the maintenance stage; and Carbonari and DiClemente (2000) excluded the preparation stage, and participants were not classified into stages so they could score highly on more than one of the stages. The transtheoretical model consists of five distinct stages, with the stage classification in the two studies potentially obscuring more subtle changes.

Carbonari and DiClemente (2000) also found that maintenance scores decreased in the abstinent group following treatment but increased in heavier drinking outcome group over time. As only four stages were investigated, it limited the conclusions that could be drawn, however, possible explanations were that the abstinent group moved into the termination stage and/or had more control over their drinking, or the heavier drinking group was beginning to realise how difficult it is to maintain changes. It may be useful to explore the combined impact of all the different stages on reducing problem drinking rather than focusing on different stages, as the transtheoretical model advocated transition through the stages, which was neglected in this study.

Daeppen et al. (2007) explored the relationship between participants' intentions to change future alcohol consumption following one 15 minute motivational style intervention and changes in alcohol consumption 12 months later. Unfortunately, although it was stated that the intervention consisted of six steps which were motivational in style, no further information was given regarding the content.

Participants were more likely to reduce alcohol consumption if they reported an intention to reduce alcohol consumption at the end of the brief intervention, however, these participants also consumed more alcohol, had heavier drinking episodes and more alcohol related problems than the control group at the start of the study. This suggested that participants actively seeking to change in the action phase were more likely to achieve changes but also indicated that a particular level of drinking severity is needed before change could be effective. This was consistent with Blomqvist (1999) who found that recovery was preceded by long term harmful drinking consequences.

Participants showing the most reduction in alcohol consumption have been found to report an intention to change their alcohol consumption, express more self-explored personal ambivalence towards change, and express more intensely their ability, commitment, desire, need and reason to change (Daeppen et al., 2007). This indicated that a stronger motivation to change may be linked to actual behaviour change, which is consistent with the markers of change in the transtheoretical model, and the theory of planned behaviour. PRIME theory also suggested that behaviour was influenced by stronger wants or needs at a particular time, with behaviour change requiring rules to generate strong wants and needs at relevant moments to overcome old sources of motivation (West, 2009). However, it was unclear whether higher motivation levels were intrinsic to the participant or as a consequence of therapist interaction.

In summary, the literature indicated that rather than change involving the progression through certain stages in a sequential order as suggested by the transtheoretical model, there was fluidity with problem drinkers moving between different states (as opposed to stages) in no fixed sequence. The action stage was highlighted as being particularly influential in the change process; however it was unclear which elements of the action stage were critical. There was also some

suggestion that stronger motivation was linked with actual change. It would be useful to explore the motivational system of problem drinkers proposed by West (2006), as this may provide further insight into the interrelationship between motivation and change.

### ***Social Support and Social Environment***

The current review identified social factors as influencing problem drinkers to initiate change (Blomqvist, 1999). For example, pressure and/or support from significant others, personal or existential crises, and drinking related frightening or humiliating experiences, were identified as initiating recovery. These social factors all indicated that there were different motivations and experiences behind what initiated change. Different motivations were also found between natural resolutions and those who sought professional treatment, with health concerns linked to the former and legal concerns to the latter, thereby highlighting that the path to recovery was varied and influenced by life context. Internal factors were also found to influence the initiation of change such as changes in will-power/self-control. The retrospective design, poor control of extraneous variables such as some participants in the 'no help group' had previously received treatment, and incomplete reporting of methods and procedures, made it difficult to establish what controls were in place and therefore questioned the validity and reliability of the results.

The initiation of change can also be influenced by the drinking goal, with a goal of abstinence being found to influence an abrupt change, and a goal of moderation influencing a more gradual change (King & Tucker, 2000). King and Tucker (2000) explored the initiation of change in unassisted recovery through a retrospective study, but did not control for participants who had previously received alcohol treatment or

attended AA, which weakened the findings even though those participants did not credit the treatment for their behaviour change. Most people who seek formal treatment have been found to have already made up their mind to change their drinking before seeking professional help, which indicates that changes take place before treatment commences (DiClemente, 2006), and that both internal and external factors contribute to initiating the change.

Social factors identified by Blomqvist (1999) as contributing to the maintenance of change include: the role of supportive significant others; changes in living circumstances; professional treatment; and new responsibilities. Stability and/or major improvements in life context and relationships were also found to be associated with more stable change (Blomqvist, 1999), which suggested that social factors impact on changes in problem drinking, consistent with the context of change in the transtheoretical model. Social networks have been found to help increase behavioural and attitudinal support for abstinence (Litt et al., 2007), and attending AA was reported to help problem drinkers to abstain from alcohol and maintain more stable remissions (McCready, Epstein and Hirsch, 1999; Moos & Moos, 2005). Therapist variables were also identified as influencing change as a reduction in alcohol consumption was associated with therapists who used significantly more skills consistent with motivational interviewing (Daeppen et al., 2007). Interpersonal relationships have been found to play a role in influencing change (Blomqvist, 1999; McKellar et al., 2008; Moos and Moos, 2005), however, further exploration is needed of the nature and interaction of interpersonal relationships that helped move the problem drinker towards change.

The impact of volunteer support on drinking behaviour changes have been explored but was difficult to evaluate as there was variability in the amount of time



volunteers spent with participants and volunteer variables were not controlled (Leigh et al., 1999). Volunteers spent on average one hour every two weeks with participants and focused on leisure and social activities. Some volunteers were described as subscribing to the disease model which may have conflicted with the treatment program. This indicated that volunteers may influence the context of change in drinking behaviour, but have limited utility. More rigorous control of volunteers and their roles is needed to provide further insight into their utility.

Helping other people to maintain their sobriety can facilitate the problem drinker in maintaining changes in their drinking behaviour (Friend et al., 2004). Interpersonal relationships in the transtheoretical model were usually perceived as either helping or hindering the problem drinker towards change (DiClemente, 2006). Friend et al. (2004) found that the interrelationship can be two-way, with the behaviour of problem drinkers towards other people having a role in the change. Support from people within their own social network who do not drink problematically, and helping others to maintain their sobriety, was shown to help problem drinkers maintain their own changes (Friend et al., 2004). Research on AA has also highlighted the positive social support as helping to maintain sobriety (Longabaugh et al. 1998; Bond, Kaskutas & Weisner, 2003). However, it was unclear from Friend et al. (2004) what helping actually involved, so further research may help to understand how helping others influences change.

In several studies interventions were targeted at the problem drinkers' social network (Litt et al., 2007; McCrady et al., 1999). Litt et al. (2007) explored whether socially focused interventions could influence changes in the participants' social network from one that reinforced drinking to one that reinforced sobriety. Socially focused interventions were not found to reduce social support for drinking but did increase behavioural and attitudinal support in the social network towards the problem

drinkers' abstinence and attendance of AA. AA attendance and abstinence were positively correlated indicating that the number of abstinent friends increased as AA attendance increased. The numbers of non-drinkers in social networks also increased and were significant predictors of success. This indicated that, rather than changing their existing social networks to be supportive of sobriety, problem drinkers gained more abstinent friends instead. Socially focused interventions also helped to reduce drinking frequency and increased continuous abstinence. However, Litt et al. (2007) also found that it was difficult to maintain changes in the social networks 15 months later.

McCrary et al. (1999) explored the impact of different alcohol treatments on male problem drinkers and their female partners. Couples were randomly assigned to: standard behavioural couple therapy, and two maintenance enhanced therapies (relapse prevention and AA). Unfortunately, the study did not assess the impact of the partner on change in the problem drinker. Drinking frequency and intensity reduced in all groups although no significant treatment effectiveness differences were found. The treatment approaches did indicate some differences: relapse prevention combined with behavioural couple therapy led to shorter drinking episodes; and length of time before the first heavy drinking day was longer for the standard behavioural couple therapy group than when AA was added. This indicated that treatment can target different areas of the change process. There was some support for AA with individuals who attended AA abstaining more from alcohol than those who do not attend AA, suggesting that involvement in AA helped to support abstinence. This was consistent with Moos and Moos (2005) who found improvements in drinking behaviour and more stable remissions when participants attended AA. It may therefore be useful to assess drinking

outcomes over a longer period of time to assess stability of change after behavioural couple therapy or AA.

Overall, the literature indicated that social factors can influence the problem drinker at different stages of change such as pressure or support of significant others influencing problem drinkers to initiate and maintain changes. Consistent with social cognitive theory (Bandura, 1989) there was support for the interrelationship between the problem drinker and the social network being bi-directional, as supporting others to maintain their own sobriety facilitated the problem drinker to maintain their own sobriety, and reinforcing social networks with abstinent friends helped to increase behavioural and attitudinal support for abstinence. However, this has not been properly tested for non-abstinence goals (i.e. controlled drinking).

## **Discussion**

In summary, a review of 15 articles was conducted relating to psychological factors underlying change in problem drinkers as they move towards resolving their problem drinking. During this process the findings were applied to theories of behaviour change which have been prominent in the field of addictions.

Overall, the reviewed studies tended to focus on individual elements of change in the problem drinker rather than consistently exploring the whole change process. For example, studies exploring different stages of change omitted certain stages, combined stages and overlooked the combined impact of the stages in a sequential process (Callaghan et al., 2007; Carbonari et al., 2000). The construct validity of the measures used was also questioned and it was difficult to establish which parts of the stage of

change were critical for change or whether it was the combined impact. Another limitation was that the studies focused on identifying factors that predict better outcomes or self-efficacy and were less focused on exploring interactions between variables or establishing the strength of factors in relation to others (Bogenschutz et al., 2008; Carbonari & DiClemente, 2000; McKellar et al., 2008; Moos & Moos, 2005). The impact of pre-treatment changes was highlighted (Bamford et al., 2005; Cook et al., 2005) but is often not considered and when combined with poor controls, this suggested that several extraneous variables such as motivation and social factors may impact on change but were not credited. The current findings indicate the complexity of processes and interacting factors in change, and also how important it is to examine all aspects of change.

The current review highlighted psychological factors underlying behavioural change in problem drinkers which included self-efficacy, stage of change, pre-treatment factors, social support and social environmental factors. Longitudinal studies have also highlighted factors important for stable change: gradual increases in self-efficacy; attending AA for longer; and major improvements and stability in life context. Risk factors for remission have also been identified such as high initial improvements in alcohol related problems, impulsivity and self-efficacy (McKellar et al., 2008; Moos & Moos, 2005; Blomqvist, 1999). In terms of the applicability of the different psychological theories of drinking behaviour change, the current review indicated that the process of change does not occur in a sequential order as suggested by the transtheoretical model but was instead fluid and unstable (Callaghan, Taylor & Cunningham, 2007). The problem drinker's motivation and goals influences the process of change, such as abstinence goals produce different pathways from someone with moderation goals (King & Tucker, 2000). Consistent with PRIME theory (West, 2009)

this indicates that our wants or needs at any one moment influence behaviour, however, PRIME theory has mainly been applied to the understanding of smoking cessation and has not been taken into alcohol treatment practices.

Motivation and goals can also be influenced by life context (Blomqvist, 1999) but, as the current review has highlighted, can be difficult to influence (Litt et al., 2007). Although PRIME theory acknowledges that behaviours are situationally determined such as events in the environment triggering behaviour (West, 2007), the current review has highlighted that social factors do more than trigger behaviour. Social support or pressure can influence the initiation and maintenance of change (Blomqvist, 1999; Litt et al., 2007) and group processes such as attending AA can influence self-efficacy and behaviour (Moos and Moos, 2005; Bogenschutz et al., 2008). Social Behaviour and Network Therapy (Copello et al., 2002) has emphasized the importance of social networks in supporting changes in the drinking behaviour and suggests strategies to gain positive network support. The current review also highlighted that the interrelationship between problem drinkers and social factors on change is bi-directional (Friend et al., 2004), as suggested by social cognitive theory. In conclusion, elements of each model of behaviour change have validity but no one model can fully explain the underlying psychological factors of drinking behaviour change.

### ***Clinical Implications***

When alcohol treatments have targeted only limited aspects of change such as self-help material or certain stages, there have been poor outcomes, indicating that all aspects of change need to be targeted. Certain areas may be more difficult to target such as social networks or require further input to support long-term changes. Further

exploration of different elements of change would support the development of treatments. The transtheoretical model and PRIME theory provide useful frameworks upon which to base this, but still require further scrutiny. The current review selected several articles which explored unassisted recovery which indicates that the path to recovery does not always involve professional interventions and that people may choose different routes to recovery, therefore it would be useful to learn more about how problem drinkers reduce their problem drinking on their own.

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## **SECTION 2: INTRODUCTION**

The introduction will discuss the background literature which influenced the development of the research. This includes the movement from work with the individual problem drinker towards family based work in alcohol treatment services with specific reference to the NTA (2006) recommendations that marks part of this transition.

Implementation research is discussed to highlight how changes in practice are not always implemented but also how psychological theories can be applied to understand the phenomenon. The aims, objectives and research questions of the current study will then be presented.

The above literature review highlighted the complexity of change but also indicated that there are many variables involved in change which included self-efficacy, readiness to change, pre-treatment factors, social support and the social environment. One of the clinical implications of the review was that interventions need to target all aspects of change.

Traditionally interventions for alcohol problems have focused on treating the individual; more recently there has been a movement towards family based approaches, where the family is perceived as influential in both the cause and maintenance of problem drinking (Chan, 2003). This was based on the assumption that drinking behaviours have a function within the family system, as an expression of distress and function to maintain the status quo. This perspective led to interventions that focused on both the individual and the family with the aim of changing family functioning to support change in the problem drinking. These approaches require therapeutic practitioners to work with, and change, the family system to be supportive of change rather than working exclusively with the individual. These family based approaches will be referred to as 'family work' throughout this thesis.

In the National Treatment Agency (NTA) 'Review of the Effectiveness of Treatment for Alcohol Problems' published in November 2006 it acknowledged that one of the factors instrumental in a person seeking help for their alcohol problems is their relationships with significant others. Family and friends have a role in both maintaining and treating the alcohol problem. The main reasons identified for involving family and friends in the treatment process were that social networks were at risk of alcohol related problems, such as family functioning being affected; plus social networks could not only help engage the client in treatment, but also support the individual to have more positive outcomes.

The NTA review indicated that psychosocial treatments such as Social Behaviour and Network Therapy (SBNT), Community Reinforcement Approach (CRA), and Coping and Social Skills training, were effective for alcohol treatment. Given the strong evidence base for psychosocial treatments the review recommended that "Family interventions should be available in all service delivery tiers at appropriate levels of complexity" (NTA, 2006, p125). The review validated the need to involve social networks in treatment, "The most effective treatments typically involve family members or friends who will be supportive of achieving the chosen drinking goal" (NTA, 2006, p117). It also highlighted that staff required certain competencies and skills, "Working with couples or families can be a useful part of an agency's treatment repertoire – staff require particular competences" (NTA, 2006, p125). Adequate training and clinical experience were also implicated as important in helping staff move towards working with the system. "The skills required to deliver more intensive treatments and especially to work with family and friends will be rooted in good quality training and clinical experience" (NTA, 2006, p117).

The movement towards family work involves change, and changes in practice as recommended by evidence-based guidelines are not always implemented effectively (Grimshaw et al., 2005; Haines & Donald, 1999). It has been suggested that if barriers to change can be identified then strategies can be applied to help overcome barriers and improve the implementation effectiveness. Shaw et al. (2005) systematically reviewed 15 studies that tailored workplace strategies to overcome identified barriers to change and found that further research was needed to identify barriers and to develop effective strategies to increase implementation. Shaw et al. (2005) also found that workplace strategies were often based on the judgements of the investigators rather than being informed by theories of behavioural and organisational change. However, it was unclear whether workplace strategies that clearly acknowledged the use of psychological theory made the intervention more effective. Shaw et al. (2005) highlights the importance of being able to identify barriers as this could facilitate the tailoring of workplace strategies to increase implementation effectiveness.

Michie et al. (2004) used psychological theories of behaviour and behaviour change to identify theoretical constructs which were used to develop the Theory-Based Implementation Interview (TBII). The TBII has been used by Michie et al. (2007) to identify and understand the domains most relevant to implementation difficulties. Michie et al. (2007) explored perceptions of difficulties and facilitators to implementing guidelines for family interventions being offered to relatives of people with schizophrenia, by using the TBII to structure interviews with key professional groups responsible for implementing the guidelines. They used 11 of the 12 domains used in the original TBII (Michie et al., 2004) as the 12<sup>th</sup> domain was a description of the behaviour which the other 11 domains were influencing. Analysis of the interviews indicated that the domains of 'emotion,' (emotions within clinicians that influenced the

offer of family interventions) plus 'environmental context and resources' were the lowest scoring indicating that they were likely barriers to the implementation. Further analysis of these domains indicated that lack of time, supervision and training, plus self-doubt in abilities and fear of doing family interventions should be areas targeted for workplace strategies to increase implementation. Michie et al. (2007) have demonstrated how psychological theories of behaviour and behaviour change can be used to understand difficulties and target improvements in the implementation of guidelines.

No studies have applied the Michie et al. (2004) TBII to the implementation of recommendations for family work in alcohol treatment services. The current research study aims to address this gap in the research. Qualitative research methods were appropriate because the aim to provide an account of the individual's experiences and give meaning to the phenomenon observed. Applying a pre-existing measure (TBII, Michie et al., 2004), psychological theories are applied to the data, then re-analysing the data using template analysis methodology will allow flexibility in the interpretation, and facilitate exploration of relationship between factors that support and impede family work. .

### ***Aims and Objectives***

Anecdotal observations suggest that the NTA (2006) recommendations that family work should be made available in alcohol treatment services may not be being followed. Based on this tenet the aims of the study were:

- To investigate staff perceptions of the implementation of the NTA (2006) recommendations that family work should be made available in alcohol

treatment services, in order to increase understanding of implementation of evidence based recommendations.

- To explore factors that staff perceive may impede or facilitate family work.

The objective was to interview staff working within seven alcohol treatment services within the Heart of England and Midlands Research area using semi-structured interviews, to explore their views on the NTA (2006) recommendations regarding family work.

### ***Main Research Questions***

The above literature review led to the following research questions about implementing family work in alcohol treatment services:

1. What do staff perceive as barriers and facilitators to success in implementation of recommendations for family work in alcohol treatment services?
2. What do staff perceive as factors facilitating and impeding family work in alcohol treatment services?



### **SECTION 3: METHODOLOGY**

The Methodology presents the study design which includes two stages of data collection. Information on the recruitment and procedures for participants in Stage 1, and the corresponding background information collected, will be presented. The recruitment and procedures for participants into Stage 2, the measures used, and analytic procedures will then be explained. Finally, the ethical approval process is explained.

#### **Design**

The study was a qualitative design which involved two stages of data collection. Stage 1 involved collecting demographic and descriptive information from each participating service with the information being used to establish the homogeneity of the different services and whether family work was offered by each service. Stage 2 involved exploration of staff perceptions of implementation of recommendations and family work through interview survey with interviews structured by the TBII (Michie et al., 2004). To achieve this, a cross-sectional design was used with staff working within seven alcohol treatment services who were recruited, initially through convenience sampling, but later by purposive sampling to cover key professions, grades and levels of training.

#### **Participants**

The recruitment of participants took place between June 2008 and March 2009. The participants in the current study were staff working at seven alcohol treatment services within the Midlands and Heart of England research areas. Participants were recruited through one non-statutory alcohol service (referred to as Service A) and

through six NHS specialist substance misuse services (referred to as Services B through to G). Initially five alcohol treatment services were contacted but due to low participation rates a further three services were approached (although one declined to participate).

### ***Recruitment and procedures for Stage 1***

By applying opportunistic sampling, alcohol treatment centres within the Heart of England and Midlands research areas were contacted by telephone or e-mail, using the contact information available in the public domain. The principal investigator verbally described the research project to the senior team members and explained what would be involved if they and their service participated. Once verbal consent was gained the senior team member was sent a participant information sheet (Appendix 4) and consent form (Appendix 5) for Stage 1. When the principal investigator received the consent form they contacted the participants to arrange a face-to-face or telephone interview to gather demographic and descriptive information about that service (See Appendix 2 for recording sheet). This was used to verify the homogeneity of the sample and to establish the atmosphere towards the recommendations. Of the seven services approached one service manager, three team leaders and one clinical psychologist participated. Unfortunately the information for Stage 1 was unable to be collected for two services due to lack of participation from senior team members. The service representatives were selected if they were currently working within the alcohol treatment service and had demographic and descriptive knowledge about their service, staff and treatment approaches.

### ***Demographic and descriptive information on services***

Of the eight services approached one of the services declined to participate citing current work pressures on staff. The demographic and descriptive information collected in Stage 1 for five of the seven services indicated that: one service provided tier 2 interventions, one service provided tier 3 but also included tier 2 work to cover the local area, and finally, one service provided a tier 3 community detox service, one service provided tier 1,2 and 3 services, one service was unclear what it was funded for as there was no service level agreement, but worked with complex alcohol problems at a tier 3 level.

There were significant differences regarding what treatment approaches were offered by the five services, which ranged from offering a limited treatment option such as providing detox, motivational enhancement therapy and relapse prevention work, to offering a multitude of services which included brief interventions, individual work (CBT, stage base and functional model of substance abuse), group work, family interventions (SBNT, five step approach and CBT), specialist population workers, and the training of other professionals.

There was a difference between services in whether family based approaches were used, ranging from those which had a clear model and supported the team in family focused work, to those where family work was offered informally, plus those where families were involved through home detox, or carer assessments that highlighted that the family required support. The number of Clinicians practising family work varied within the five services indicating that their staff worked with family members to varying degrees. Only one service had received training in family work within the last year, which included two days training looking at 5 step and SBNT, followed by

monthly supervision provided by the trainers over nine months with a booster session planned at the end of the nine months.

Each service was also asked what key policies and guidelines were currently influencing their service. Only two services cited NTA documents as influencing their service.

### ***Recruitment and procedures for Stage 2***

For Stage 2 participants were recruited from NHS and non-statutory alcohol treatment services with the inclusion criteria specifying that they had to be involved in directly working with clients in the alcohol treatment service. A brief 15 minute presentation was given during a team meeting at each of the services to inform staff of the study and to invite interested staff to participate. Interested participants were given the Information Sheet on the research project (Appendix 6), Consent Forms (Appendix 7) and stamped-addressed envelopes. The number of staff attending the meeting ranged from four to twelve people, with the research project not being suitable to all those present. Some potentially suitable participants who were unable to attend the meeting were given the information sheet, consent form and stamped addressed envelope by the service representative identified in Stage 1 for that service. To gain a range of responses, key professional groups were interviewed (See Table 1). The representative interviewed in Stage 1 were also approached to help identify potential staff that could be approached to participate in Stage 2, and to remind interested participants to return the consent forms. Exclusion criteria included staff not currently working within the alcohol treatment service, those who only assessed clients, who only did brief interventions, or detoxification only interventions, and were not involved in the whole treatment process.

When the principal investigator received the signed consent form from staff members they contacted the participant to arrange the telephone or face-to face interview. The participant was asked to book a private room for the interview if necessary. Interviews were audiotaped using a phone adaptor and dictaphone for the telephone interviews or a dictaphone for the face-to face interviews.

No further contact was made by the researcher when they had received five respondents from an alcohol treatment service or had reminded the alcohol treatment service twice.

Table 1: Number of participants according to professional group

|                       |   |
|-----------------------|---|
| Nurse background      | 7 |
| Clinical Psychologist | 3 |
| Counsellor            | 2 |
| Alcohol Worker        | 4 |
| Social Worker         | 1 |
| Team Leader           | 1 |

For Stage 2 the only demographic information gathered about the participants was the service they worked for and their profession, to protect their anonymity. Only the Principal Researcher who conducted the interviews knew the identity of the participants. Interviews were audiotaped and transcribed by the Principal Researcher, with both the audiotape recording and the corresponding transcription assigned a code to maintain anonymity. The audio recordings were kept within a secure and locked location. Anonymity of staff was preserved by removing identifying information from the transcripts of the interviews which could be used to identify the interviewee from

the public domain and by making the research project multi-site. Once the research project is complete the audio tapes will be destroyed and the transcripts will be transferred to the Clinical Psychology Department at the University of Leicester where the transcripts will be kept within a secure filing cabinet in a locked room until the transcripts are destroyed five years after the thesis is submitted.

The aim was to gain a range of responses from different professions across different alcohol treatment services, with 18 alcohol workers recruited. This is consistent with the recommendations for sample size of between 10 to 30 interviews for template analysis methodology given by Professor Nigel King, the founder of template analysis (See appendix 8).

### **Measures/Questionnaires Used**

In Stage 1 questions were devised to gain demographic and descriptive information on each service (Recording sheet in Appendix 2). These included questions asking about the treatment approaches offered by the service, what the service was funded for, whether the service offered family work, staffing professions and number of staff practicing family work, what training had been provided to staff on family work and what training was planned for the next year. Questions were also asked about supervision and what were the key policies and guidelines that influenced the service and how new policies were implemented and implementation monitored.

### ***Theory-based implementation interview (TBII) (Michie et al., 2004)***

The TBII (Michie et al., 2004) was developed through an interdisciplinary consensus which identified psychological theories of behaviour and behaviour change relevant to implementation research. Psychological theories were identified in three

areas: behaviour change in people not motivated to engage in a particular behaviour, behaviour change of people who are motivated to change, and organisation change at a social and systems level. Theories and constructs were then prioritised that were particularly relevant to changing behaviour in health care professionals, then simplified into 12 theoretical domains which were then evaluated. Health psychologists without specific expertise in behaviour change or implementation research conducted backward validation on the domains, which involved identifying theories and constructs which reflected the content of each domain.

After validating the domain list interview questions were developed and piloted structured around the 12 domains. These domains included: knowledge; skills; social/professional role and identity; beliefs about capabilities; beliefs about consequences; motivation and goals; memory, attention and decision processes; environmental context and resources; social influences; emotion; behaviour regulation; and nature of the behaviours. The interview questions focused on identifying the nature, processes and explanations of the behaviour change relevant to each domain. The TBII developed by Michie et al. (2004) can be used to identify and understand the domains most relevant to implementation difficulties.

The current study amended the TBII so that all questions related to the implementation of family work in alcohol treatment services, thus relating to the NTA (2006) recommendations for family work (See Appendix 3). The domain asking about the nature of the behaviour was removed consistent with the Michie et al. (2007) study as this was a description of the behaviour. Three other questions were added to the TBII in the current study: two questions assessed whether participants had attended any courses, or had any qualifications in family based approaches. This information was used to triangulate staff attitudes towards family work with what qualifications or

courses have they taken in family work. The third question asked about leadership style, as a peer review of the research proposal had highlighted the need to assess organisational influences on implementation.

### ***Pilot Interviews***

Two pilot interviews were conducted with staff from two different alcohol treatment services to aid the development of the research. The TBII was not used for the pilot interviews, as at that stage the research proposal was still being developed. The research proposal was informed by the pilot interviews, to gain a more general description of the service, treatment approaches, clinical work and views of family work. The pilot interviews indicated that the NTA (2006) recommendations for family work were being implemented to different extents.

## **Analytic Procedures**

### ***Analysis 1 analytic procedures***

The methods used to initially analyse the transcript data in the current study replicates those used by Michie et al. (2007). In the current study, interviewee's responses to the TBII were analysed by selecting sections of text deemed relevant to one or more domains, which were then scored. Sections of text were rated 1, 0.5 or 0 depending on whether there is good, partial or no evidence for indicating successful implementation of the recommendation. Domains were then rated based on a global impression of all the scores for the domain, with lower scores indicating that the domain may explain poor implementation of the recommendation.



### ***Analysis 1 coding reliability procedures***

Coding reliability for the interview transcripts in the first analysis replicated the methods employed in the Michie et al. (2007) study. Inter-rater reliability for the coding of transcripts was assessed using Cohen's Kappa (Cohen, 1960), which is used to assess the level of agreement between two independent ratings. Cohen's Kappa can range from +1 to -1 with a kappa of +1 indicating perfect agreement, a kappa of -1 indicating perfect disagreement and a kappa of 0 indicating that there is no relationship between the ratings. A kappa agreement of .60 to .70 is generally considered high enough to indicate a good level of agreement.

### ***Analysis 2 analytic procedures***

Template Analysis methodology was applied to the transcripts for the second analysis. Template Analysis is a technique of analysing qualitative data initially developed by Crabtree and Miller (1992), but subsequently developed by King (1998). The approach involves developing a list of codes which represent themes that are organised in a meaningful way to indicate relationships between themes. The themes are usually organised hierarchically with more specific themes grouped together to form broad themes. King (1998) recommends between two to four levels of coding to help ensure clarity in the interpretation. Whilst frequency of codes can be used to record the strength of a theme, all themes (even less frequent ones) are coded, as the emphasis is on identifying significant themes, not just the most frequent ones.

A unique feature of Template Analysis is that a priori codes can be used to develop an initial template prior to conducting the data analysis. These a priori codes can be deleted or modified as the template is developed. A priori themes can develop

from themes identified in the research literature, what the researcher knows about the area, plus preliminary information gathered from discussions with people working in the research area (King, 1994). This suited the current study as pilot interviews, the research literature and the TBII used in the study had identified potential themes. The purpose of analysing the data twice was to ensure that important themes were not missed during the first analysis, and also to investigate if and why the NTA (2006) recommendation for family work were being implemented to differing extents. The impacts at different levels from problem drinkers, family, staff, to organisation were also highlighted as important to consider and suggested a template for organising the data.

In qualitative research, different methodologies exist each with a different epistemological stance. Template analysis is flexible in its approach and can take a critical realist (postpositivism) stance whereby reality exists but is only approximately known; or it can take a social constructivist stance whereby reality is constructed through interaction which is influenced by both the researcher and the social context.

In the current study it was felt that the realist stance suited the research question of trying to uncover the underlying causes of why the recommendations may be implemented to differing extents, but also permitted the use of a priori codes. Grounded Theory takes a critical realist stance and is based on the tenet that there is no predetermined hypothesis to test; however, this approach was unsuitable because it was incompatible with the structure of the TBII. Content Analysis was also considered, but it only focuses on the existence and frequency of concepts. Template analysis was felt to provide a more in-depth analysis, could structure the coding hierarchically which would indicate relationships between and within the data, and would facilitate the exploration of further codes through the revision of the template.

Template Analysis was therefore chosen for the study. The grouping of more specific themes into broad themes allowed distinctions to be made both within and between cases which aided the exploration of the differences between low and high implementers of family work. The data had previously been analyzed which permitted the cases to be classified into low and high implementers based on their overall scores for all 12 domains, and also permitted other themes to be encapsulated rather than being lost in the transcripts. A further advantage of Template Analysis was that it permitted measures of strength, as the frequency of themes could be recorded, which again facilitated the process of identifying what specifically differentiated high and low implementers.

### ***Analysis 2 reliability of coding***

By taking a realist stance the reliability of the coding process was particularly important; King (2007) recommends that this can be addressed through quality checks and reflexivity. A quality check was performed by giving research supervisor (MC) a sample of transcripts which were coded using the revised version of the template. MC was asked to note any themes that were found difficult to apply, or to identify parts of the transcript which were deemed important but are not encapsulated under existing codes. Following this process of triangulation, the template was revised. Through this process assumptions that the principal investigator has made about the data are questioned through reflexivity. However, it is also important to note that reflexivity is an ongoing process as it involves reflecting on the research process, and on the principal investigators own role in the process through the study.

### ***Analysis 2 quality assurance***

To help ensure openness in the interpretation and analysis of the data, regular supervision meetings were held to discuss the coding, templates and interpretations. During supervision reflective discussions were used to explore the themes further. One of the interviewee's from the pilot interviews was also the field supervisor, and was consulted, and agreed with the analysis. The field supervisor was also able to contribute to reflective discussions regarding the interpretations of the interviews, discussion topics and recommendations that emerged from the data.

### **Ethical Approval**

The study was initially approved by the University of Leicester Research and Assessment Committee. Later the study underwent and passed peer review by a member of the course staff at the University of Leicester Clinical Psychology Unit. The study was submitted to the Nottingham Research Ethics Committee and gained approval on the condition that management approval was gained from each Trust site approached in the study. The participant information sheets were also amended as the Committee felt that they were not user-friendly enough. The Committee asked for clarification regarding anonymity of the participants, and were satisfied once it was explained that participants were asked to arrange a private room for the interview, identifying information was removed from the transcripts so that the participant and their service could not be identified in any report or publication written about this study, and that the study was multisite which would help protect the identity of participants and services. It was also emphasised that although members of the service may be aware of who was taking part in the research project, no one would know what has been said. If any direct quotes were used in the research findings of the research, they would be anonymised.

Management approval was gained from each trust involved in the study; Derbyshire Mental Health Services NHS Trust, Leicester Partnership NHS Trust, Bedford and Luton Partnership NHS Trust, Birmingham and Solihull Mental Health NHS Foundation Trust, and Coventry and Warwickshire NHS Partnership Trust. Approval of participants through the non-statutory service (Service A) was gained separately.

## **SECTION 4: RESULTS**

The background information collected in Stage 1 indicated variability across services in whether family work was offered. The analysis of data collected in Stage 2 initially focuses on staff perceptions of the implementation of recommendations for family work. The coding reliability of the data and a comparison of the level of implementation success across professions and services are presented in the first analysis, before the overall highest and lowest scoring domains are discussed which indicate areas that staff perceive support or impede implementation success. The second analysis used template analysis methodology to identify staff perceptions of facilitators and barriers to family work, which were found at different levels (staff; problem drinker and family; and organisation), and explored the relationship between different factors.

### **Results for Analysis 1**

#### ***Coding Reliability***

Two researchers (CL and MC) independently coded 33% (6 out of 18) of the interview transcripts by rating each domain as showing good, partial or no evidence of supporting implementation. The inter-rater agreement was 83% with an overall kappa of 0.69, which indicates a good enough level of agreement. A kappa score was unable to be calculated for the 'beliefs in capabilities' domain because the two ratings were constants. The kappa score for the 'environmental context and resources' domain was also low, at 0.33 (with 66.6% agreement). This was the only domain where two coding categories were used instead of three, as there were no instances of good support for successful implementation of the recommendation. This may explain why the chance-corrected measure of agreement produced a low kappa despite a 66.7% agreement.

Responses also indicated potential interrelationships, for example, the participant's interpretation of family work influences their perception of what resources are needed. Resources are also interpreted as agency resources but also the participant's own resources such as time, indicating that there was some ambiguity in the interpretation of questions for this domain.

### ***Variability across the Alcohol Treatment Services***

Table 2 shows that only one social worker (32%) and one team leader (50%) contributed to the study, therefore it was difficult to determine variability in these professional groups. For Nurses (45%), Psychologists (46%) and Alcohol workers/counsellors (47%) there was little variation in the overall scores, suggesting that profession did not influence implementation. Greater variation is observed between the different services indicating that there are differences in perceptions of implementation across services. Two services (C and E) have the same overall lowest implementation scores of 34% indicating more perceived barriers to implementing family work in these services. The two overall highest implementation scoring services score 68% and 72% (A and D), indicating more perceived success in implementing family work in these services. The other three services score 44%, 45% and 45% indicating similar overall implementations scores for these three services (B, F and G).

Table 2: Overall scores for perception of level of success at implementation of recommendations for family work by Profession and Service.

| <u>Profession (n)</u> | <u>total/maximum possible score</u> | <u>percentage of total sample*</u> |
|-----------------------|-------------------------------------|------------------------------------|
|-----------------------|-------------------------------------|------------------------------------|

|                                 |         |     |
|---------------------------------|---------|-----|
| Nurse (7)                       | 35/77   | 45% |
| Psychologist (3)                | 15.5/33 | 46% |
| Alcohol workers/counsellors (6) | 31.5/66 | 47% |
| Social worker (1)               | 3.5/11  | 32% |
| Team leader (1)                 | 5.5/11  | 50% |
| <hr/>                           |         |     |
| SERVICE (n Staff)               |         |     |
| A (2)                           | 15/22   | 68% |
| B (3)                           | 15/33   | 45% |
| C (2)                           | 7.5/22  | 34% |
| D (1)                           | 8/11    | 72% |
| E (2)                           | 7.5/22  | 34% |
| F (5)                           | 24.5/55 | 44% |
| G (3)                           | 15/33   | 45% |

*\*Higher percentage scores indicate more success at implementation*

### **Facilitators of Implementation**

Table 3 (see appendix 13) shows the number of participants identifying each theory based domain as a potential explanation for implementation facilitators and difficulties. The four domains showing the highest total scores which corresponds to factors supporting implementation were: skills (11/18), social/professional role and identity (11.5/18), beliefs about consequences (11.5/18), and motivation (11.5/18).

#### ***Skills***

The analysis indicated that participants had the skills to do family work; however there are different levels of family work, which impact on the participant's



perspective. Different levels of intervention reported include: telephone contact; group interventions; individual counselling; informal and formal interventions with problem drinkers and their relatives (either jointly or separately); joint working with other agencies involved in supporting relatives or children; and providing support and education around substance misuse to families.

*“So it’s about a more flexible view on treatment rather than the individual versus family therapy.” (18-1-15, L 331-332)*

There was an association between level of skill and what training or qualifications participants had received in family work. The additional questions added to the start of the interview were used to identify the level of training each participant has received. Six participants had not received any training or qualifications in family work. Four participants had received training on working with families as part of their professional training. Four participants attended brief training which their agency provided. Four participants identified specific training on family based approaches, which corresponded to scores of good evidence for implementation in the skills domain. Some participants clearly based their approach upon a particular therapeutic approach which they had received training on.

Overall participants reported low intensity family interventions (even those trained in specific family work) and had skills in working with families. Many of the participants had their own way of doing family work, which often drew upon different therapeutic approaches and techniques.

*“I’ve always tried to include the family but not in any sort of formal way, not like inviting people into a proper family therapy session.” (9-2-10, L53-54)*

Participants reported doing a degree of family work, but many did not recognise it as family work, because it was not following a structured approach or they had not received specific training in family work. This may also partially explain why the domain, 'beliefs about capabilities' score were lower (7 out of 18) than skills (11 out of 18).

*“ one of the barriers is that they kind of see that the, what we will be providing is family therapy... when what we are actually talking about is that there are a lot of lower level interventions that can make a massive different to family members.” (18-1-15, L93-98)*

### ***Beliefs about Consequences***

Participants who believed family work results in positive consequences also thought it resulted in better outcomes for clients. Families can support the intervention, and improve relationships between the problem drinker and their relatives, which may also reduce risks for children.

*“The support of families will continue long after you have dropped out.” (4-1-18, L146)*

### ***Social/Professional Role and Identity***

Participant's perception of their 'social/professional role and identity' was compatible with providing family work. The recommendation for family work was

generally not perceived as affecting their professional autonomy: if there was an impact, it was to increase their professional autonomy.

The responses indicated that in between the recommendations and implementation there were several levels that influenced the participants' professional role to different degrees, which included: Government; NTA; Drug Action Teams; Commissioners; treatment providers; service models; and service managers.

*"I know that they have highlighted motivational interviewing as one of the most effective treatments for individuals and I certainly agree with that, so if they make other recommendations...it's something that should be considered and implemented into services." (11-4-18, L99-102)*

When the recommendations for family work are incorporated into the service policies or models, and supported at different levels, it was generally felt to facilitate implementation.

*"It's put across at management level then sold to us that this is how this agency works..." (1-1-16, L86)*

It was also evident following the recommendation for family work, that some participants clearly perceived it as part of their professional role.

*"it's certainly a very positive thing to be following any guidelines, and in particular ones around these family based ideas, because of how, you know, family is so intertwined with our client group." (7-3-18, L113-115)*

## **Motivation**

Participants' motivation to work with families tended to be more informal support or interventions, or at least an option for families, rather than structured family work. There was also a distinction between motivation to do family work in theory and the practical constraints on doing it in reality.

*"I've just seen what it can do to families as a whole, one person's drinking and how it can affect so many people. I think if we can start helping them all then they are all going to benefit."* (16-2-19, L246-248)

### **Difficulties in Implementation**

The lowest scoring domain was 'environmental context and resources' (3.5 out of 18), which indicated that these are likely reasons for low implementation of the recommendation for family work. The next two lowest scoring domains were 'Social influences' (5 out of 18) and 'Emotions' (5.5 out of 18).

#### ***Environmental Context and Resources***

Within the 'environmental context and resources' domain, several areas were identified as problems: time, no extra funding, inadequate space, inaccessible working hours and staffing levels.

*"I don't have the person power in the service. I don't have the flexibility of time. It would involve additional one-to-one or additional sessions on top of what is already offered. We have a waiting list of almost twelve months."* (17-3-19, L246-248)

## ***Social Influences***

The team and management were identified as not always supporting family work. Management had a more direct influence on whether family work was offered, whereas team influences were more indirect and generally relate to whether there were pressures on the team, such as waiting lists, which do not permit extra time for family work.

*“Other people’s views of a particular way of working wouldn’t affect the way I tend to practice. My kind of overall line manager and above that, ideas would the way I work but not my colleagues particularly.”* (11-4-18, L278-280)

*“I would always discuss it, discuss what the client has done, and not be influenced by other. I’d see whether there is a pressure on waiting lists with the team.”* (8-1-10, L223-224)

Some participants possessed a degree of autonomy, or were champions of family work, and did it regardless of what the team’s views were. Some did family work because no one else in the team would do it.

*“I feel very autonomous in the sense of what I do and what I can offer.”* (14-2-17, L316)

## ***Emotions***

Low scores for ‘emotion,’ reflect ambiguity regarding whether emotions related to the participant or emotions within the family, but also negative emotions, such as

fear, anxiety and lack of self-confidence, which act against the implementation of the recommendation.

*“it’s having the confidence to do that or whether you feel unsure or whether you are feeling a bit fearful or uncomfortable about having more than one person in the room.”*  
(18-1-15, L419-420)

There is a distinction between participants’ experiences of negative emotions, which deter participants from family work, and participants experiencing negative emotions but having the confidence to manage the situation. Some participant did not recognise any emotions as impacting on implementation, or used supervision to help them manage their emotions, which contributed to the low scores for this domain.

*“We are all provided with our own clinical supervision, independent of the agency so that if there are any emotive issues we have got an arena to address them in.”* (2-2-16, L308-309)

*“Emotional as in a bit frightened of it, yes but not in that it would be sad or difficult to deal with.”* (12-5-18, L223-224)

### ***Summary of Analysis 1***

Analysis 1 applied a theoretical framework of behavioural change to identify facilitating and impeding factors in the implementation of the recommendation for family work. The results identified ‘skills,’ ‘social/professional role and identify,’ ‘beliefs about consequences,’ and ‘motivation’ as the domains most supportive of implementation. Three domains which identified the most with implementation

difficulties were: ‘environmental context and resources,’ ‘social influences,’ and ‘emotion.’

## **Results for Analysis 2**

After creating the initial template, it was applied to the data. It soon became apparent that the template needed to be revised and separated into six templates to incorporate participants' perceptions of barriers and facilitators, staff perceptions of client barriers and facilitators, and staff perceptions of organisational barriers and facilitators, due to the amount of complexity and different themes emerging from the data. All the transcripts were re-coded using the revised template, and amended to minimise the potential for missing, mislabelling or submerging important codes. The codes were then organised hierarchically to create higher level codes which contained the lower level codes. The final template was applied to the transcripts again, to check, modify and to get a qualitative measure of frequency and strength of the different codes. Some of the codes were re-named or re-ordered to give a clearer understanding of the interrelationships between the different codes.

The six main themes of the final template (Staff facilitators and barriers, Staff perceptions of client barriers and client facilitators, and organisational barriers and facilitators) are presented and discussed separately and supported by quotations from the interview transcripts. The templates are categorised into separate staff, client and organisational templates because from a theoretical perspective, different theories can be used to understand these different levels and because this would help target recommendations.



## **Theme 1: Participant perceptions of Staff facilitators**

(See Appendix 14 for Template 1)

### ***Self-Efficacy***

Participants' level of self-efficacy was an important facilitator for family work. Training increased self-efficacy, as elaborated in Analysis 1. Follow-up support after training helped embed family work into clinical practice, which also included an awareness of limitations and seeking support or supervision to help develop skills and competency in it.

'Experiences of different levels of interventions with problem drinkers and families,' facilitated 'beliefs about capabilities,' and helped develop self-efficacy. These experiences include: 'joint work with clients and relatives;' 'formal and informal work with relatives for relatives needs;' and 'work with family members to help engage problem drinkers in treatment.' Participants had the most experience with informal work with relatives.

*"I always tried to include the family but not in any sort of formal way not like inviting people into a proper family therapy session. But you know I'll always try and see relatives and friends and we always encourage when we see them at home that you know there's somebody with them." (9-2-10, L53-56)*

Participants untrained in family work often do it, but don't recognise that they have the skills. Participants have self-efficacy to work one-to-one with problem drinkers, but often have less confidence in managing more than one person in a session.

*"I do think that they know how to offer it but they are not recognising that they know, that they've got the skills. Unfortunately there's the culture not just within this agency but with a lot of service providers that unless they have this magical certificate saying that they can do it then they can't possibly do it."* (2-2-16, L113-117)

### ***Family orientated Service Procedures;***

'Holistic assessments' were seen to facilitate family work by, for example, involving and assessing the needs of social networks, but did not always facilitate later working with the relatives. However, holistic assessments were perceived to help participant's direct relatives to other services. Assessment of 'risk' also helped prioritise risk issues related to the network, which would sometimes necessitate an intervention. For example, if child protection issues were identified, the participants have a duty of care to follow service procedures pertaining to risk issues.

'Family orientated service procedures' which facilitated the 'presence of family or significant others,' such as 'home visits,' encouraged family work. For example, a home detox intervention often required contact with families to support the intervention. Interventions involving relatives which was 'part of the professional's role,' such as family support groups or individual counselling support for relatives, facilitated family work.

*"I wouldn't offer a home detox without actually visiting the home and talking to the people who would be around for that week whilst the person was detoxing, for pure safety reasons."* (5-2-12, L257-259)

### ***Team and Managerial Support***

‘Team support’ which facilitates family work includes supervision or informal support, and multi-disciplinary team (MDT) working (team members jointly working with the problem drinker and relatives, reviewing cases in the MDT, providing supervision and guidance, and sharing perspectives about family issues).

*“The opportunity to review cases on a regular basis, which is again within the MDT meetings... would prompt a few questions about what is happening within the family.”*  
(6-2-18, L501-503)

‘Managerial support’ of family work, includes providing permission for formal family work, but also allowing staff autonomy in their clinical work which facilitates informal work with relatives.

*“if somebody said to me can I bring my children to talk to you, I would use my own discretion as to whether that was appropriate or not. And that is how my line manager would view it.”* (2-2-16, L221-222)

At a service level, ‘Managerial support’ facilitates family work to be part of a ‘choice of treatment options,’ with a flexible approach to avoid problem drinkers being excluded who do not have a network. Participants recognised that no one treatment approach was suitable for all and valued individually tailoring interventions to suit the needs of problem drinkers and their relatives. ‘Recognising the need for resources and service development’ for family work, was facilitated by opportunities to discuss this

within the service. In addition, advertising family work as a treatment option promoted referrals, allowed other agencies to be aware of the service and encouraged multi-agency working.

‘Networking with other agencies’ was also seen to facilitate family work, such as joint work with social services, to support children whose parents have a substance misuse problem. Participants found it useful to have knowledge of what services were provided by other agencies, and to use this information to refer relatives onto other agencies.

### ***Supportive Motives and Goals***

‘Priorities’ was cited as a facilitator, which included: ‘risk and safety’ and ‘best interests of problem drinker and relatives.’ In one service, risk and safety were prioritised, with the safety of children and relatives being addressed before attempts were made to reduce the drinking behaviour. In this service, the family were prioritised, on the premise that making the home environment safe and reducing risks such as domestic abuse, created more time to work with the problem drinker. Prioritising the ‘best interests of the problem drinker and relatives,’ rather than focusing exclusively on the problem drinker, were also perceived to facilitate working with the family, when participants saw family work as being in the best interests of both the problem drinker and relative.

*“With us there is much more of an immediate focus on safety, right now. So the angle of our intervention would be to go in and say let’s assume your drinking isn’t going to change right now because that is a safer assumption, and what do we need to put in place right now to make the family safe.” (18-1-15, L123-127)*

‘Perceptions of family work as an intervention’ were reported to motivate participants towards family work, especially when it was viewed as a ‘flexible approach’ which included low intensity interventions. This was linked to ‘beliefs about consequences’ which was elaborated on in Analysis 1. Additional themes underlying motivation included ‘viewing family as a resource’ and perceptions of substance misuse as a psychosocial problem which understands the problem within its social context.

*“Particularly with alcohol misuse... It’s not an isolated issue that you can deal with one person and things are sorted out. It’s very much a familial and environmental and social problem...you can do so much if you can treat all of them.” (2-2-16, L263-266)*

In summary, self-efficacy, family orientated service procedures, team and managerial support, and supportive motives and goals, were identified by participants as facilitating clinicians in family work. Self-efficacy, MDT working and perceptions of family work and substance misuse were cited most frequently by participants, and indicate these themes are facilitating family work.

## **Theme 2: Participant perception of staff barriers**

(See Appendix 15 for Template 2)

### ***Professional Responsibility***

Barriers relating to ‘professional responsibility’ include family work ‘not being part of the participant’s job description,’ and concerns about ‘liability’ if something goes wrong when working with families, particularly if family work is ‘not formally recognised’ and offered by the service. Uncertainty regarding who is responsible for the

family was another barrier, particularly when families were seen informally, and the identified client is the problem drinker.

*“If I’m a key worker for a client and yes I take full responsibility for what goes on in the sessions and but if the partner or the children of that client, how much responsibility I would hold if there was a complaint about me or something went wrong in the whole situation then I’m not certain who would carry the can for that.” (5-2-12, 151-155)*

‘Confidentiality’ barriers included concerns regarding sharing information with the network, or being unable to contact the family due to client confidentiality. Some participants and service structures kept the problem drinker and the family separate due to conflict of interests and concerns over maintaining confidentiality. Gaining ‘consent’ from both the problem drinker and the family was another barrier. Problem drinkers were reported to restrict information sharing or not consent to the involvement of their family, such as not inviting their relatives to sessions or not passing on information regarding family support services. Participants were also unsure how to record information collected in informal contact with relatives and services were not set up to monitor family contact.

*“there are concerns around confidentiality. You know how do I share information, how do I record information, I suppose recording comes into do I have separate files or do I have a family file, so certain things like that which need kind of sorting out.” (18-1-15, L243-247)*

### ***Lack of Self-Efficacy***

‘Lack of self-efficacy’ relates to the participant’s ‘perceptions about family work,’ but also their ‘experience,’ ‘emotions,’ and ‘skills and knowledge.’ Narrow

perceptions of family work,’ included participants’ beliefs that it required specialist family therapy training and specialist theoretical knowledge and skills. Some participants felt that because they were not trained in family therapy or specific family based approaches, they were unable to provide family work.

*“I suppose one of the barriers is that they kind of see that the, what we will be providing is family therapy and the idea of long term interventions involving lots of other members of the family and we need specialist training for this and specialist supervision.” (18-1-15, L93-95)*

A common ‘perception of family work’ was that it required additional ‘resources and demands,’ such as extra time, more organisation and planning, additional supervision, and was also more difficult. This frequently linked to the organisational priorities of being performance managed and having to meet targets. There was an incompatibility between the perception of the additional demands of family work and services not being structured to support those demands.

*“I suppose it would require a lot more coordination and person time to deliver family interventions which goes at odds with the pressures to put people through the system.” (3-1-12, L241-243)*

Participants’ own ‘experiences’ of ‘relationships/families’ can influence perceptions of family work, which was often associated with ‘lack of practical experience’ and reduced the participant’s self-efficacy. For example, some participants felt that they did not have the ‘skills and knowledge’ to deal with conflict, work with different family members, manage more than one person in a session, engage families, or control the session. This was linked to several ‘emotions,’ which were evoked when faced with family work and elaborated on in Analysis 1.

*"I get anxious...It's dealing with conflict, and people sort of arguing and not being able to control it." (12-5-18, L228-232)*

### ***Unsupportive Service Structure***

'Demands on service,' included 'other priorities,' such as targets and waiting lists, which had to be addressed before working with families. These demands were frequently associated with lack of 'capacity' which was associated with 'narrow perceptions of family work,' as many participants reported not having the capacity to take on additional work, which they believed demanded more time and resources.

'Recording and collecting data' was another barrier due to administrative demands or services not being set up to record and collect data regarding family work.

*"I don't have the person power in the service. I don't have the flexibility of time. It would involve additional one-to-one or additional sessions on top of what is already offered. We have a waiting list of almost twelve months." (17-3-19, L246-248)*

'Limited accessibility' within the 'service structure,' refers to practical barriers such as the clinic rooms being too small and locations being unsuitable for families. Time constraints were reported to limit home visits and available time for family work. Referral pathways were another barrier, as families were often seen as unable to directly access services or services do not cater for the families' needs in an official capacity.

*"We are not a direct open access service. We are not set up to deal with specific third party issues by people ringing up." (6-2-18, L353-354)*

The 'unsupportive service model,' was a barrier, when 'work within boundaries and rules of the service' meant that family work was not formally offered by the service. This restricted what participants were able to do with families, such as keeping



problem drinkers and relatives separate. Without a formal framework for family work, participants often felt unsupported, plus had 'liability' concerns and do not want to compromise their service by providing informal family work. There was often an 'unsystematic approach to family work,' such as informal contact with the family during home visits or when clients bring relatives to the session. 'Lack of support' from the team and/or manager was also evident, as family work was sometimes discouraged or brought into question by either their team or manager.

*"It's frowned on by the rest of the team, its part really resource based because it takes longer." (12-5-18, L181-182)*

The 'focus' of the service, such as dual diagnosis or individual, can make it difficult for participants to prioritise and work with the family. Family work was often perceived as an add-on service, with the needs of the social network being of unequal status to the problem drinker. The 'focus' also meant that in some services, family work was only undertaken if there was capacity, and after other priorities had been met.

*"Well we are in 2009 and I've not seen any massive changes. Not any very significant changes in the way that things have been run, it's still very much focused on the individual and the substance misuser." (18-1-15, 193-195)*

### ***Insufficient Resources***

'Insufficient Resources' was a frequently cited barrier which was elaborated in Analysis 1. Additional barriers identified included 'lack of procedures' and 'lack of supervision' for family work and related to the lack of formal family work within the service.

*“It would be useful to have a service level agreement with clear targets on the sorts of work we would be doing. To have more staff. To have appropriate facilities to see people...we would need staff trained specifically in family approaches.” (3-1-12, L165-168)*

Some participants described family services being withdrawn, when similar services had been provided by ‘alternative providers.’ The ability to refer families onto other services or team members also reduced the participant’s responsibility and gave them somewhere to direct the family to, rather than taking on the family work themselves.

*“One of the forms of family work which we offered was a family support group. We were told not to offer that any more as we were not being paid to do it and someone else was.” (3-1-12, L199-201)*

In summary, responsibility, lack of self-efficacy, unsupportive service structures, and insufficient resources, were identified by participants as clinician barriers to family work. Participants lack of self-efficacy, particularly their lack of skills and capacity to do it, and other priorities of the services were identified most frequently by staff as barriers to family work.

### **Theme 3: Participant perception of problem drinker and family facilitators**

(See Appendix 16 for Template 3)

#### ***Family Orientated Service Procedures***

‘Family orientated service procedures’ which facilitate family work included: holistic assessments; interventions involving families and/or significant others: and

families contact with the service. The presence of family and/or significant others created opportunities, which service procedures such as holistic assessments and home visits facilitated.

*“We always try and include the carer or a relative and when we go out to see people in the home, and you know if there are children or anyone around we try and involve them, not in any sort of formal way but as part of the discussion.” (9-2-10, L73-77)*

### ***Therapeutic Alliance***

The ‘therapeutic alliance’ was identified as facilitating family work, such as the clinicians’ encouragement of engagement through supporting the problem drinker to involve the network in interventions and using specific strategies like role plays or coaching. Certain ‘therapeutic characteristics’ such as neutrality and honesty, were also seen to help encourage engagement.

*“I am quite honest about that right from the start of the session and so they kind of know where I am coming from and how I intend working with them.” (1-1-16, L132-133)*

The participant’s role in providing ‘education regarding substance misuse and interventions’ contributed to the problem drinkers and their network becoming involved in family work. This included education about what interventions involve, and the nature and impact of substance misuse. Education was reported to help challenge client barriers to family work by highlighting the psychosocial nature of substance misuse. Providing a safe environment, such as introducing ‘boundaries and rules,’ ‘reducing

conflict,’ and facilitating ‘openness’ in the therapeutic session were also perceived to facilitate family work.

*“To actually hear her daughter say what she was thinking and feeling, and it gave them the opportunity to actually discuss it with me there as referee if you like.” (2-2-16, L86-87)*

### ***Supportive attitudes of Problem drinker and network; Motivation and Goals***

Clarifying the ‘motivation and goals’ of family work such as being clear about the purpose and having shared goals was perceived to facilitate problem drinkers and relatives supportive attitudes towards it. The problem drinker could facilitate family work when they were motivated to involve their family and brought them to sessions. The attitude of the network was also critical, such as when the network contained ‘positive supportive relationships,’ and wanted to be involved in the process. Associated with this was the network’s ‘beliefs about consequences,’ such as outcomes of their involvement but also the nature of the outcomes. Some networks ‘advocate family work,’ such as asking the clinician if they can be involved, or attending the session with the problem drinker. Having the network engage in the intervention helped to reduce conflict and risks, and developed strategies for the network to use in managing the problem drinking, and supporting the problem drinker in high risk situations. Being open to the therapeutic intervention and engaging in sessions also facilitated family work.

*“I think it depends on how supportive and the families understanding of what the work is all about. What the involvement is going to be and if they are open to sort of being involved.” (8-1-10, L80-81)*

In summary, family orientated service procedures, therapeutic alliance, and supportive attitudes of problem drinkers and network, are identified by participants as problem drinker and family facilitators to family work. Encouraging family involvement and providing education regarding substance misuse and interventions were most frequently cited by staff as facilitating problem drinkers and relatives in family work.

#### **Theme 4: Participants perceptions of problem drinker and family barriers**

(See Appendix 17 for Template 4)

##### ***Resistance***

‘Resistance’ from the problem drinker in not wanting to involve their family in the intervention was perceived as a barrier. One of the factors underlying this resistance was the ‘readiness to change’ of the problem drinker and the network, who may not be at a stage to accept responsibility and make changes in relation to the problem drinking. Concerns about confidentiality and openness were also barriers when, for example, problem drinkers were concerned information would be shared which they did not want their family to hear.

*“There’s some resistance from the client themselves...when everyone was there, the person with the identified problem, tried to, I suppose sabotage the process.” (3-1-16, L151-154)*

An ‘Attitude of defused responsibility within the network’ was frequently cited as a barrier, as the network’s perception of substance misuse was often that the problem

drinker needed treatment and not them. The network may not want to hear that their behaviour may be responsible for some of the problem drinking, and subsequently do not want to hear that they need to make changes in order to facilitate changes in the problem drinker's behaviour. 'Perception of the therapist as expert,' also directed the responsibility for changing the problem drinker onto the clinician. Some networks were perceived to want to see changes in the problem drinker before they engaged in the intervention. Previous failed attempts of the problem drinker to reduce their drinking and the longstanding nature of substance misuse problems were perceived to contribute to the network becoming tired of trying to help the problem drinker.

*"All the fault is with the drinker and they don't actually always recognise or don't always like to hear that maybe if they make the changes the other party may also make some changes." (1-1-16, L113-115)*

### ***Difficulty maintaining engagement***

Another participant perception of a client barrier was, 'difficulty maintaining engagement' with social networks being motivated to engage in an intervention during a crisis but disengaging once the crisis had blown over. The 'family's dissatisfaction with intervention,' was also cited for disengagement. Some participants suggested that networks dissatisfaction was due to their expectations of the intervention not matching the outcomes of the actual intervention.

*"The only problem I had with it was that the person didn't stop drinking, so the family disengaged...most people are willing to engage when there is a crisis but when the crisis has blown over, they tend to, "well everything's ok now for a while" until the next crisis." (16-2-19, L81-84)*

‘Accessibility’ was also cited as a barrier to maintaining engagement, which included practical difficulties for families accessing the service, and finding a mutually convenient time and location for the problem drinker, family and clinician to meet.

*“It’s often quite difficult with our client group to get an individual to come to a number of sessions let alone adding in those other sort of factors of multiple people having to get their diaries together. It’s very much timing is an issue and I guess even geographics as well.”* (7-3-18, L194-197)

### ***Problematic Networks***

‘Problematic networks,’ can make ‘family work not appropriate,’ which includes ‘systemic problems of which alcohol is a symptom,’ ‘significant relationship difficulties within the network,’ and ‘risk issues,’ such as the potential for it to increase domestic violence. For some problem drinkers there is ‘no network’ to include in family work.

‘Substance misuse in the social network’ was another named barrier, due to the conflict in interest, particularly when couples both have a substance misuse problem or different motivations. This related to ‘different attitudes’ as both the problem drinker and network’s agendas and expectations could impede family work, particularly when they are incompatible with the goals of the intervention.

*“Whereas they come expecting us to gang up with them on the drinker. When they find that that doesn’t always happen...they perhaps go away a little bit disgruntled.”* (1-1-16, L148-150)

In summary, resistance, difficulty maintaining engagement and problematic networks, were identified by participants as problem drinker and family barriers to family work. Resistance from the client and family members were the most frequently cited barrier to family work identified by participants.

## **Theme 5: Participant perceptions of Organisational facilitators**

(See Appendix 18 for Template 5)

### ***Organisational Support; Systemic focus***

When organisations are motivated by the ‘psychosocial model’ of substance misuse, it takes the focus away from the individual problem drinker, and gives a more ‘systemic focus.’ Participants suggested that for family work to move from being seen as specialist add-on service to being part of mainstream services, this requires both the needs of problem drinkers and relatives to be given equal status. Substance misuse was also reported to need to be understood within its social context to significantly facilitate family work. This required organisational change which has not yet occurred.

*“we need to make family approaches part of mainstream services rather than specialist or add-on... we should kind of make the whole organisation in terms of mainstream work that its offered, as good a service to relatives as it does to drinkers.” (18-1-15, L56-69)*

### ***Organisational Support; policy validating family work***

‘Policy validating family work’ was also reported to facilitate family work, particularly when policy was ‘interpreted to be supportive of family work,’ and ‘incorporated into agency policy.’ Different recommendations and guidelines from several agencies, made it difficult to know which to follow. However, incorporating policy into local agency policy appeared to concrete family work into practice, and validated it.

*“It’s put across at management level then sold to us that this is how this agency works rather than this is recommendations from some other body which it first comes from in the first instance.” (1-1-16, L85-87)*



In summary, organisational support which incorporated a systemic focus and policy validating family work, are identified by participants as organisational facilitators to the implementation of family work. Participants most frequently cited services being motivated by the psychosocial model and incorporating family work into mainstream services as organisational facilitators.

### **Theme 6: Participant perceptions of organisational barriers**

(See Appendix 19 for Template 6)

#### ***Lack of Infrastructure Support: Insufficient Service Resources***

Participants' perceptions of organisation barriers included 'insufficient service resources,' under which service capacity was cited as a recurrent theme, with services being under resourced and not having the capacity to do family work. Funding was another barrier, when the service's capacity to meet targets influences future funding. *"...so it can be supportive but ultimately unless you meet your targets for the contract we won't be asked to offer that service again, so there's that pressure."* (3-1-12, L307-310)

Targets were seen to focus on the problem drinker and do not take into consideration family work. Inappropriate facilities for family work were another organisational barrier since inadequate room size or unsuitable environments were outside the participants' control.

*"Well you would need a decent sized room and somewhere that people could sit round but we've got a little room which you could have the key worker, the client and we*

*could bring someone else in,... it wouldn't be I don't think conducive to a therapeutic environment."* (13-1-17, L354-357)

***Lack of Infrastructure Support: Unsupportive Organisational Climate and Culture***

'Management' barriers included having 'other priorities' such as targets, resources and focus which detracted from family work. Lack of continuity in management such as changes in personnel at a higher level management, may also contribute to changes in priorities and focus over time. Service level agreements reportedly influenced managers and often did not facilitate family work. For example, commissioning services for problem drinkers might exclude family work, and services involving the network might be actively discouraged.

*"Organisational systems need to change... how things are recorded, how you collect data. ...people aren't collecting any data on how much family work is happening. And commissioners aren't asking for it so the commissioning process, those all sort of need to change too."* (18-1-15, L254-255)

'Trust and government agencies' barriers included: 'lack of follow-up or support of implementation of recommendations.' Targets were not perceived to have changed to incorporate family work, and when an interest is shown in family work, such as government agencies conducting a needs assessment with relatives, this was not followed up.

*"I suppose my impression of the National Treatment Agency is, particularly around families, is that there have been lots of recommendations that there should be more family work, but I've not seen it backed up at a local level with commissioning."* (18-1-15, L153-155)

The focus on performance management seemed incompatible with family work, since the emphasis was on getting people off the waiting list and through the system, rather than investing time to deal with the underlying root cause of the problem. Family work remained an add-on service in many settings, with services not being structured or commissioned for it.

*"I feel that as a mental health worker, alcohol is very much a bolt on service, so therefore it doesn't get the prominence that is probably should have given the nature and extent of the problem."* (3-1-12, L315-317)

The individual focus of the organisation was reported to be incompatible with family work, with several participants citing an interest in family work but not having the capacity or formal permission to carry it out, since the focus was on meeting targets and other service demands. The majority of work reported with relatives was informal, with most participants only being involved in family work for the minority of their clients. 'Culture' also acted as an organisational barrier, as alcohol misuse was not treated with the same seriousness as drug misuse. Culture was also seen to influence the individual focus of organisations and reflected the focus on the individual problem drinker in 'dominant models in the health care system.'

In Summary, lack of infrastructure support which included insufficient service resources and unsupportive organisational climate and culture, were identified by participants as organisational barriers to family work. The other priorities of management, lack of follow-up support from the Trust and Government, and services not being structured for family work were the reasons most frequently identified by participants as organisational barrier to family work.

## **SECTION 5: DISCUSSION AND RECOMMENDATIONS**

The discussion section will initially summarise the results of the two methods of analysis. Three important themes which emerged from the data will then be discussed using psychological theory. Finally, recommendations which led on from the findings will be presented.

### **Summary of results**

The aims of the current study were to investigate staff perceptions of facilitators and barriers to the implementation of the NTA (2006) recommendations that family work should be made available in alcohol treatment. This included exploration of staff perceptions of factors which impede or facilitate family work.

Stage 1 indicated that there was variability across services in the implementation of family work. Stage 2 explored this variability by identifying factors which impeded or facilitated implementation of family work. To achieve this staff working within alcohol treatment services were interviewed using an adapted version of the TBII (Michie et al., 2004), which explored their views on the NTA (2006) recommendation and family work. The transcripts were initially analysed by rating pre-determined categories of behavioural change which the TBII explored as showing good, partial or poor evidence of successful implementation. This initial analysis gave an indication of staff perceptions of the level of success of implementation but also identified pre-determined factors which supported or impeded implementation. The transcripts were reanalysed using template analysis methodology to identify factors which supported or impeded family work, to show any relationships between themes (which was not permitted in the first analysis), provided a hierarchical framework for organising the

themes, and prevented themes that may have been missed by the first analysis being lost in the data.

The first analysis indicated variability in the level of success of implementation across services. Further exploration indicated that factors contributing to more successful implementation included staff believing that family work was likely to lead in positive results, providing it was compatible with their skills and perceptions of their role and identity, and they were motivated to provide it. Barriers to implementation of family work identified by staff included: 'environmental context and resources,' (e.g. lack of funding, time, space, staff); 'social influences' (e.g. lack of support from management and the team); and 'emotions' (e.g. fear, anxiety and lack of self-confidence). The first analysis identified potential difficulties that impede successful implementation of the recommendations for family based work, and through this process also indicated areas (i.e. barriers) to be targeted to increase implementation. For example, interventions targeted at increasing team and management support will need to incorporate theories of change at an organisational level.

The templates developed in the second analysis identified facilitators and barriers at different levels: Staff participant; problem drinker and family; plus organisation. Different themes: 'Staff perceptions of family work,' 'the culture of working within addiction services,' and 'who has got the problem?' emerged from the data which encapsulated the different templates, and will be presented and discussed in turn.

### **Staff perceptions of family based work**

A postmodern or third order systemic perspective can be used to guide the interpretation of the results as it focuses on relationships, interactions and

communication and views the problem within its context rather than focusing on the presenting problem per se (Fredman, 2006), which reflects some enduring concepts from earlier systemic ideas. Although the term 'systemic' has had many meanings, it is used here as a metaphor to reflect the organisational and wider socio-cultural influences on the problem, with a particular emphasis on patterns of meanings and how meanings are constructed (Fredman 2006). This move towards social constructionist ideas was deemed important due to the research focusing on perceptions, which this approach would understand as staff interpretations of the world which has been socially constructed through language (Fredman and Combs, 1996).

The social constructivist premise that truths are not discovered but are instead constructed, suggests that the meanings underlying the beliefs which any system holds about the situation rather than the actual behaviour (i.e. resistance to family work) needs to be considered. For example, the term 'problem drinker' is a socially constructed term which has changed over time as has the response of society towards this client group, and reflects the influence of socio-cultural aspects. To elaborate further, when 'problem drinking' is perceived as a moral failing, it needs to be punished, and when 'problem drinking' is perceived as an illness, it needs to be treated, as reflected in historical constructions of the term (May, 2001). According to a social constructionist approach, staff perceptions of family work can never be neutral but are instead influenced by personal, cultural and social contexts.

Within a social constructionist approach, narrative theory considers wider socio-cultural contexts and focuses on language as conveying underlying beliefs (Freedman & Combs, 1996). This is demonstrated in the current transcripts through the participants' interpretation of 'family work,' which influences their behaviour. When participants interpret family work as referring to formal family therapy, this narrow perception acts

as a barrier. This perception focuses upon family therapy principles with participants believing that family work requires specialist family therapy training, and/or specialist theoretical knowledge and skills. For example, several participants stated that they could not do family work because they were not trained in family therapy. Although there are different forms of family therapy, the general focus is on influencing interactions between family members to facilitate change, with sessions usually involving several family members. When several participants were asked if they do family work, they interpreted this as referring to family therapy and answered “no,” however, with further exploration it was revealed that participants did informal work with families, but did not recognise this as family work. This finding is consistent with narrative theory, which suggests that the dominant narrative can overshadow other narratives which do not fit.

Consistent with a narrative perspective whereby beliefs influence behaviour, an alternative definition of family work may influence clinicians to behave differently. Alternative definitions refer to the different levels of family work such as joint work with relatives and problem drinkers, informal and formal work with relatives, and working with the family to engage the problem drinker (Copello, Velleman, & Templeton, 2005). These approaches can be based on specific therapeutic approaches such as Social Behaviour and Network Therapy (Copello et al., 2002) or the Community Reinforcement Approach (Myers & Miller, 2001) but can also include low intensity interventions. When participants interpret family work as referring to more flexible approaches and perceive the family as a resource, this facilitates it. Rather than asking the relatives to commit to long term family therapy, low intensity interventions refer to providing relatives with support e.g. a five minute phone call to relatives or engaging relatives in some of the sessions with the problem drinker. This is similar to

the informal support which many of the current participants were already engaging families in. Participants' overall domain scores for 'beliefs about own capabilities' were lower than their 'skills' domain scores, which corresponds with participants having the skills to do family work but lacking the self-efficacy and belief in their capabilities to do it. This indicates that if family work can be reframed for clinicians, it would help to increase their self-efficacy and beliefs in their capabilities, and validate their work with families (Smith & Velleman, 2002)

A 'narrow perception of family work' frequently reported in the current study also influences the participants' perception that it requires additional resources and demands. For example, many participants reported that they did not have the capacity to take on family work as they believed it took more time, organisation and planning, additional supervision (which their service did not provide), and required more flexibility in their working hours, which many participants felt unable to provide. These perceptions were often based on their experiences, or rather lack of experience and knowledge of family work. For participants who had received training on family work, resources and demands were less of a barrier, because they recognised the value of low intensity interventions, which do not necessarily require additional resources and demands.

Participants' perceptions of family work influenced their perceptions of resources, with the 'environmental context and resources' domain scoring low for implementation in the first analysis. Ordinarily this would suggest that more resources are needed for services to develop services for family work. However, a systemic approach does not necessarily require additional resources such as larger rooms, more staff or additional time (Lynggaard & Baum, 2006). This was evident in the current study as participants identified multi-disciplinary working as a facilitator, such as



reviewing cases and valuing team members' perspectives on the family. However, due to the narrow definitions of family work, participants generally believed that it required the presence of the problem drinker and/or the family. A more systemic perception of family work may help overcome this barrier as relatives do not need to be present for a systemic intervention. Instead, asking "who" questions about the family can broaden the focus, such as "who is involved?" "who is affected?" and "who has a view?" (Fredman, 2001), and incorporating systemic practices into current ways of working such as inviting multiple perspectives on the problem during peer supervision, and asking about the wider social network during work with clients.

Level of 'skills' was associated with what training or qualifications participants had received in family work. Participants who have received training in family work scored highly in the skills domain in the first analysis. Self-efficacy was associated with training received and follow-up support, suggesting that the development of skills in family work is facilitated by training, but also needed follow-up support to imbed it into clinical practice, particularly while self-efficacy is developing. Training in family work appears to facilitate self-efficacy but also provides more insight into what it entails, therefore challenging some of the narrow perceptions which participants hold. For example, participants who have high levels of self-efficacy may feel more confident to carry out work with families, and are able to incorporate family work into their everyday work without working strictly to a formal model. This is consistent with Bandura (1977) theory of self-efficacy where higher levels of self-efficacy increases confidence in the activity whereas lower levels of self-efficacy leads to avoidance behaviour. Training and service context influenced the participants' perceptions of family work but also their expectations about what their professional role involved,

which indicates that a systemic approach is beneficial to the implementation of family work in alcohol treatment services.

### **The culture of working within addiction services**

The culture of addiction services also seems important in influencing whether participants offer family work. Narrative and social constructionist ideas can be applied to help understand the culture of working within addiction services since it considers wider culturally shared beliefs as influencing the clinician's behaviour. Shifting the focus to viewing the problem within context allows the underlying meanings to be explored which have shaped the systems dynamics. Within some services, the culture focuses upon treating the individual problem drinker. For these services, many participants believed in the psychosocial nature of substance misuse and were aware that family work can have positive consequences, however continued to value working with the problem drinker more than working with the relatives. There is an apparent stuckness, with participants' beliefs about problem drinking not matching their clinical work, which means that they do not take it to the next step and work with the social context of the problem drinking.

In order to understand why clinicians prioritise the problem drinker, it is important to understand the attitudes and beliefs which inform this behaviour. Attitudes and beliefs are influenced by the social context and in many services, the needs of relatives seem less important than the problem drinker. For example, although holistic and risk assessments consider the needs of relatives, these needs are often not addressed by the services, and relatives tend to be referred on to other services for support. At times of change, it is important to consider not only the ethos of the organisation but

also the roles staff are expected to assume (Smyly, 2006). The current study indicated that there was a culture within the alcohol treatment services that the clinical staff's primary role was to work with the problem drinker, as defined by their job description. Influenced by the social context, under these circumstances it is easier for the participants to blame lack of confidence, when the underlying cultural attitude is that work with relatives is not recognised as important, as highlighted by the 'priorities' barrier in the current findings. In addition, the organisational structure may not yet be established for family work, and has not put in place the necessary network supports such as supervision, training or recording systems for it. By focusing attention on the problem drinker, this reduces opportunities for systemic work and keeps the emphasis on the individual problem drinker.

Expectations about family work also influenced the beliefs and attitudes of participants towards the narrow perceptions of it. The clinicians were not only influenced by the system but were also influencing it to remain focused upon the problem drinker. However, when the culture of the service prioritises the needs of relatives above those of the drinker, such as addressing risk issues before focusing upon reducing the problem drinking, there is a clear shift in priorities which is more conducive of family work. The presence of family members such as during home visits, or when relatives accompany problem drinkers to sessions, was also identified by participants as contributing to a broadening focus that included a consideration of family dynamics. This is consistent with a narrative approach, whereby when the meanings shift, this leads to changes in feelings and behaviour, which is demonstrated by the change in the culture, leading to changes in how participants behaved towards the problem.

The term 'problem drinker' is now the preferred term in UK alcohol treatment services, however, this term continues to evoke shared ideas about the problem being within the individual. Participants' perceptions of client barriers included 'attitude of defused responsibility,' but also 'resistance' from the problem drinker in involving family members, which reflects the culturally shared idea of the problem being within the individual. This reflects a cultural discourse about the appropriate way to tackle substance misuse (May, 2001), but also if the problem drinking is a symptom of the wider system dysfunction, this resistance from the problem drinkers and relatives may mask an avoidance of dealing with the underlying problem of the system. By services offering interventions mainly targeted at the problem drinker, this not only reinforces the avoidance but also locates the cause of the problem as being within the individual. These culturally shared beliefs influence the way clinicians view appropriate ways of dealing with distress and may also account for why only the surface of the problem is addressed (Dallos, 2006). A narrative approach suggests that clinicians reformulate the term 'problem drinker' to be less self-denigrating, but to also reflect the socio-cultural context of the problem, while alcohol interventions may also need to reflect and include the social context of the problem.

For participants who were motivated to do family work, this was often difficult to achieve when the culture of their addiction service was focused upon only the problem drinker. For example, some services were structured around treating the problem drinker, with relatives being referred on to other services. Although there are some movements which are starting to address the needs of relatives, such as holistic assessments, there is still a dearth in services for relatives. Resources also seem to restrict the services which are provided for relatives. For example, some participants had experienced services for relatives being withdrawn, were given no extra time or

supervision to support family work, and many considered the demands on the service before considering taking on family work. From a first order systemic perspective, problems emerge from the failed attempts of the system to solve the problem (Watzlawick, Weakland & Fisch, 1974), which is evident here by half-hearted attempts to explore and address the needs of relatives, but still failing to address the problem as a whole. This indicates that a whole system transformation is required to fully address the problem rather than trying to focus on specific aspects of the service.

Some of the participants interviewed considered themselves champions for family work, however, it was apparent that it is difficult to influence the overall service culture from within the team, and that what is required is management to take a lead. Many participants were also unaware of what family work their colleagues were doing and were unclear how motivated their colleagues were towards it. This is supported by the 'social influences' domain scoring low for the first analysis, with the second analysis indicating that the team influence is weaker than the management influence. Some participants had experienced lack of management support, both in terms of deterring them from accessing family based training, but also in pursuing work with relatives, particularly as management seemed preoccupied with meeting targets. This indicates that a top-down approach is needed whereby the management and organisation need to be instrumental in influencing their service towards a more family based approach.

### **Who has got the problem?**

In exploring 'who has got the problem?' it is important to consider this from the perspectives of the participants, organisation, problem drinker and the network. From a

social cognition perspective, the reciprocal relationship between behaviour, cognition and other personal factors, as well as environmental factors are important in understanding causation (Bandura, 1989). Within these factors, historical, social and cultural aspects that inform beliefs will also be considered.

The current study indicated that the organisational focus is very much on the individual problem drinker. From a historical perspective, the UK government has been influenced by moral, legal and medical models (Donovan and Marlatt, 1988), which all view the individual as the problem. These models support a 'blame culture,' which make it difficult to balance the needs of the 'problem drinker' against the needs of people who have been affected by the drinking behaviour, particularly if the societal discourse is condemning the problem drinking. An awareness of the negative impact that the moral model had on problem drinkers, was instrumental in influencing political agenda to work towards persuading the general public that moral judgements increased the problem (Berridge, 1990). Government organisations are also influenced by societal discourses, which perceive alcohol misuse as less serious to drug misuse, focus on a binge drinking culture, and have a greater tolerance of alcohol intoxication. The UK government also has a conflict in interests, since large amounts of revenue are generated from the taxes on alcoholic substances and liquor licenses (Schrad, 2005). It is therefore easy to understand why the motivation for tackling this societal problem may be contraindicated, but may also partially explain why the societal problem is being maintained. Alcohol producers also like to see the drinker as the problem rather than the substance per se.

Social learning theory (Bandura, 1989) highlights cultural and environmental experiences as being important in the development of the problematic drinking behaviour. Within alcohol treatment services, alcohol is not just the focus of

interventions, this is based on the tenet that problem drinking is the symptom of another problem such as system dysfunction or difficulty coping with life, but also because the environmental context can act as a protective factor against problem drinking. However, due to the organisational focus on treating the individual problem drinker, the cultural and environmental experiences which are central to the problem are being neglected. From a first order systemic perspective, contrasting beliefs function in maintaining the problem (Proctor, 1981), which is evident here by the contrast between what organisations are commissioning services to provide, and the beliefs held about what underlies substance misuse.

Alcohol Services are not on the whole structured for family work, with the priorities and targets of the organisation relating to the problem drinker. Since the NTA recommendations for family work were published in 2006, services have not noticed a shift in recorded targets or commissioning, with services continuing to feel pressured to reduced waiting lists, and move problem drinkers quickly through the system. The target-driven culture is also being maintained by the funding of services being influenced by the services' capacity to meet the targets. Media portrayal of NHS targets indicates that the target-driven culture is threatening patient care, as patients have stopped being treated as individuals (Hope, 2008). Clinicians are doing what they are asked to do and nothing more in order to meet targets, which are reducing holistic care. From a first order systemic perspective, the focus on the problem drinker reflects the current stuckness, which the organisation is maintaining by failing to address the organisational changes that need to occur in order to support the recommendations for family work.

An alternative perspective which is less blaming of the system can be informed by narrative theories to help understand how wider socio-cultural shared ideas can be

taken on by the system and influence its dynamics (White and Epston, 1990). Societal discourses influenced by the medical model facilitate the construction of a problem-dominated narrative, which locates the problem as inside the drinker. The dynamic of the system therefore works towards trying to alleviate the problem and focuses on treating the individual. The problem-dominated narrative is also maintained by organisations continuing to fund services and set targets relating to the individual drinker, rather than addressing the problem within its social context. In New Zealand, a community action approach was found useful in encouraging systemic change, both within alcohol treatment services and at a higher organisational level through the redirection of priorities and resources (Conway et al., 2007).

With organisations structured for only the problem drinker, this makes it difficult for clinicians to engage and work with the social network. This is evident when clinicians struggle to find the capacity to work with the family in their everyday work. There was a clear discrepancy between participants' perception of substance misuse as a psychosocial problem, and being able to work with the drinker and their social network, which is central to understanding substance misuse in its social context. This highlights the interrelationship between behaviour, cognitions and environmental factors, as even though the beliefs of clinicians regarding substance misuse are influenced by the psychosocial model, it will take more than this belief to influence their clinical practice.

The theory of planned behaviour (Ajzen, 1985) can be applied to understand the current participants' intentions and behaviour towards working with the social network by considering three factors that determine intention: attitudes; subjective norms; and perceived behaviour control. Many participants' attitudes towards family work as indicated by their high scores on the 'beliefs about consequences' and 'motivation' domains, suggested that they believed it would be beneficial and were motivated to do



it. However, the participants' evaluation of performing family work which influences their attitudes indicated that they felt limited by their capacity and lack of self-efficacy. These findings suggest that, although the participants were aware of the positive consequences of family work and know that interventions need to be targeted at the problem drinker and the family, there were other factors which prevented them from being able to carry out this work, which resulted in the problem drinker being the focus of their interventions. Motivation on its own was not enough to facilitate work with families.

Subjective norms refer to the participants' perceptions of social pressure from significant others which influenced whether or not they worked with relatives. In relation to the current study, in the first analysis 'social influences' was one of the lowest scoring domains. Many participants reported that social pressure from their manager influenced whether they worked with relatives or not. Social pressure from team members was often more indirect and links to pressures on the team such as service demands, which can reduce the capacity to provide family work. There were mixed levels of support within the team, which could vary from being very supportive to 'frowning upon' family work. There is some indication that when the motivation and goals of the organisation is geared towards the psychosocial model and incorporates family work into the mainstream service, this can positively influence the participants towards it. However, triangulation of the demographic and descriptive information about each service suggests that this has only partially occurred in the minority of services.

Perceived behaviour control (Ajzen, 1985) refers to the amount of control the participants feel they have in their clinical work with social networks. Concern about maintaining control over sessions with families was one of the barriers identified by the

participants. However, another barrier was not feeling they had control over their clinical work. Participants who had high self-efficacy and a reasonable degree of clinical autonomy, felt a higher degree of perceived behaviour control over their clinical work with families and were more likely to be involved in family work. Perceived barriers and facilitators also influence perceived behaviour control, which the current study has focused upon.

For many staff participants they identified an ‘attitude of defused responsibility’ within relatives of problem drinkers, which indicated that relatives perceive the problem drinker as the one with the problem. From a systemic perspective, if relatives perceive the problem as being within the problem drinker, then a systemic approach may not be appropriate. This is consistent with family work not being appropriate for all clients, such as clients without a family, or substance misuse within the social network. From a theory of planned behaviour (Ajzen, 1985) perspective this perceived attitude of defused responsibility may relate to the relatives lack of behaviour control for the problem drinking and their perception of the therapist as the expert, which gives the clinician the control to work with what relatives perceive is the problem. Perceived barriers, such as confidentiality concerns and accessibility difficulties, also inform these control beliefs, which need to be addressed to facilitate family work.

Perceived consequences of family work also influence problem drinkers’ and relatives’ motivation to be involved in it, which staff participants identified as a client barrier of perceiving the intervention as not leading to positive consequences. When the family displays positive supportive relationships and wants to be involved in the process, this facilitates family work. This may link to the family’s evaluation of the intervention leading to positive consequences. Problem drinkers are often resistant to involving their families in the intervention, which indicates that the problem drinker

perceives that they are the one with the problem, or because they are avoiding dealing with the underlying dysfunction within the system. This may also reflect wider socio-cultural beliefs in which the problem drinker is the one with the problem, with the relatives being perceived as the victim.

The attitude of the current participants towards families also provides insight into what may be maintaining difficulties with engaging families. The problem drinker and family were frequently labelled as “resistant” to family work, due to them either not wanting to engage or not maintaining engagement. Without interviewing relatives and/or significant others, it is difficult to establish what underlies their dissatisfaction with the intervention. However, from a systemic perspective, the participant’s interpretations of resistance are obscuring the power relations which underlie the problem (Guilfoyle, 2001). The dominant discourse is focusing on trying to understand the resistance, and not recognising the power relations that exist between the client and the clinician. As soon as a client and a clinician enter into a therapeutic alliance, they adopt the roles of client and clinician. The cultural discourse of the clinician as the expert “who knows best”, implies power through knowledge, which the client can oppose through resistance (Guilfoyle, 2005). Therefore when resistance is experienced, it may be more useful to explore the power relations that are masked by the resistance.

It may also take time for the family to identify what they want to commit to changing, which is consistent with participants identifying different agendas and expectations as a client barrier to family work. From a systemic perspective, families often want strategies for actively dealing with the problem or emotional support, which clinicians may not necessarily address (Clegg & King, 2006). Engagement problems should be expected but also families may need to disengage for different reasons. Research indicates that problem drinkers often disengage or make several attempts at

reducing their problem drinking (Moos & Moos, 2005). Providing clinicians with opportunities to reflect upon and understand engagement difficulties but also developing creative ways to engage families and clients in family work should be pursued.

Madsen (1999) suggested three guidelines for engaging clients and families:

1. Get to know the client as individuals beyond the influence of their problems, i.e. allow clinicians to sidestep problems of resistance.
2. Do not try to help until invited to do so.
3. Once the client and the social network have identified a problem they would like to work on, the clinician's role is to keep the focus upon addressing this problem.

Organisational, clinician and family perspectives indicate that they advocate the problem as being within the individual. Consistent with narrative theories, the problem which is located inside the individual has developed from and is being maintained by the oppressive stories which dominate the problem drinker's life (White, 1995). The current participants' perceptions of problem drinker's barriers to family work, indicates that the problem drinker does not always want to involve their family, which may be due to their beliefs that the problem drinking is their problem. The problem drinker's readiness to change, lack of openness, and concerns about confidentiality, were also identified by participants as barriers for problem drinkers, and reiterate the narrative of the problem being in the individual, rather than a shared problem. The dominant narratives of the system are focusing on the problem behaviour, which is in turn becoming the problem drinker's identity. In addition, the term 'alcoholic' or 'problem drinker' is maintaining the problem by linking the problem with the individual's identity. This may be an underlying barrier to change since societal discourses are suggesting identity change is needed rather than

behavioural change (West, 2009). Narrative therapies would suggest externalising the problem, therefore making the problem drinking separate from the individual's identity, and freeing the problem drinker from the oppressive narratives in societal discourses (White, 1995).

In narrative therapy, the process of re-authoring narratives can change the problem, as this shifts the narrative from being problem-dominated, and considers other narratives about the problem (Carr, 1998). Gaining multiple perspectives can also enhance the process, and is consistent with the perception that involving family in interventions can facilitate family work, since their views will be taken into consideration. The process of re-authoring involves the clinician taking a non-expert stance and working co-operatively with the client to re-author new narratives about the problem (Carr, 1998). This approach would not be inconsistent with some of the motivational interviewing approaches used by participants with problem drinkers (Miller & Rollnick, 2002). Certain therapeutic characteristics are critical in the process and reflect the therapeutic characteristics identified by participants which include the clinician being non-judgemental and open about the intervention, motivation and goals. This indicates that a narrative approach may be beneficial for work with this client group, however, it requires the clinician to understand the narratives problem drinkers are using to make sense of their lives, the influence of language, and the power relationships in which problem drinkers find themselves (White, 1995).

In summary, the clinicians, organisation, problem drinker, family and significant others have located the problem within the problem drinker, therefore it is important to work upon challenging this narrative at different levels. Consistent with Grol (2004), recommendations need to be targeted at different levels: the clinician, the drinker, the social context, the organisational context, and the government (economic and political context).

## **RECOMMENDATIONS**

### ***Recommendation for Clinicians:***

1. Training on family based work specifically around challenging the narrow perceptions of family work.
2. Clinicians to make contact with other clinicians interested in working systemically (this does not necessarily mean seeing the problem drinker and family together but rather a consideration of the social context of the problem), and with the family, with the aim of sharing skills and experiences, working through difficulties and to increase support for family work. This may include linking with clinicians outside of their speciality service.
3. Clinicians to receive systemic supervision and guidance.
4. Clinicians to create opportunities to reflect on and understand engagement difficulties, e.g. during peer supervision or team meetings.
5. Clinicians to be encouraged to access training on systemic approaches e.g. the previously discussed ideas of Madsen (1999).
6. Clinician roles and job descriptions to be re-evaluated to take into consideration work with relatives.
7. Clinicians to be encouraged to apply systemic thinking not only to clients, but also to their own practice such as supervision, training and research.

### ***Recommendations for working with the person with a drink problem:***

1. Clinicians to incorporate systemic approaches such as narrative and social-constructionist theories into clinical practice.

2. Externalise the drinking problem by naming the problem and referring to it as separate from the individual. For example, “How has the problem drinking affected your life?” “Are you happy with what the problem drinking is doing to your relationships?” “Were you in charge or was the problem drinking in charge?”

***Recommendations for working with Social Network:***

1. Rather than being the expert, the clinician’s skills should be in eliciting, acknowledging and elaborating the family’s knowledge, skills and expertise.
2. Clinicians to consider the question: why is it important to involve families? Not only are the family part of the problem but they are also the most powerful solution to the drinking problem.
3. Clinicians to encourage multiple views on the problem.

***Recommendations for Management:***

1. Validate the informal work which clinicians are already doing with families. This could be achieved through a change in culture within teams to focus more on family issues e.g. reviewing cases, peer/clinical supervision, assessment forms and care plans. It may help to emphasize the importance of low intensity interventions, validating brief contact and support to family members, and challenging the perception that family work does not necessarily entail greater commitment and resources.
2. Follow-up support is highlighted as important; therefore it will be useful for a lead clinician to take a role in supporting the team in family based work as part of the change in the team culture towards valuing it. This means being trained in family

based work (not necessarily family therapy) and supervision, with the aim of providing clinical and management support for family work.

3. Those in higher management positions with strategic responsibilities to receive education in the current models and evidence for family based work and substance misuse (Smith & Velleman, 2002).
4. Management to take a more proactive lead in moving the service towards being more family focused and facilitate systemic working.
5. Explore options for accessing systemic supervision for the service.

***Recommendations for Organisations:***

1. A whole systems approach to be taken towards tackling the problem thereby targeting interventions at the organisation, management, clinicians and client group, to be more family orientated. By organisations changing this will help challenge cultural expectations of the problem being within the problem drinker.
2. Organisations to incorporate systemic approaches, therefore considering the problem drinking as a contextual and societal problem.
3. Services to consider accessing systemic consultation as the service system may be mirroring family issues. Systemic supervision to be made available for clinicians.
4. A Community Action approach is recommended to help change priorities and resources by shifting the focus onto social, cultural and environmental factors e.g. providing education on social construction of problem drinking, as changing knowledge and attitudes of the system can change behaviour, and re-orientating organisations to support these transitions.
5. Organisations to review the impact of the target-driven culture on the quality of holistic care in alcohol treatment services.



6. To review targets, recording systems and commissioning of services to include work with relatives.
7. Audit, evaluate and disseminate the work that is being done with families.
8. Involve service users and whole staff teams in the development of the services for social networks.

***Recommendations for the Government:***

1. To help increase awareness of the impact of societal discourses on the problem.
2. To incorporate systemic approaches into understanding the problem.
3. Policies to work towards changing perceptions of problem drinking so that they include the social context and are less de-valuing of the problem drinker.
4. To revise financial arrangements in line with a systemic approach to alcohol misuse.

**Further research**

1. Future research should explore the use of systemic approaches such as narrative and social constructionist interventions in alcohol treatment services, but also other health care services. These should focus not only on work with clients but also as applied to the organisation.
2. Research which explores the implementation of guidelines within health care systems should adopt a social constructionist stance and consider the impact of the socio-cultural discourses on the whole system.
3. Due to the research identifying the importance of considering client, clinician and organisational perceptions, it would be useful in implementation research to

incorporate views from clients, family members, managers, and from higher organisational management.

4. Further research to explore the impact of societal discourses on the drinking problem.

## **SECTION 6: CRITICAL APPRAISAL**

The research idea developed from my interest in family work in substance misuse and through discussions with my research supervisors (MC & SK). The movement towards family work involved change and changes in practices as recommended by evidence-based guidelines were not always implemented effectively, which directed the focus of the research onto exploring staff perceptions of barriers and facilitators of family work in alcohol treatment services. Consultation with researcher NR who has a specialist interest in implementation research brought my attention to the TBII (Michie et al., 2004) which was adapted for use with staff in alcohol treatment services.

### ***Sample***

Recruitment difficulties meant that eight services were approached. It was anticipated that between four and five participants would be recruited from each service approached, however, for several services, only one or two participants were recruited due to lack of responses to my invitation. The sample size for each service was too small to draw any conclusions about differences between services or across professions. The impact of professional training was highlighted as a facilitator for the implementation of family work, however, due to low numbers this was unable to be explored. An area for future research is to investigate the impact of professional training

on clinicians' perceptions of family work. For example, only one manager participated in the current study, and as the findings have highlighted, further considerations from a management position would have been useful, due to the impact of social-cultural factors.

Difficulty collecting data for Stage 1 meant that for two services, the demographic and descriptive information was not gathered within the time frame. Another way to gain this information would have been to extend to the data collection period, and to have focused more time on collecting this information earlier in the study. Unfortunately due to time constraints this was not possible in the current study. The different procedures for gaining local research and development approval for each site, and the low response rate from some services, delayed the initial start dates for recruitment. In hindsight, time could have been saved by finding out the process for each Trust, and applying for local research and development approval for all sites at the same time, such as when ethical approval was gained, rather than applying to additional services, after other services had not generated the anticipated numbers. Greater consistency in the process for acquiring research and development permission across Trusts, and clearer guidelines for the procedures, would facilitate this process.

The study was multi-site which posed a difficulty in terms of travelling to different Trust sites, and often meant that a considerable amount of research leave was spent travelling to different locations. This was however important since it is likely that meeting directly with potential participants, and presenting the research at each site, enhanced recruitment. Not all clinicians were able to attend the meeting during which the research presentation was given, which may have contributed to low recruitment rates from different services. Again due to time constraints only one visit to each site was possible.

### ***External validity of the current study***

It is unclear whether the findings of the current study will generalise to all alcohol treatment services within the UK. Alcohol treatment services were targeted within the Heart of England and Midlands research hub, however, there are other alcohol treatment services particularly in the non-statutory sector within this region, which may have provided more diversity in the sample. The diversity across the structure and service models of participating services, such as some services being focused on the problem drinker, dual diagnosis, or family work, also makes it difficult to generalise.

### ***Research design***

The use of interviews for collecting data captures something of the interviewee's experience (Madill, 2008). Dingwall (1997) suggests that the relationship between what is reported during an interview and real experiences of the participants are unknowable. It is therefore important to consider the position of the participant to the data. A social-constructionist approach has helped to address some of these issues, however, further exploration of this relationship might provide insight into participants' agendas.

A limitation of the current study was that the research design focused on clinician perceptions. The development of the template and the analysis highlighted the importance of considering the perceptions of different levels within the system. Therefore, it would have been useful to directly interview problem drinkers, relatives and managers in higher organisational positions, rather than relying on the clinicians' perceptions of these different levels. The diversity within the perceptions of problem

drinkers, relatives, significant others, and organisation, is also limited, since these groups were not directly interviewed.

### ***Analysis of data***

In the first analysis, low scores for some of the domains may reflect ambiguity in the participants' interpretation of the question. Greater clarity in the questions for each domain may have ensured that each participant had a similar interpretation of the question and also prevented some of the information in the transcripts being lost. However, this process highlighted important themes which may not have emerged, without this diversity in question interpretation. The transcripts also identify potential interrelationships between different domains and key themes, which again is lost through this simple coding process in the first analysis. The focus on high and low scoring domains also means that some of the domains in between this range are not focused upon.

During the interviews in Stage 2, it became apparent that participants have different definitions of family work. The terms 'family based approaches' or 'family based work' were used, but some participants interpreted these terms as referring to 'family therapy.' From a social constructivist position, it was important to consider my own position, in relation to the term, 'family based approaches.' My lack of knowledge of alcohol treatment services meant that my initial assumptions about family work included the specific family based approaches mentioned in the NTA (2006) guidelines, and highlighted in the research literature, such as Social Behaviour and Network Therapy (Copello et al., 2002). However, due to the different descriptions and experiences of participant's working with relatives, my understanding of the term

‘family based approaches’ now includes more flexible approaches. Through my clinical psychology training and placement experiences, I have worked flexibly with families and systems so it would have been natural to assume that it would be difficult for clinicians to describe exactly what they were doing with problem drinker and social networks. Through this experience, it has increased my understanding of the difficulty of exploring phenomenon through the interview process.

Initially the a priori template was based on pilot interviews and research literature, however, this was significantly revised since the format of the interview changed and was focused around TBII (Michie et al., 2004), which was not used in the pilot interviews. This was an unforeseen difficulty, since it was only after the pilot interviews had been conducted, that the TBII came to my attention.

Considerable attention was given to how to format the templates during the analysis. The aim of analysing the data twice was to prevent any important information being lost during the first analysis, but also to highlight relationships between the different domains. During the first analysis the importance of considering different levels of the system was highlighted: the clinician’s perceptions of barriers and facilitators for themselves, problem drinkers, families and the organisation. In addition, by both conducting the interviews and doing the first analysing, this meant that there was already a relationship between myself and the data. Further exploration of this process may have provided more insight; however, a concerted effort was made to maintain reflexivity, which was supported through regular supervision and by keeping a research diary. The later change in epistemology position during the analysis of the data also indicated that further attention should have been applied to my position as the researcher, and the social context of the research.

In the second analysis of data, initially one template was used during the development of the template. However, it quickly became apparent that several templates needed to be created to encapsulate all the codes and themes, which were emerging from the data. There was also concern that the second analysis might replicate the first analysis. Initially the developments of two templates were considered: one template for low implementers; and one for high implementers. However, the data indicated that there was overlap in some of the barriers and facilitators. The emergence of the importance of considering the participants perceptions of barriers and facilitators from their own perspective, the problem drinkers and relatives, and the organisation, led to the creation of six templates. Concerns over losing important themes through condensing the codes, but also because I wanted to show the relationship between different themes, meant that the templates were larger than initially anticipated. It may have been beneficial to have consulted an expert in template analysis during the revision of the template, as their perspective may have helped reframe and condense the templates without compromising the data.

Once the six templates were created, they were applied to all of the transcripts, with the frequency of the codes and themes being qualitatively observed. This gave an informal indication of the strength of the different codes, however, due to overlap of themes and the qualitative nature of the observations it made it difficult to apply this rigorously to the interpretation of the data. In hindsight, it was over ambitious to consider that ratings of strength could be applied to the data due to time constraints and interrelationships between the different codes.

### ***Epistemological Stance***

At the time when the research study was devised, a realist epistemological stance fitted with the aims of the study, since this approach can help to understand the causes for recommendations being implemented to different extents. However, through analysing the data, a social-constructionist approach emerged as such a strong theme, that it felt important to apply this approach to the interpretation of the data. The development of the template was influenced by a realist position; however, it was only during the interpretation of the data during the discussion, that a social-constructionist approach seemed more applicable. For example, the importance of barriers and facilitators relating to organisational, and problem drinker and relatives, emerged during the analysis. Through this process the different levels of influence indicated the value of considering the socio-cultural context. The quality assurance checks during the development of the template are consistent with a realist stance. However, if the change in epistemological stance had occurred earlier such as during the development of the template, this would have caused greater problem, since more focus on reflexivity and the position of the researcher to the data would have been required.

An advantage of using template analysis is that the epistemological stance can either be realist or constructivist. More insight into the social context at the start of the development of the research study may have influenced a different epistemological position to be taken. It may have been beneficial to have taken a constructivist position at the start of the research study; however, it is unlikely that this would have significantly changed the templates. However, it does indicate that more consideration of the position of the researcher to the interviewee, and to the data, would be beneficial.

My switch in epistemological stance is also influenced by my own experiences and familiarity with systemic approaches. I have previously been influenced by systemic, social constructivist and narratives theories in my clinical work, and have



found it particularly useful in understanding phenomenon. The teaching I have received as part of the doctoral training in clinical psychology at the University of Leicester and the emphasis placed on systemic approaches during the second year of training, has also contributed to developing my awareness of systemic factors. These experiences reflect the contribution of the wider socio-cultural discourses, and the development of psychological theories throughout history, to my position as a researcher in the current study.

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## **APPENDICES**

### ***Appendix 1: Chronology of Research Process***

Pilot interviews with two alcohol workers by December 2007.

Nottingham Research ethics committee 1 meeting 8/4/2008.

Ethics approval gained 4/6/2008.

Research and Development Approval gained for each trust site:

Derbyshire Mental health services NHS Trust 24/7/2008

Leicestershire Partnership NHS Trust 4/3/2008 (Sponsors of research study)

Birmingham and Solihull Mental Health NHS Foundation Trust 30/7/2008

Bedford and Luton Mental health and social care partnership NHS Trust  
2/9/2008

Coventry and Warwickshire NHS Partnership NHS Trust 2/1/2009

Data collection June 2008 to March 2009.

Analysis data February to April 2009.

Writing up thesis January to April 2009.

Submit Thesis by 7/5/2009.

***Appendix 2: Recording Sheet to be used in Stage 1 (Version 2: 14/12/2007)***

Name of Service: \_\_\_\_\_

Job title: \_\_\_\_\_

How many years have you worked in – this service? \_\_\_\_\_

- this role? \_\_\_\_\_

**Description of Service**

**Treatment:**

What treatment approaches are currently being offered by your service?

What is your service funded for?

Do you use family based approaches to alcohol treatment in your service? Yes/ No

How many family/significant others were involved in the treatment process in the last years? (Please specify whether 1-1 work or working with more than one person in a session)

Do you have a planned length of treatment? (please specify)

- Average?
- Time-Limited?
- Min/Max?

**Staffing:**

Total number of Clinical Staff:

Staff professions and number of paid sessions:

Number of staff practicing individual work:

Number of staff practicing family based work:

- Specialist workers?
- Attempting to use some family based approaches?

**Training:**

In the last year what training has been provided to staff on family based approaches? (If yes what?)

What training is planned for next year?

**Supervision/ Support:**

How often is supervision provided to staff?

Who provides supervision to staff?

What style and format do staff receive supervision?

Are there other forms of support available to staff? (If yes what?)

**Policy/Guidelines:**

What key policies/ guidelines are currently influencing your service?

What is the process for implementing new policies/ guidelines within your service?

How do you ensure that these new policies/ guidelines are being implemented within your service?



***Appendix 3: Theory-based implementation interview (TBII) adapted from Michie et al. (2007) to be used in Stage 2 (Version 2: 04/01/2008)***

Additional Questions to be asked as start of interview:

1. What courses have you taken in family based approaches?
  2. What qualifications do you have in family based approaches?
- Theory-based implementation interview

1. Have you heard about the 'Review of the Effectiveness of Treatment for Alcohol Problems' produced by the National Treatment Agency and Substance Misuse in 2006?  
If yes – Are you aware of the recommendations regarding family intervention/therapy?  
If yes – What is your understanding of the recommendation for family therapy?  
If no – The recommendations are..... [KNOWLEDGE]
1. Pre-amble: To what extent do you think the recommendations are being implemented? Can you give me a recent example of it happening? Do you know how to offer family therapy? Do you think that other members of your team know how to offer family therapy? [SKILLS]
2. What are your views about recommendations by the NTA in general? Does that opinion apply to this recommendation? Do you think it is an appropriate part of your job to be following this recommendation? Would following this recommendation create a problem for your professional autonomy? [SOCIAL/PROFESSIONAL ROLE AND IDENTITY]
3. Is it easy or difficult to do? What problems have you encountered? What would help you to overcome these problems? [BELIEFS ABOUT CAPABILITIES]
4. What are the consequences of offering family therapy (prompt for advantages and disadvantages, e.g., time, people, etc.)? Would you say that the benefits outweigh the costs? What would happen if you didn't offer it? [BELIEFS ABOUT CONSEQUENCES]
5. Do you feel motivated to offer family therapy? Do you feel that you should be offering family therapy? Does offering family therapy conflict with any of your other goals as a health professional? [MOTIVATION AND GOALS]
6. How often do you offer family therapy? What are your reasons for not offering family therapy (prompt for attention, forgetting, time constraints, etc.) [MEMORY, ATTENTION AND DECISION PROCESSES]
7. To what extent do resources influence whether you offer family therapy (prompt for existence of trained staff, time constraints, etc.)? [ENVIRONMENTAL CONTEXT AND RESOURCES]
8. What do you think the views of the other team members are? Do these views influence whether you offer family therapy? [SOCIAL INFLUENCES]
9. Do you think that any emotional factors influence whether family therapy is offered? And what about for you? [EMOTION]
10. Are there procedures or ways of working that encourage offering family therapy? If you see a patient and decide they should be offered family therapy, what are your next steps? [ACTION PLANNING]

Additional Questions to be asked as end of interview:

1. How do you feel about the leadership style within your service?  
*Appendix 4: Participant information sheet – stage 1. (Version 2, April 25, 2008)*



**University of  
Leicester**  
**Clinical Psychology Unit**  
**104 Regent Road,**  
**Leicester**  
**LE1 7LT**

**Tel: 0116 2231639**

## **PARTICIPANT INFORMATION SHEET- STAGE 1.**

**(Version 2, April 25, 2008)**

**Applying psychological theory to understand the difficulties in  
implementing family based approaches in alcohol treatment services.**

Name of Researcher: **Claire Lee**

**You are invited to take part in a research study about implementing guidelines in  
alcohol treatment services. Before you decide, it is important for you to understand  
why the research is being done and what it will involve. Please take time to read  
the following information and then consider whether you want to take part. Talk  
to others about the study if you wish. Please contact Claire Lee (tel: 0116 223 1639)  
if there is anything that is not clear or if you would like more information.**

**What is the purpose of the study?**

The purpose of the study is to explore factors which support and pose difficulties to carrying out family based approaches in alcohol treatment services. One aim is to define what needs to be in place for such work to become commonly available to problem drinkers. This would be an initial step to developing interventions to overcome these difficulties which may ultimately benefit services and clients.

**Why have I been selected?**

You have been selected as you are currently working in a senior position within your alcohol treatment service. For Stage 1 of this research study we are hoping to contact at least five alcohol treatment services within the Midlands and Heart of England region to gather demographic and descriptive information about each service.

**Do I have to take part?**

It is up to you to decide. We will describe the study and go through this information sheet, which we will then give to you. We will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason. This will not affect you or your alcohol treatment service.

**What will I have to do?**

If you choose to take part you will be interviewed about your service by the Researcher, Claire Lee. The interview will either be face-to-face or over the telephone and will take approximately 15 minutes.



The Researcher, Claire Lee will also ask you to arrange a time when she could attend a team meeting so that she can discuss Stage 2 of the research study with your staff. Stage 2 will involve interviewing workers to find out about what supports and poses difficulties to carrying out family based approaches in alcohol treatment services.

**Will information obtained in the study be confidential?**

The views you express to the researcher are confidential between you and the researcher unless you disclose information which puts yourself or others at risk of harm. If you do say something which may prove harmful to you or someone else, the researcher will discuss it with you beforehand, and may have to inform your organization.

Information about you and your service will have identifying information removed so that you and your service cannot be recognised in any report or publication written about this study. The research study is multisite which will also help protect the identity of services participating in the study.

You and your service will not be identified in any report that is written about this study.

**What if I am harmed by the study?**

NHS research is covered for mishaps in the same way as for patients undergoing treatment in the NHS i.e. you are open to the usual NHS complaints procedures and compensation is only available if negligence occurs.

If after completing the interview you feel that you would like any advice or support, please contact your local staff counselling service.

**What if I want to make a complaint?**

If you have a concern about any aspect of this study, you could speak to the Supervising Researcher, Marilyn Christie who will do her best to answer your questions (0116 223 1671). If you remain unhappy and wish to complain formally, you can do this through the Leicester Partnership NHS Trust Complaints Office (0116 246 3461).

**What are the possible disadvantages and risks of taking part?**

In the unlikely event that information puts you or others at risk of harm, it may be necessary to pass on this information to your organisation to avoid a risk to the public or to protect staff, but the researcher would discuss this with you beforehand.

**What are the possible benefits of taking part?**

We cannot promise the study will help you but it may result in your reflection about training and/or supervision issues in your service. The information we get from this study will help to understand difficulties in implementing recommendations. The results of the study may also be used as an initial step in developing interventions for families of problem drinkers to improve the implementation of guidelines which may ultimately clients.

**Will I receive out of pocket expenses for taking part in the study?**

There will not be any expenses involved in participating in the study. The Researcher will incur costs of telephone calls, travel expenses and any postage costs.

**What happens if I do not wish to participate in this study or wish to withdraw from this study?**

If you do not wish to participate in this study or if you wish to withdraw from the study you may do so without explaining your decision. Your future work practice or employment will not be affected if you decide to withdraw from the study at any time. You may, however have to identify another senior person in your service who could answer the interview questions.

**What will happen to the results of the research study?**

A summary report will be sent to each participating team/service. It is also intended to publish the results in a scientific journal that is accessible to alcohol workers and commissioners of services.

**Who has reviewed the study?**

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by Nottingham Research Ethics Committee.

The study forms part of the Doctorate in Clinical Psychology qualification being undertaken by Claire Lee, Researcher, at the University of Leicester.

Thank you for taking the time to read this information.

Claire Lee, Researcher

Dr Marilyn Christie, Supervising Researcher

Dr Noelle Robertson, Supervising Researcher

*Appendix 5: Participant consent form – stage 1. (version 2, April 25, 2008)*



**University of  
Leicester**  
**Clinical Psychology Unit**  
**104 Regent Road,**  
**Leicester**  
**LE1 7LT**

**Tel: 0116 2231639**

**PARTICIPANT CONSENT FORM- STAGE 1. (Version 2,**  
**April 25, 2008)**

**Title of Study: Applying psychological theory to understand the  
difficulties in implementing family based approaches in alcohol  
treatment services.**

**Name of Researcher: Claire Lee, Trainee Clinical Psychologist**

This form should be read in conjunction with the Participant Information Sheet, Version  
2 dated 25 April 2008.

Please initial box

I confirm that I have read and understand the information sheet –  
Stage 1 dated April 25, 2008 (version 2) for the above study. I have  
had the opportunity to consider the information, ask questions and  
have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without affecting my work practice or legal rights.

☐

I understand medical research is covered for mishaps in the same way as for patients undergoing treatment in the NHS i.e. I can access the usual NHS complaints procedures and compensation is only available if negligence occurs.

☐

The nature and the purpose of the interview to be undertaken has been explained to me and I understand what will be required if I take part in the study.

☐

I agree to take part in the above study.

☐

---

Name of participant

Date

Signature

(Name in BLOCK CAPITALS)

I confirm I have explained the nature of the study, as detailed in the participant information sheet, in terms which in my judgement are suited to the understanding of the participant.

---

Name of person taking consent

Date

Signature

(if different from principal investigator)

|                        |      |           |
|------------------------|------|-----------|
| Principal Investigator | Date | Signature |
|------------------------|------|-----------|



Clinical Psychology Unit  
104 Regent Road,  
Leicester  
LE1 7LT

Tel: 0116 2231639

## **PARTICIPANT INFORMATION SHEET – STAGE 2**

**(Version 2, April 26, 2008)**

**Applying psychological theory to understand the difficulties in  
implementing family based approaches in alcohol treatment services.**

**Name of Researcher: Claire Lee**

**You are invited to take part in a research study about implementing guidelines in  
alcohol treatment services. Before you decide it is important for you to understand  
why the research is being done and what it will involve. Please take time to read  
the following information and then consider whether you want to take part. Talk  
to others about the study if you wish. Please contact Claire Lee (tel: 0116 223 1639)  
if there is anything that is not clear or if you would like more information.**



### **What is the purpose of the study?**

The purpose of the study is to explore factors which support and pose difficulties to carrying out family based approaches in alcohol treatment services. One aim is to define what needs to be in place for such work to become commonly available to problem drinkers. This would be an initial step to developing interventions to overcome these difficulties which may ultimately benefit services and clients.

### **Why have I been selected?**

You are currently working directly with individual clients or working with clients and their family or significant others in an alcohol treatment service. You may have been identified as fitting these criteria by a senior member of your team. We are hoping to conduct interviews with at least twenty members of staff from five different alcohol treatment services so that no one team/service can be identified.

We will be recruiting participants through alcohol treatment services within the Midlands and Heart of England research areas.

### **Do I have to take part?**

It is up to you to decide. I will describe the study and go through this information sheet, which we will then give to you. I will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason. This will not affect you or your alcohol treatment service, and at no time will your line manager be informed.

### **What will I have to do?**

If you choose to take part you will be interviewed about your work, perspective and experiences. The interview will either be face-to-face or over the telephone with the Researcher, Claire Lee. You may have to arrange a private room where you can carry out the telephone or face-to-face interview to make sure that what you say is not heard by anyone at your workplace. The interview will take approximately 30 minutes to 1 hour of your time.

### **Will information obtained in the study be confidential?**

The views you express to the researcher will remain confidential between you and the researcher unless you disclose information which puts yourself or others at risk of harm.

If you do say something which may prove harmful to you or someone else, the researcher will discuss it with you beforehand, and may have to inform your organization.

Any identifying information will be removed so that you and your service cannot be recognised in any report or publication written about this study. The research study is multisite which will also help protect the identity of individuals and services taking part in the study.

With your consent, the interview will be audio-taped. Once we have transcribed the audio-tape, the tape will be destroyed. The audiotapes and transcripts will be assigned a code to protect your anonymity. The transcripts will be kept electronically for 5 years in a secure room at the University of Leicester. At no time will be audiotapes or transcripts

be traceable to you. The transcripts will be destroyed 5 years after the study has been completed (September 2014). The audiotapes will only be accessible to the researcher Claire Lee. The transcriptions will only be accessible to the researcher Claire Lee and the Supervising Researchers involved in the project (Marilyn Christie and Noelle Robertson).

You may be aware who is taking part in the research project in your team; however, no one will know what has been said. Direct quotes may be used when we present the research findings of our research, but no one will know who said them. You will not be personally identified in any documents relating to the study.

### **What if I am harmed by the study?**

NHS research is covered for mishaps in the same way as for patients undergoing treatment in the NHS i.e. you are open to the usual NHS complaints procedures and compensation is only available if negligence occurs.

If after completing the interview you feel that you would like any advice or support, please consider talking to your clinical supervisor, line manager or peer support. It may be that your local staff counselling service may be available to you, if you so wish.

### **What if I want to make a complaint?**

If you have a concern about any aspect of this study, you can speak to the Supervising Researcher, Marilyn Christie who will do her best to answer your questions (0116 223 1671). If you remain unhappy and wish to complain formally, you can do this through the Leicester Partnership NHS Trust Complaints Office (0116 246 3461).

**What are the possible disadvantages and risks of taking part?**

If you find discussion of any topics sensitive, embarrassing or upsetting you would be advised to contact the staff counselling services at your organisation and your manager.

If anything is identified during the interview which puts you or others at risk of harm, the researcher would discuss this with you beforehand but it may be necessary to pass on this information to your organisation to avoid a risk to the public or to protect staff.

**What are the possible benefits of taking part?**

We cannot promise the study will help you but it may assist you to examine your training and/or supervision needs. The information we get from this study will help understand difficulties in carrying out best practice. The results of the study may also be used as an initial step in developing interventions to improve the use of guidelines which may ultimately benefit clients.

**Will I receive out of pocket expenses for taking part in the study?**

There will not be any expenses involved in participating in the study as the Researcher will incur costs of telephone calls, travel expenses and any postage costs.

**What happens if I do not wish to participate in this study or wish to withdraw from this study?**

If you do not wish to participate in this study or if you wish to withdraw from the study you may do so without explaining your decision. Your future work practice or employment will not be affected if you decide to withdraw from the study at any time.

### **What will happen to the results of the research study?**

If you would like to know the outcome of the research, a summary report will be sent to each participating team/service. It is also intended to publish the results in a scientific journal that is accessible to alcohol workers and commissioners of services.

### **Who has reviewed the study?**

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by Nottingham Research Ethics Committee.

The study forms part of the Doctorate in Clinical Psychology qualification being undertaken by Claire Lee, Researcher, at the University of Leicester.

Thank you for taking the time to read this information.

Claire Lee, Researcher

Dr Marilyn Christie, Supervising Researcher

Dr Noelle Robertson, Supervising Researcher

*Appendix 7: Participant consent form – Stage 2. (Version 2, April 26, 2008)*



**University of  
Leicester**  
  
**Clinical Psychology Unit  
104 Regent Road,  
Leicester  
LE1 7LT**

**Tel: 0116 2231639**

**PARTICIPANT CONSENT FORM – STAGE 2 (Version 2,  
April 26, 2008)**

**Title of Project: Applying psychological theory to understand the difficulties in  
implementing family based approaches in alcohol treatment services.**

**Name of Researcher: Claire Lee, Trainee Clinical Psychologist**

This form should be read in conjunction with the Participant Information Sheet – Stage  
2, version no 2. dated 26 April 2008.

Please initial box

I confirm that I have read and understand the information sheet –  
Stage 2 dated April 26, 2008 (version 2) for the above study. I have  
had the opportunity to consider the information, ask questions and

have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without affecting my work practice or legal rights.

☐

I understand medical research is covered for mishaps in the same way as for patients undergoing treatment in the NHS i.e. I can access the usual NHS complaints procedures and compensation is only available if negligence occurs.

☐

The nature and the purpose of the interview to be undertaken has been explained to me and I understand what will be required if I take part in the study.

☐

I consent to the interview being audiotaped and transcribed.

☐

I understand that direct quotes may be used when the project is written up, although they will be anonymised.

☐

I agree to take part in the above study.

☐

You may contact me on tel no: \_\_\_\_\_ or \_\_\_\_\_

to arrange a time for the interview.

---

Name of Staff participant

Date

Signature

(Name in BLOCK CAPITALS)

I confirm I have explained the nature of the study, as detailed in the participant information sheet, in terms which in my judgement are suited to the understanding of the participant.

---

Name of person taking consent

Date

Signature

(if different from principal investigator)

---

Principal Investigator

Date

Signature



***Appendix 8: Copy of email from Nigel King***

shumnk [n.king@hud.ac.uk]

Sent: 23 November 2007 15:24

To: Lee, C.E. [cel16@leicester.ac.uk]

Hi Claire

I tend to think that TA works best on sample sizes between about 10 and 30 interviews (depending on interview length – and yours look to be at the shorter end of the spectrum). Much more and it just gets hard to manage; much less and you might as well use a more in-depth approach. TA works well when you have several different sub-groups in your sample – so you might do three or four per service within a manageable scale project. Given your sample will be quite big for a qualitative study, I would also recommend you use a fair few a priori themes, and try to define your initial template as early as possible – once you begin to see clear common patterns in the preliminary coding.

Hope that helps

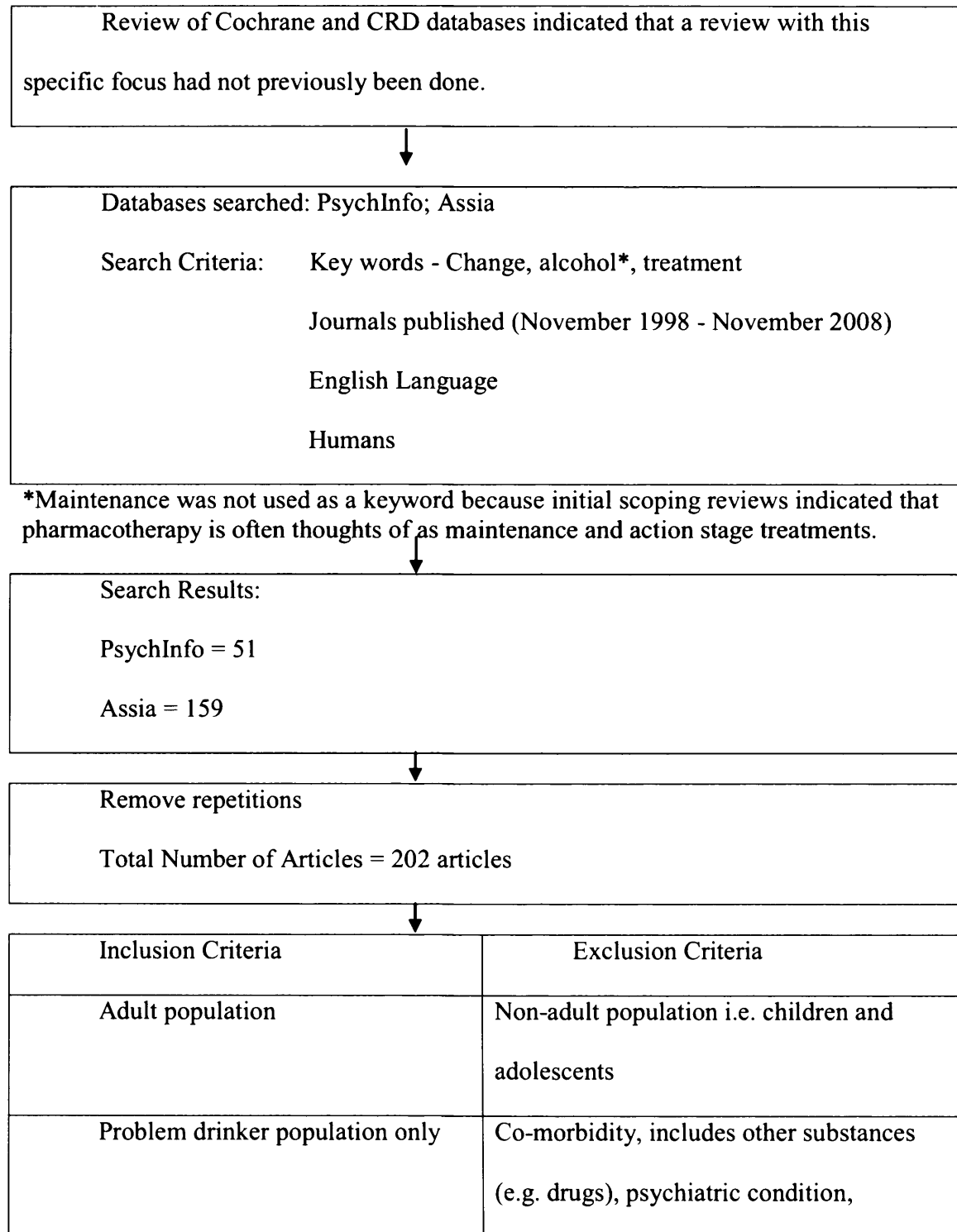
Cheers

Nigel

Nigel King  
Professor in Applied Psychology  
Centre for Applied Psychological Research  
School of Human and Health Sciences  
University of Huddersfield  
Queensgate  
HD1 3DH

**Appendix 9: Figure 1: Flow diagram of screening and selection process of journal articles for review**

Figure 1: Flow diagram of screening and selection process of journal articles for review



|  |   |
|--|---|
|  | cognitive impairment  |
| Not focused on pharmacotherapy as interested in psychological factors underlying change mechanism.     | Focused on pharmacotherapy  |
| Focused on mechanisms of change or factors related to maintenance of change for problem drinker s.     | Not focused on mechanisms of change or factors related to maintenance of change for problem drinker |
| Quantitative e.g. Randomised Controlled Trial (RCT), Secondary data of RCT or assess change over time. | Qualitative<br><br>Does not assess change over time.  |



|   |
|---|
| Total Number of Articles left after inclusion and exclusion criteria applied = 15 |
|---|

***Appendix 10: Table 2: Design Information for the 15 studies examined in the literature review***

Table 1:

Design Information for the 15 studies examined in the literature review

| <u>Author</u>             | <u>Sample Size</u> | <u>Research Design</u>    |
|---------------------------|--------------------|---------------------------|
| Bamford et al. (2005)     | 361                | RCT                       |
| Bogenschutz et al. (2006) | 1284               | Secondary analysis of RCT |
| Blomqvist (1999)          | 136                | Retrospective             |
| Callaghan et al. (2007)   | 68                 | Secondary analysis of RCT |
| Carbonari et al. (2000)   | 1183               | Secondary analysis of RCT |
| Cook et al. (2005)        | 102                | RCT                       |
| Daeppen et al. (2007)     | 367                | RCT                       |
| Friend et al. (2004)      | 1501               | Secondary analysis of RCT |
| King et al. (2000)        | 55                 | Retrospective             |
| Leigh et al. (1999)       | 106                | RCT                       |
| Litt et al. (2007)        | 185                | RCT                       |
| McCrary et al. (1999)     | 90                 | RCT                       |
| McKellar et al. (2008)    | 420                | Longitudinal              |
| Moos et al. (2005)        | 461                | Longitudinal              |
| Piderman et al. (2007)    | 74                 | Cross-sectional           |

**Appendix 11: Total Scores for domains**

**Descriptive Statistics**

|                    | N | Minimum | Maximum | Sum | Std.<br>Deviation |
|--------------------|---|---------|---------|-----|-------------------|
| KnowlEdge          | 1 |         | 1.      | 6.  |                   |
|                    | 8 | .0      | 0       | 0   | .3430             |
| skills             | 1 |         | 1.      | 1   |                   |
|                    | 8 | .0      | 0       | 2.0 | .2970             |
| socprof            | 1 |         | 1.      | 1   |                   |
|                    | 8 | .0      | 0       | 2.5 | .3888             |
| beliefschap        | 1 |         | 1.      | 7.  |                   |
|                    | 8 | .0      | 0       | 0   | .3234             |
| beliefsconseq      | 1 |         | 1.      | 1   |                   |
|                    | 8 | .0      | 0       | 1.5 | .3346             |
| motivation         | 1 |         | 1.      | 1   |                   |
|                    | 8 | .0      | 0       | 2.0 | .3835             |
| memory             | 1 |         | 1.      | 8.  |                   |
|                    | 8 | .0      | 0       | 5   | .3627             |
| resources          | 1 |         | .5      | 4.  |                   |
|                    | 8 | .0      | 0       | 0   | .2557             |
| socialinflu        | 1 |         | 1.      | 6.  |                   |
|                    | 8 | .0      | 0       | 5   | .3760             |
| emotion            | 1 |         | 1.      | 5.  |                   |
|                    | 8 | .0      | 0       | 5   | .3038             |
| actionplan         | 1 |         | 1.      | 1   |                   |
|                    | 8 | .0      | 0       | 0.0 | .3792             |
| leadership         | 1 |         | 1.      | 8.  |                   |
|                    | 8 | .0      | 0       | 0   | .3792             |
| Valid N (listwise) | 1 |         |         |     |                   |
|                    | 8 |         |         |     |                   |

## Appendix 12: Cohen's Kappa Scores for inter-rater reliability

### Knowledge

|                      | V<br>alue | A<br>symp. Std.<br>Error(a) | A<br>pprox. T(b) | App<br>rox. Sig. |
|----------------------|-----------|-----------------------------|------------------|------------------|
| Measure of Agreement | .500      | .260                        | 2.000            | .046             |
| N of Valid Cases     | 6         |                             |                  |                  |

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

### Skills

|                      | V<br>alue | A<br>symp. Std.<br>Error(a) | A<br>pprox. T(b) | App<br>rox. Sig. |
|----------------------|-----------|-----------------------------|------------------|------------------|
| Measure of Agreement | .571      | .353                        | 1.549            | .121             |
| N of Valid Cases     | 6         |                             |                  |                  |

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

### Social Profession/Role and Identity

|                      | V<br>alue | A<br>symp. Std.<br>Error(a) | A<br>pprox. T(b) | App<br>rox. Sig. |
|----------------------|-----------|-----------------------------|------------------|------------------|
| Measure of Agreement | .100      | .000                        | 2.449            | .014             |
| N of Valid Cases     | 6         |                             |                  |                  |

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

### Beliefs about capabilities

No measures of association are computed for the crosstabulation of cap \* cap2. At least one variable in each 2-way table upon which measures of association are computed is a constant.

### Beliefs about consequences

|                      | V<br>alue | A<br>symp. Std.<br>Error(a) | A<br>pprox. T(b) | App<br>rox. Sig. |
|----------------------|-----------|-----------------------------|------------------|------------------|
| Measure of Agreement | .571      | .353                        | 1.549            | .121             |
| N of Valid Cases     | 6         |                             |                  |                  |

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

### Motivation

|                      | V<br>alue | A<br>symp. Std.<br>Error(a) | A<br>pprox. T(b) | App<br>rox. Sig. |
|----------------------|-----------|-----------------------------|------------------|------------------|
| Measure of Agreement | 1.000     | .000                        | 2.449            | .014             |
| N of Valid Cases     | 6         |                             |                  |                  |

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

### Memory, attention and decision making

|                      | V<br>alue | A<br>symp. Std.<br>Error(a) | A<br>pprox. T(b) | App<br>rox. Sig. |
|----------------------|-----------|-----------------------------|------------------|------------------|
| Measure of Agreement | .500      | .289                        | 1.732            | .083             |
| N of Valid Cases     | 6         |                             |                  |                  |

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

### Environmental Context and Resources

|                      | V<br>alue | A<br>symp. Std.<br>Error(a) | A<br>pprox. T(b) | App<br>rox. Sig. |
|----------------------|-----------|-----------------------------|------------------|------------------|
| Measure of Agreement | .333      | .287                        | 1.095            | .273             |
| N of Valid Cases     | 6         |                             |                  |                  |

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

### Social Influences

|                      | V<br>alue | A<br>symp. Std.<br>Error(a) | A<br>pprox. T(b) | App<br>rox. Sig. |
|----------------------|-----------|-----------------------------|------------------|------------------|
| Measure of Agreement | .7        | .2                          | 2.               | .01              |

Appendix 13: Table 3: Implementation domains for total sample

| Domain  | Knowledge | Skills | Professional | Capabilities | Consequences | Motivation | Memory      | Environmental | Social    | Emotion    | Action   |
|---------|-----------|--------|--------------|--------------|--------------|------------|-------------|---------------|-----------|------------|----------|
|         | Role      |        |              |              |              |            | & Attention |               | Resources | Influences | Planning |
|         | X ? ✓     | X ? ✓  | X ? ✓        | X ? ✓        | X ? ✓        | X ? ✓      | X ? ✓       | X ? ✓         | X ? ✓     | X ? ✓      | X ? ✓    |
| Scores  | 8 8 2     | 1 11 6 | 3 6 9        | 6 10 2       | 2 9 7        | 3 7 8      | 5 10 3      | 10 8 0        | 9 7 2     | 9 8 1      | 4 9 5    |
| Total   | 6.5       | 11     | 11.5         | 7            | 11.5         | 11.5       | 9           | 3.5           | 5         | 5.5        | 8        |
| Kappa   | .5        | .571   | 1.00         | ---          | .571         | 1.00       | .5          | .333          | .739      | .667       | 1.00     |
| A (N=2) | 2 0 0     | 0 0 1  | 0 0 2        | 0 1 1        | 0 0 2        | 0 0 2      | 0 1 1       | 1 1 0         | 0 0 2     | 2 0 0      | 0 1 1    |
| B (N=3) | 1 1 1     | 1 2 0  | 0 2 1        | 0 3 0        | 0 2 1        | 0 2 1      | 0 2 1       | 2 1 0         | 1 2 0     | 2 1 0      | 1 2 0    |
| C (N=2) | 0 2 0     | 0 2 0  | 1 0 1        | 1 1 0        | 1 1 0        | 1 1 0      | 1 0 0       | 2 0 0         | 0 2 0     | 1 1 0      | 0 0 2    |
| D (N=1) | 1 0 0     | 0 0 1  | 0 1 0        | 0 0 1        | 0 0 1        | 0 0 1      | 0 0 1       | 0 1 0         | 1 0 0     | 0 0 1      | 0 0 1    |
| E (N=2) | 1 1 0     | 0 2 0  | 1 1 0        | 1 1 0        | 1 1 0        | 0 1 1      | 1 1 0       | 1 1 0         | 1 1 0     | 0 2 0      | 1 1 0    |
| F (N=5) | 1 3 1     | 0 5 0  | 0 1 4        | 3 2 0        | 0 3 2        | 1 3 1      | 2 3 0       | 2 3 0         | 3 2 0     | 2 3 0      | 2 3 0    |
| G (N=3) | 1 2 0     | 0 0 3  | 1 1 1        | 1 2 0        | 0 2 1        | 1 0 2      | 0 3 0       | 2 1 0         | 3 0 0     | 2 1 0      | 0 2 1    |

Key: X (Score of 0) = No evidence of the domain being relevant to the implementation of the recommendation; ? (Score of 0.5) = partial evidence of domain being relevant to implementation; ✓ (Score of 1) = good evidence of domain being relevant to the implementation of the recommendation.



***Appendix 13: Table 3: Implementation domains for total sample***

**Appendix 14: Template 1 - Participant perceptions of Staff facilitators**

| LEVEL 1                                       | LEVEL 2  | LEVEL 3  | LEVEL 4   |
|---|--|--|---|
| Participant perceptions of staff Facilitators | Self-efficacy<br><br>(Beliefs about capabilities)          | Skills   | Training  |
|   |  |  | Follow-up support   |
|   |  | Experience of different family based interventions | Formal and informal work with relatives for relative's needs                              |
|   |  |  | Joint involvement with problem drinkers and relatives                                     |
|   |  |  | Work with family members to engage clients  |
|   | Family orientated  | Assessments & screenings                           | Holistic (include carer assessments)  |
|   |  |  | Risk  |
|   | Service Procedures   | Interventions involving relatives                  | Part of professional role   |
|   |  |  | Family presence e.g. home visits  |
|   | Team and Managerial Support<br><br>(Social Influences)     | Team   | MDT working e.g. review cases in MDT, joint working, other perspectives about family work |
|   |  |  | Supervision   |
|   |  | Management   | Management supports family work   |
|   |  |  | Recognising need for resources and service development                                    |
|   |  |  | Advertise services  |
|   |  |  | Choice of treatment options (which includes family work)                                  |
|   |  | Networking with Other Agencies                     | Provide Services for relatives  |
|   |  |  | Multi-agency working  |
|   | Supportive Motives and goals<br><br>(Motivation and Goals) | Priorities   | Best interests of problem drinkers and relatives  |
|   |  |  | risk and safety   |
|   |  | Perceptions of family work as an intervention      | Beliefs about consequences  |
|   |  |  | Substance misuse a Psychosocial problem   |
|   |  |  | Family viewed as a resource   |
|   |  |  | Flexible approach (includes low intensity interventions, generic skill)                   |

|  |  |  |  |
|--|--|--|--|
|  |  |  | Dependent on problem drinker and families engagement |
|--|--|--|--|

***Appendix 15: Template 2 - Participant perception of staff barriers***

| LEVEL 1                                  | LEVEL 2                        | LEVEL 3                           | LEVEL 4  |
|--|--------------------------------|-----------------------------------|--|
| Participant perception of staff barriers | Professional                   | priorities                        |  |
|  | Responsibility                 | Not part of job                   | Liability  |
|  | (Social/                       | description                       | Lack of formal recognition   |
|  | <b>Professional</b>            | confidentiality                   | Consent  |
|  | <b>role and</b>                |                                   | Restrictions on sharing information  |
|  | <b>identity)</b>               |                                   |  |
|  | Lack of self-efficacy          | Narrow perceptions of family work | Belief that family work requires family therapy training, specialist theoretical knowledge and skills                            |
|  | (Beliefs about capabilities)   |                                   | Resources and demands  |
|  |                                | <b>Skills &amp; knowledge</b>     | control, dealing with conflict, working with different family members, engagement  |
|  |                                | Experience                        | Family/relationships   |
|  |                                |                                   | Lack practical experience  |
|  |                                | emotions                          |  |
|  | Unsupportive Service Structure | Demands on Service                | Other priorities e.g. targets and waiting lists  |
|  |                                |                                   | Capacity   |
|  |                                |                                   | Recording and collecting data  |
|  | (Environmental Context)        | Limited Accessibility             | Practical issues e.g. Environmental context, limited flexibility.  |
|  |                                |                                   | Referral pathway   |
|  |                                | Unsupportive Service Model        | Focus e.g. dual diagnosis, individual, family work viewed as an add-on service   |
|  |                                |                                   | Work within boundaries and rules of service e.g. family work not formally offered, keep problem drinkers and relatives separate. |

|  |                                   |   |  |
|--|-----------------------------------|---|--|
|  |                                   |   | Unsystematic service approach to family work |
|  |                                   |   | Lack of support (team, manager)              |
|  | <b>Insufficient<br/>Resources</b> | No extra funding<br>or resources for<br>family work | Time   |
|  |                                   |   | Lack of procedures for involving family      |
|  |                                   |   | No supervision for family work               |
|  |                                   | Alternative<br>providers                            | Services provided by other agencies          |
|  |                                   |   | Service provided by other staff              |
|  |                                   |   |  |

**Appendix 16: Template 3 - Participant perception of problem drinker and family facilitator**

| LEVEL 1  | LEVEL 2  | LEVEL 3  | LEVEL 4   |
|--|--|--|---|
| Participant perceptions of Problem drinker and family facilitators | Family orientated<br>Service procedures<br><b>(Action Planning &amp; procedures)</b> | Contact with service                                   | Family/significant others presence  |
|  |  | Interventions involving families/significant others    |   |
|  |  | Holistic Assessment                                    | Staff show interest in and support family   |
|  | Therapeutic Alliance   | Education regarding substance misuse and interventions |   |
|  |  | Encourage engagement                                   | Encourage family and/or significant others' involvement                                 |
|  |  |  | Support problem drinker in involving family/significant others e.g. role play, coaching |
|  |  |  | Therapeutic characteristics   |
|  |  | Safe environment                                       |   |
|  |  | Motivation & goals                                     |   |
|  | Supportive attitudes of Problem drinker and networks (Motivation and goals)          | Network  | Positive supportive relationships   |
|  |  |  | <b>Reduce conflict and risk</b>   |
|  |  |  | Beliefs about consequences  |
|  |  |  | Advocate family work  |
|  |  |  | Openness  |
|  |  | Problem drinker  | Problem drinker wants to involve family/significant others                              |
|  |  |  | Problem drinker brings family/significant others to session                             |

**Appendix 17: Template 4: Participants perceptions of problem drinker and family**

**barriers**

| LEVEL 1   | LEVEL 2  | LEVEL 3   | LEVEL 4   |
|---|--|---|---|
| Participants<br>perceptions of<br>problem drinker<br>and family<br>barriers | Resistance<br><br><b>(motivation &amp; goals)</b>                              | Attitude of defused<br>responsibility within<br>Network | Perception that client needs<br>treatment not network |
|   |  |   | Perception of therapist as expert                     |
|   |  |   | Family want to see change in<br>client first          |
|   |  |   | Family disengaged from client                         |
|   |  | Problem drinker<br>don't want family<br>involved        | Readiness to change                                   |
|   |  |   | Lack of openness<br>confidentiality                   |
|   | Difficulty<br>maintaining<br>engagement<br><br><b>(motivation &amp; goals)</b> | disengage after initial<br>crisis resolution            |   |
|   |  | Family dissatisfied<br>with intervention                |   |
|   |  | Accessibility   |   |
|   | Problematic<br>Networks<br><br><b>(Social Influences)</b>                      | Family work not<br>appropriate                          | No network  |
|   |  |   | Risk issues   |
|   |  |   | Systemic problems of which<br>alcohol is a symptom.   |
|   |  |   | Substance misuse in social<br>network                 |
|   |  | Different attitudes                                     | Expectations  |

|  |  |  |          |
|--|--|--|----------|
|  |  |  | Agenda's |
|--|--|--|----------|

***Appendix 18: Theme 5 - Participant perceptions of Organisational facilitators***

| LEVEL 1  | LEVEL 2                | LEVEL 3                                      | LEVEL 4  | LEVEL 5  |
|--|------------------------|--|--|--|
| Participant perceptions of Organisational Facilitators | Organisational Support | Systemic Focus<br><br>(Motivation and Goals) | Psychosocial model   | outcomes   |
|  |                        |  | Family work moves from specialist add-on service to mainstream service | Problem understood within social context           |
|  |                        |  |  | Problem drinkers and relatives given equal status. |
|  |                        | Policy validating family work                | Interpret to be supportive of family work                              |  |
|  |                        |  | Incorporated into agency policy  |  |

**Appendix 19: Template 6 - Participant perceptions of organisational barriers**

| LEVEL 1  | LEVEL 2                        | LEVEL 3   | LEVEL 4                     | LEVEL 5   |
|--|--------------------------------|---|-----------------------------|---|
| Participant perceptions of Organisational Barriers | Lack of infrastructure Support | Insufficient Service Resources;<br><b>(Environmental Context &amp; resources)</b> | Funding                     | Funding influenced by service capacity to meet targets  |
|  |                                |   | Service capacity            |   |
|  |                                |   | facilities                  |   |
|  |                                | Unsupportive Organisational Climate and Culture; <b>(Social Influences)</b>       | Management                  | Other priorities (e.g. targets, resources, focus)   |
|  |                                |   |                             | Influenced by service level agreements (commissioned services)  |
|  |                                |   | Trust & Government agencies | Lack of follow-up or support of implementation of recommendations (e.g. targets not changed to match family work) |
|  |                                |   |                             | Services not structured for family work   |
|  |                                |   |                             | Lack of higher level management continuity  |
|  |                                |   | Culture                     | Individual focus  |
|  |                                |   |                             | Alcohol not treated with same seriousness as drugs  |
|  |                                |   |                             | Dominant models   |



**Appendix 20: Letters stating ethical approval from Nottingham Research Ethics Committee 1 and letters of approval from each trust site research and development office.**



# **National Research Ethics Service**

## **Nottingham Research Ethics Committee 1**

1 Standard Court  
Park Row  
Nottingham  
NG1 6GN

Telephone: 01159123344 Ext: 39425  
Facsimile: 01159123300

04 June 2008

Miss Claire E. Lee  
Trainee Clinical Psychologist  
Leicester Partnership NHS Trust  
Clinical Psychology Unit, 104 Regent Road,  
Leicester, LE1 7LT

Dear Miss Lee,

**Full title of study:** Applying psychological theory to understand the difficulties and supporting factors in implementing family based approaches in alcohol treatment services

**REC reference number:** 08/H0403/52

Thank you for your letter of 12 May 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

### **Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

### **Ethical review of research sites**

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

### **Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

## Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

| <i>Document</i>                             | <i>Version</i> | <i>Date</i>      |
|---|----------------|------------------|
| Application                                 | AB/132205/1    | 04 March 2008    |
| Investigator CV                             |                | 22 February 2008 |
| Investigator CV: Supervisor                 |                |                  |
| Protocol                                    | 4              | 18 January 2008  |
| Letter from Sponsor                         |                | 04 March 2008    |
| Peer Review                                 |                | 15 January 2008  |
| Questionnaire                               | 2              | 04 January 2008  |
| Letter of invitation to participant         | 1              | 14 December 2007 |
| Participant Information Sheet: Stage 2      | 2              | 26 April 2008    |
| Participant Information Sheet: Stage 1      | 2              | 25 April 2008    |
| Participant Consent Form: Stage 2           | 2              | 26 April 2008    |
| Participant Consent Form: Stage 1           | 2              | 25 April 2008    |
| Response to Request for Further Information |                | 12 May 2008      |
| Recording Sheet                             | 2              | 14 December 2007 |
| Confidentiality Statement for Transcribers  |                | 01 January 2008  |

## Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

## After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

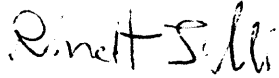
- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email [referencegroup@nres.npsa.nhs.uk](mailto:referencegroup@nres.npsa.nhs.uk).

With the Committee's best wishes for the success of this project

Yours sincerely

A handwritten signature in black ink, appearing to read 'Rinat Jibli'.

**Miss Rinat Jibli**  
**Committee Coordinator**

Email: [rinat.jibli@nottspct.nhs.uk](mailto:rinat.jibli@nottspct.nhs.uk)

*Enclosures:* "After ethical review – guidance for researchers"

**Copy to:** Dr David Clarke, R&D office for NHS care organisation at lead site -  
LPT

Research & Development Office  
Daisy Peake Building  
Towers Hospital  
Gipsy Lane  
Leicester  
Tel: 0116-225-3743  
Fax: 0116-246-3591  
David.Clarke@leicspart.nhs.uk

DC/CEL/NS

04 August 2008

**SPONSOR'S APPROVAL LETTER**

To: Nicole Stokoe  
Research Assistant  
Research Governance Approvals Group  
Bedfordshire and Luton Partnership Trust  
Disability Resource Centre  
Poynters House  
Poynters Road  
Dunstable, LU5 4TP

Re: Applying psychological theory to understand the difficulties and supporting factors in implementing family based approaches in alcohol treatment services. (PI: Claire Lee)

I can confirm that I have read the proposal for the above-mentioned project, and the attached document regarding Sponsor's responsibilities, and I am happy to support this research taking place. This project was also subject to review by the Trust "Research Governance Review Group" where it was confirmed that Leicestershire Partnership NHS Trust would act as the Sponsor for the study.

Name

DAVID CLARKE

Job Title

ASSOCIATE DIRECTOR (R&D)

Base

LEICESTERSHIRE PARTNERSHIP NHS TRUST

GIPSY LANE, LEICESTER

Date

04/08/2008



LEICESTERSHIRE PARTNERSHIP  
NHS TRUST  
RESEARCH & DEVELOPMENT

Research & Development Office  
Daisy Peake Building  
Towers Hospital  
Gipsy Lane  
Leicester  
Tel: 0116-225-3743  
Fax: 0116-246-3591  
David.Clarke@leicspart.nhs.uk

DC/CEL

04 March 2008

Miss Claire E Lee  
88 Salisbury Crescent  
Newbold  
Chesterfield  
Derbyshire S41 8PP

Dear Claire

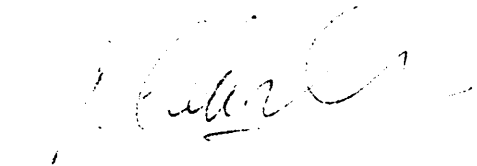
**Re: Implementing family-based approaches in alcohol services**

Thank you for forwarding details of the above study. This study has approval in principle to be conducted within Leicestershire clinical sites, and you should seek similar approval from the other sites listed in your documentation. This is of course subject to gaining a favourable ethical opinion in due course.

Leicestershire Partnership NHS Trust also agrees in principle to be the principal sponsor for this study.

I enclose your submitted documentation signed and dated.

Regards,



Dr. Dave Clarke  
[Associate Director of Research & Development]

Mental Health Research Unit  
Kingsway House  
Kingsway Hospital  
Derby  
DE22 3LZ  
01332 623579  
01332 623576  
[Corinne.Gale@DerbysMHServices.nhs.uk](mailto:Corinne.Gale@DerbysMHServices.nhs.uk)

24 July 2008

Claire Lee  
Clinical Psychology Department  
University of Leicester  
104 Regent Road  
Leicester  
LE1 7LT

Dear Claire

I am writing to inform you that the Derbyshire Mental Health Services NHS Trust Clinical Research Committee has reviewed and approved the following study:

**Title:** Applying psychological theory to understand the difficulties and supporting factors in implementing family based approaches in alcohol treatment services

**Business Unit/Service area:** Community Care – Substance Misuse

**Start date:** 28/07/08

**End date:** 1/04/09

**Outline:** The Principal Investigator will contact the team leaders of the two alcohol treatment services to discuss the study and whether the team would be interested in participating. If the team leader agrees, the Principal Investigator will arrange to meet with a senior service representative (this is likely to be the team leader, clinical director or senior grade team member) and undertake a short interview with them to collect demographic and descriptive information about their service. The Principal Investigator will then do a brief presentation to the team about the study. The Principal Investigator will also contact staff unable to attend the presentation by letter to invite the staff member to participate in the study. All staff will be given a Participant Information Sheet, Participant Consent Form and letter inviting them to participate in the research study.

Once the staff member has consented they will be contacted by telephone by the Principal Investigator to arrange an interview. Interviews will be conducted either by telephone or face-to-face and will be audiotaped and transcribed.

As part of our monitoring requirements, we will ask you for a progress report six months after the start of your study, and every six months as applicable. We will also ask you for a short summary of your research findings once the study is complete to assist in the dissemination process within the Trust.

If you require any further information please do not hesitate to contact me.

Yours sincerely

Corinne Gale  
Research and Research Development Manager

On behalf of Dr John Sykes and the Clinical Research Committee

CC: Mick Burrows, Area Service Manager (Acting) – Substance Misuse



# Bedfordshire and Luton



Mental Health and Social Care Partnership NHS Trust

Research Governance Approvals Group  
Bedfordshire and Luton Partnership Trust  
Disability Resource Centre  
Poynters House  
Poynters Road  
Dunstable, LU5 4TP

Claire Lee  
Clinical Psychology Department,  
104 Regent Road,  
University of Leicester,  
Leicester,  
LE1 7LT

2<sup>nd</sup> September 2008

Dear Claire,

*Re: Applying psychological theory to understand the difficulties and supporting factors in implementing family based approaches in alcohol treatment services.*

Thank you for submitting your research proposal to the Research Governance Approvals Group. The group felt that this was an interesting and worthwhile subject, and I am pleased to confirm research governance approval for the above study.

If you make any changes to your proposal please inform the group of these. If they are substantial changes you will need to resubmit your full proposal for review.

In receiving this letter you are accepting that your study must be conducted in accordance with the research governance framework and in line with health and safety and data protection guidelines. If you are unsure about your obligations in relation to these three areas, please contact me immediately. Throughout the course of your research you will be sent monitoring forms and audits. It is important that you fill these in and return them. A failure to do so may result in your approval being withdrawn.

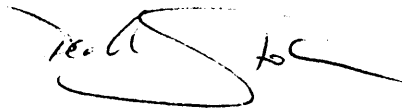
Additionally, brief details of your project (title, aim and project lead), may be posted on our internal website to give other staff a flavour of the research currently taking place in the organisation. Details of research funded by pharmaceutical companies will not be added but all others may be used, unless you notify me of your objection.

Please inform me of any amendments to the approved research proposal / protocol, participant information sheet or consent form and use the usual incident reporting channels to report any adverse events relating to your study.

At the end of your study, please forward a copy of the final report to me, together with presentations or publications relating to the project so that I can keep an accurate record of the outcomes of research in our area.

I look forward to hearing about the progress of your research,

Best wishes,

A handwritten signature in black ink, appearing to read 'Nicole Stokoe', with a large, stylized 'S' and a horizontal line extending to the right.

**Nicole Stokoe**  
Research Assistant to  
**Prof F.Besag**  
Acting Chair of Research Governance Approvals Group

R&D Unit, BSMHT  
Radclyffe House  
66/68 Hagley Road  
Edgbaston  
Birmingham  
B16 8PF

Tel: 0121 678 4326  
Fax: 0121 678 4319

Miss Claire Lee  
Trainee Clinical Psychologist  
Leicester Partnership Trust  
Clinical Psychology Unit  
104 Regent Road  
Leicester  
LE1 7LT

Dear Claire

30 July 2008

**Re: "Applying psychological theory to understand the difficulties and supporting factors in implementing family based approaches in alcohol treatment services"**

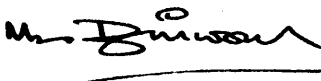
Thank you for returning your completed Trust Research Application Form for the above project. This research was approved by the Director of Research & Development and we have received notification of a favourable ethical opinion. You may therefore commence the work.

Please note that the Trust's approval of this research is given on the understanding that you are aware of and will fulfil your responsibilities under the Department of Health's *Research Governance Framework for Health and Social Care*, including complying with any monitoring/auditing of research undertaken by the Research & Development Unit.

In particular, whilst conducting your study you should respect the confidentiality of data obtained from participants.

Please do not hesitate in contacting the Research & Development Unit should you require any advice or support on any aspect of your project. When contacting us it would be helpful to quote our reference number for this project: **NRR 910**.

Yours sincerely



Max Birchwood  
Director of Research and Development

R&D Unit, BSMHT  
Radclyffe House  
66/68 Hagley Road  
Edgbaston  
Birmingham  
B16 8PF

Tel: 0121 678 4326  
Fax: 0121 678 4319

Miss Claire Lee  
Trainee Clinical Psychologist  
Leicester Partnership Trust  
Clinical Psychology Unit  
104 Regent Road  
Leicester  
LE1 7LT

Dear Claire

30 July 2008

**Re: "Applying psychological theory to understand the difficulties and supporting factors in implementing family based approaches in alcohol treatment services"**

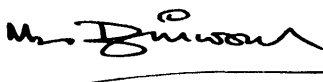
Thank you for returning your completed Trust Research Application Form for the above project. This research was approved by the Director of Research & Development and we have received notification of a favourable ethical opinion. You may therefore commence the work.

Please note that the Trust's approval of this research is given on the understanding that you are aware of and will fulfil your responsibilities under the Department of Health's *Research Governance Framework for Health and Social Care*, including complying with any monitoring/auditing of research undertaken by the Research & Development Unit.

In particular, whilst conducting your study you should respect the confidentiality of data obtained from participants.

Please do not hesitate in contacting the Research & Development Unit should you require any advice or support on any aspect of your project. When contacting us it would be helpful to quote our reference number for this project: **NRR 910**.

Yours sincerely



Max Birchwood  
Director of Research and Development

# Coventry and Warwickshire

Partnership Trust

West Midlands (South) Comprehensive Local Research Network  
CLRN Office  
Fourth Floor Rotunda (ADA40017)  
University Hospitals Coventry & Warwickshire NHS Trust  
University Hospital  
Clifford Bridge Road  
Coventry  
CV2 2DX

2<sup>nd</sup> January 2009

Miss Claire Lee  
Trainee Clinical Psychologist  
Leicester Partnership NHS Trust  
Clinical Psychology Unit  
104 Regent Road  
Leicester  
LE1 7LT

Dear Miss Lee,

***Re: Applying psychological theory to understand the difficulties and supporting factors in implementing family based approaches in alcohol treatment services.***

**R&D Ref:** **PAR281108**  
**MREC:** **08/H0403/52**

I am pleased to inform you that the R&D review of the above project is complete and has been formally approved to be undertaken at Coventry and Warwickshire Partnership NHS Trust. Your research activity is now covered by NHS indemnity as set out in HSG (96) 48, and your trial has been entered onto the Trust's database.

The following documents were reviewed:

- **Protocol Version 3** dated 04/01/2008
- **Patient Information Sheet and Consent Stages 1** Version 2 dated 25/04/2008
- **Patient Information Sheet and Consent Stages 2** Version 2 dated 26/04/2008
- **NHS NRES Application Form** Version 5.5 (AB/132205/1) with signed declarations
- **NRES Site Specific Information Form** Version 5.6 (C/132205/229775/1) with signed declaration
- **NRES Approval Letter** dated 04/06/2008
- **Investigator and academic supervisors CV's**
- **Confidentiality Statement for Transcribers** dated January 2008
- **Letter from Sponsor** dated 04/03/2008

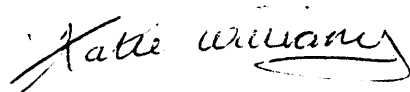
Your responsibilities are set out in the attached agreement, which must be signed and returned to the R&D Office. You should keep a copy for your records.

All research must be managed in accordance with the requirements of the Department of Health's Research Governance Framework (RGF) and to ICH-GCP standards. In order to ensure that research is carried out to these standards, the Trust employs the services of an external monitoring organisation to provide assurance. Your study may be randomly selected for audit at any time, and you must co-operate with the auditors.

The duration of Trust approval extends to the date specified in the NRES application form. Action may be taken to suspend Trust approval if the research is not run in accordance with RGF or ICH-GCP standards, or following recommendations from the auditors. Research must commence within two years of the LREC approval date, and within six months of R&D approval.

I wish you well with your project. Please do not hesitate to contact me should you need any guidance or assistance.

Yours sincerely

A handwritten signature in cursive script, reading 'Katie Williams', with a horizontal line underneath the name.

**Katie Williams**  
**Research and Development Facilitator**

**Enc: PI Agreement**

Nicole Stokoe  
Research Governance  
Psychology Department  
Disability Resource Centre  
Poynters Road  
Dunstable  
LU4 5TP

Tel: 07818076332

1<sup>st</sup> May 2009

Claire Lee  
Clinical Psychology Department,  
10 Regent Road  
University of Leicester  
Leister  
Leistershire  
LE1 7LT

Dear Claire Lee,

**Re: Applying psychological theory to understand the difficulties and supporting factors in implementing family based approaches in alcohol treatment services.**

In order to identify support needs and to ensure that, as an organisation we are research governance compliant, each project approved by the Research Governance Approvals Group through BLPT is requested to answer the following questions. These serve as a self-completion audit tool to reflect on the way in which your research project is being conducted. It also offers the chance to highlight any additional advice you (and your team if appropriate), may need.

In addition to this self completion tool, a sample of 10% of all the projects approved will be selected for a visit from a member of the Research Governance team to discuss the project in more detail and to review the documentation relating to its conduct. Please return your questionnaire within one month of receipt.

Thank you for your help.

Best wishes,



Nicole Stokoe  
Research Officer