Evaluation Report for the
Improving Outcomes for the Children of Alcohol Dependent Parents Experiencing High Levels of Inter-parental Conflict Programme

A partnership between Tavistock Relationships, Adfam and OnePlusOne

TAVISTOCK RELATIONSHIPS

oneplusone thinking relationships

Adfam Families, drugs and alcohol

Contents

Executive Summary

Children who grow up in a family where alcohol misuse is a problem are at an increased risk of experiencing negative emotional and behavioural problems (e.g., Chen & Weitzman 2005) and are more likely to drink heavily and frequently than their peers (Chalder, Elgar & Bennett 2006). Furthermore, alcohol misuse is associated with an increased risk of familial conflict (e.g., Reich, Earls, & Powell 1988), which is well associated with a significant risk of experiencing poor long-term outcomes for children (e.g., Harold et al. 2016; Reynolds 2014).

Tavistock Relationships, along with Adfam and OnePlusOne were commissioned, by the Department of Health and Social Care and the Department for Work and Pensions, to develop and pilot a multi-stream programme to reduce problematic alcohol use and interparental conflict, through an upskilled workforce, digital behaviour change resources, and face-to-face couples therapy.

The project aimed to improve outcomes for children in families affected by interparental conflict in the context of alcohol dependence, by enabling parents to find new ways of managing conflict, thereby reducing couple conflict and alcohol dependency. To achieve this, we developed three workstreams.

Strand 1. Frontline practitioner training – two-day training workshops for practitioners working with parents for whom alcohol use and interparental conflict may be an issue.

Strand 2: 'Coping with Stress and Drinking' digital platform for parents – based on a therapeutic model of couple coping, providing insights and guidance around managing conflict, understanding stress and coping with stress. This includes a supplementary practitioner guide for professionals wishing to use the platform with their service users.

Strand 3: BCT-AD practitioner training - four-day training in BCT-AD followed by submission of three clinical tapes from training cases with parents, written reflections on learning and 15 clinical group supervisions. Cohorts of counsellors, psychotherapists, social workers and alcohol misuse workers attended the training. Each practitioner was expected to work with two cases following the training.

The project was evaluated using a combination of qualitative and quantitative approaches tailored to the content of each intervention strand. This meant targeting practitioners in strands one and three and parents and practitioners in strand two. Challenges in engaging practitioners and parents in the digital resource, and in recruiting parents to the BCT-AD training both limited data collection and the conclusions that can be drawn about the impact of these interventions.

Key findings

Frontline practitioner training

The frontline practitioner training was well received. Practitioners saw significant improvement in their knowledge and confidence in working with parents where alcohol use is a problem, in their knowledge and confidence around problematic alcohol use and the couple relationship, and the impact of couple conflict on children. There were also significant improvements in their confidence in opening up conversations about alcohol and conflict and in identifying and responding to harmful alcohol use. Practitioners saw value in the resources discussed during the training and intended to use them with parents.

'Coping with Stress and Drinking' digital resource

A total of 1,826 users engaged in 2,585 sessions with the 'Coping with stress and alcohol' digital resource. Reach and engagement with the resource was lower than anticipated, reflecting the challenges this strand faced in rolling out the resource. However, the majority (67%) of users who progressed beyond the introductory page went on to the rest of the resource, suggesting that the course effectively sustained engagement amongst users who made it past that first page.

Feedback from our case study echoes this conclusion. This parent found the resource engaging, accessible and easy to use and valued the way in which it normalised her experiences. In addition, the case study suggests that the course was effective in raising awareness about conflict in relationships, teaching conflict communication skills and, increasing mindfulness about alcohol use.

We lack insight into reasons behind potential users' lack of engagement with the resource. One significant barrier is likely to be the result of the lack of synergy between timing of frontline practitioner training and the launch of the resource. As practitioners were not able to explore the resource during the training, it appears that few went on to integrate it into their practice and refer parents to it.

For those parents who did find their way to the resource, one barrier may have been confusion about the target audience for the resource, and whether the stress messaging was too prominent. This is suggested by high drop off rates on the page where users were able to read about the purpose of the resource, and comments from practitioners.

Practitioners interviewed about the resource also found it accessible and easy to navigate. They saw the potential to use the resource with parents in different ways, depending on level of need; using it with some parents to prompt conversations whilst signposting others to work through it alone.

Although positive about the resource, practitioners talked about the challenges of staying on top of the volume of new resources being shared with them, meaning that even seemingly useful resources are not picked up. This highlights the need to ensure new

interventions are marketed in an engaging way to practitioners. Perhaps utilising co-production and co-design to ensure that the right groups of practitioners are involved and 'on board' before the resource goes out itself.

BCT-AD training

BCT-AD focuses on the relational aspects of alcohol dependence and looks for the bi-directional causal and maintaining factors in the relationship that are contributing to the problematic use of alcohol. The training in this model was very well-received, with the majority of participants very or completely satisfied with the training. Participants were satisfied with the training experience and felt that they had increased their understanding of alcohol dependence on relationships, and couple dynamics.

Areas for improvement noted by participants included adding more time for the training and more role play activities. In addition, participants' experience in working with couples with alcohol dependency was somewhat low. As noted by one of the practitioners who was interviewed, that may reflect lack of experience in couple work, a need for further training, or the time-lag between training and working with couples.

The BCT-AD training demonstrated an appreciable appetite among workers in alcohol services for training to work with couples, and couple distress, in the context of alcohol dependence. However, challenges in recruiting parents suggest that services are not set up in such a way to facilitate such work. In addition, relatively few of those working in alcohol services have sufficient counselling training to be able to work with couples in the way set out in the BCT-AD model.

Future Research

Areas for further research, which were beyond the scope of the current project include addressing questions such as:

- What difference does training frontline practitioners make to the conflict behaviours and alcohol use of the parents they work with?
- What is the impact of the BCT-AD model on parents who are supported by specially trained practitioners?
- Does connecting parents to a digital stress, conflict and coping resource increase parents' knowledge about conflict and stress and prompt changes in behaviour, including reduced alcohol use?

The challenges encountered in the delivery have also flagged other issues for future research, including:

- Is it possible to reach our target audience of parents by putting the resource on trusted online pages, supported by a marketing strategy that drives parents to the resource?

- Is it possible to increase practitioner engagement with a digital resource, and their use of it with parents, through greater co-production and synergy with training?
- Are there other groups of practitioners, such as public health professionals, social workers, police and probation officers, who are better placed to signpost parents to a resource and work through it with them where helpful? What are the best ways to identify and work with such practitioners?

Conclusions and recommendations

The I-CADeP programme provides a continuum of support for couples struggling to varying degrees with conflict and problematic drinking. Good take-up of frontline training and for the more specialist BCT-AD training illustrates an appetite amongst practitioners to develop their capacity to support couples caught in cycles of alcohol misuse and conflict.

The digital platform showed promise, with positive feedback from practitioners and a case study parent. However, low take-up for the digital platform and the difficulties practitioners faced in recruiting couples to undertake the BCT-AD programme both highlight the challenges in reaching their respective target audiences. Putting to one side many of the practical obstacles that both strands encountered, there may also be issues around how alcohol misuse and couple relationship difficulties are framed and owned which compounded recruitment difficulties, both for potential service users and services themselves. The work of the NHS IAPT service in supporting individuals suffering from depression shows that this type of systemic change is possible, over time. Whereas the service previously worked solely with individuals, it now also works with couples. Similar changes from individual to couple focused treatment may therefore be possible in the future for those experiencing alcohol misuse, conflict and relationship difficulties.

In terms of the digital resource, learning from this and other projects suggest that a successful supported referral model is likely to require working with more clearly defined groups of practitioners, such as public health professionals, ensuring they are closely involved with the development of the resource, enabling them to have conversations with parents about alcohol and placing the resource in a place where these parents go. Secondly, the findings suggest that the resource could operate as a stand-alone intervention, reaching parents at earlier stages of need. Parents are most likely to find and use the resource, however, if it is placed it in trusted online settings and a marketing programme helps to drive traffic to those sites.

1. Introduction

1.1 About the programme

Between 12-29% of parents in the UK are estimated to be hazardous drinkers (McCovern et al. 2018), which means their alcohol use poses a risk to their physical, mental and social well-being (WHO 2020). Risks extend to their children. Children who grow up in a family where alcohol misuse is a problem are more likely to experience physical, emotional, and behavioural problems (e.g., Chen & Weitzman 2005) and are more likely to drink heavily and more frequently than their peers (Chalder, Elgar and Bennett 2006). Furthermore, alcohol misuse is associated with an increased risk of familial conflict (e.g., El Sheikh & Flanagan 2001), which is itself strongly associated with a significant risk of experiencing poor long-term outcomes (e.g., Harold et al. 2016; Reynolds 2014). Public Health England (PHE) estimate that there approximately 200,000 children in England currently living with parents suffering from alcohol dependency.

As part of a cross government strategy to reduce the harm caused by problem drinking, in April 2018, the Department of Health and Social Care (DHSC) and Department for Work and Pensions (DWP) launched a joint funding package to improve outcomes for children of alcohol dependent parents (CADeP). The funding is designed to harness the creativity and capacity of the voluntary and community sector to improve outcomes of CADeP whilst at the same time building the evidence base concerning what works; complementing other government work, such as that taking place under the Challenge Fund (2019) programme aimed at reducing interparental conflict. Tavistock Relationships, along with Adfam and OnePlusOne were commissioned, through this funding, to develop and pilot a multi-stream programme designed to improve outcomes for children in families affected by interparental conflict in the context of alcohol dependence, by enabling parents to find new ways of managing conflict, thereby reducing couple conflict and alcohol dependency.
This programme combined workforce training, digital behaviour change resources, and face-to-face couple therapy.

Programme rationale

There is strong evidence that one of the most powerful routes to effecting individual change is through work with the couple. This is particularly so in the context of problem drinking, where the association between drinking and dyadic adjustment is reciprocal (e.g., Bamford et al. 2007; Levitt & Cooper 2010). That is, drinking has the potential to both affect and be affected by the couple relationship. Interventions that work with both partners, rather than just one appear to be more successful. For example, a seminal study on the efficacy of Behavioural Couples Therapy for Alcoholism and Drug Abuse (BCT-AD) (O'Farrell & Shein 2000) demonstrated that BCT-AD produced greater abstinence and better relationship functioning than individual-based treatment. The *'Improving outcomes for children of alcohol dependent parents experiencing high levels of inter-parental conflict'(I-CADeP)*

project therefore adopted a dyadic approach to reducing alcohol misuse, focusing support on the couple relationship and both partners' ability to cope with stress.

Project approach

The project aimed to improve outcomes for children in families affected by interparental conflict in the context of alcohol dependence, by enabling parents to find new ways of managing conflict, thereby reducing couple conflict and alcohol dependency. To achieve this, we developed three workstreams, these were:

i. **Frontline practitioner training**: training workshops developed and run by Adfam and Tavistock for front-line practitioners working with parents for whom alcohol use and interparental conflict may be an issue.

ii. **'Coping with Stress and Alcohol' digital platform for parents:** a digital resource for parents developed by OnePlusOne, based on a therapeutic model of couple coping which provides insights and guidance around managing conflict and understanding and coping with stress. The resource includes a supplementary practitioner guide for professionals wishing to use the platform with their service users.

iii. **Behavioural Couple's Therapy-Alcohol Dependency (BCT-AD) training for counsellors:** a four-day training course in BCT-AD run by Tavistock. The training was attended by counsellors, psychotherapists, social workers and alcohol misuse workers. Each practitioner was expected to work with two cases following the training.

1.2 Overview of the evaluation

A logic model was developed for the evaluation of the digital resource (see Appendix A). The overall evaluation comprised both quantitative and qualitative data collection designed to assess the effectiveness of the respective training strands and the impact of the programme on parents. This involved:

i. Evaluation of frontline practitioner workshop training
    a. Pre- and post-workshop training questionnaires.

ii. Evaluation of digital platform for parents
    a. Pre- and post-resource questionnaires.
    b. Interviews with parents.
    c. Interviews and focus groups with practitioners.

iii. Evaluation of practitioner guide to the digital platform
    a. Feedback questionnaire.

iv. Evaluation of BCT-AD training

a. Post-training questionnaires.
b. Post-supervision questionnaires
c. Clinical supervision

Further details about the evaluation are included in the chapters describing each project strand.

1.3 Report outline

The report is structured to reflect the different strands of the project. Chapters two to four each describes the development, implementation, evaluation approach and findings for the frontline practitioner training, digital platform, and BCT-AD training respectively. Chapter five concludes with a discussion bringing together essential learning and recommendations for next steps across the project as a whole.

2. Training for frontline practitioners working with service users

This chapter describes the development and delivery of the Adfam-Tavistock training programme for frontline practitioners along with details of the evaluation and key findings from it.

2.1 Development and content of the training programme

The training involved a two-day training workshop for frontline practitioners who worked with service users for whom alcohol use and interparental conflict may be an issue. The training was designed to help practitioners:

- Explore the nature of couple relationships.
- Screen for high risk levels of drinking and deliver an evidence based brief intervention.
- Develop skills to open up conversations with the parental couple and to hold the child 'in mind'.
- Increase participants' awareness of the nature and impact on the child of parental alcohol dependence and parental conflict.

Following the training, practitioners were able to access a digital platform that contained the training materials used during the two-day skills workshop as well as links to further information and sources of support. This platform was not evaluated.

Development Process

The two-day training course was developed in collaboration between Adfam and Tavistock Relationships, combining the content and materials of accredited courses run by each organisation as well as bringing in new materials where relevant. Two trainers from Tavistock Relationships and one from Adfam delivered all sessions. On both days, sessions alternated between a focus on the parental relationship and on the impact of parental drinking on children, with each organisation delivering two sections of training per day. The content included discussion, videos, role play, case studies, question and answer and practical group work activities. Learners were able to build a toolkit of interventions and resources to equip them in their work. The training continued to evolve over the course of the project as further sessions were run and modified in response to feedback and trainer observations.

Training content

The content and theoretical underpinnings included the following:

Day 1

Identification and Brief Advice (IBA): IBA is described as the most evaluated and effective form of early intervention for alcohol problems (Babor et al. 2006) and is recommended by the Department of Health, the Alcohol Treatment Effectiveness Review (Heather et al. 2006), and the World Health Organisation (Babor et al. 2001). The use of a combination of a validated screening tool, the AUDIT, and a motivational five-minute intervention (FRAMES: Bien et al., 1993) is considered highly effective in eliciting changes in drinking behaviours among non-dependent risky drinkers.

Dysfunctional Family Roles (Weischeider 1981)**:** This model, describing systemic disfunction in households where alcohol is an issue, explains the ways in which family members become 'stuck' in roles. Using examples of these roles from popular culture, the dynamic played out between characters was explored with learners.

Adverse Childhood Experiences (ACE: Bellis et al. 2016): The trainers utilised a selection of resources on the impact of childhood trauma on physical and mental health in adulthood to encourage learners to consider the impact of parental drinking on the child's experience.

Institute for Alcohol Studies: The Alcohol and Families Alliance report (2017): Examples and statistics from this report were used to underpin the need for intervention and to raise awareness amongst parents of the impact of heavy drinking on the child's experience.

Day 2

The **Transtheoretical Model of Change** (Prochaska & DiClemente 2005) was used to illustrate different approaches to working with adults whether they are ready to make changes to their drinking behaviour or not.

Motivational Interviewing (Miller & Rollnick 1991) is an evidence-based intervention for behaviour change and learners were taught techniques from this model in order to support parental motivation to make changes.

Blue Light Family Toolkit: Developed by Adfam and Alcohol Concern, this toolkit focuses on how families can encourage a drinker to change. Utilising concepts from across the addiction field, it provides practical resources for use by practitioners and family members. Resources from the toolkit were used in role-play and group exercises and learners were given a link to the full toolkit.

2.2 Programme delivery - Frontline practitioner training

A total of 285 practitioners, from a range of professional backgrounds, attended two-day training sessions in six localities: East London (65); Leeds (52); Bristol (55); Norwich (30), Birmingham (43), and South East London (40). The workshops were conducted by trainers from Adfam and Tavistock Relationships.

Delivery Challenges

A number of challenges were encountered in delivering the training.

- Changes in trainers meant amending and adapting the slides and delivery methods between training events. This resulted in different slide decks being created so the slides on the digital portal differed considerably from those used in some of the training sessions.
- Practitioners from a wide range of disciplines were present at the training making it difficult to tailor content to meet the needs of all attendees.
- There was some confusion about the target recipients of interventions from the training. Whilst originally dependent drinkers were to be targeted, it became apparent that resources were actually more suitable for hazardous drinkers. This caused some confusion among learners.

2.3 Evaluation of the frontline practitioner training

Approach

Practitioners were presented with a pre-training questionnaire (Appendix C) at the start of the training workshop, to provide a baseline prior to training. Post-test questionnaires were distributed at the end of the workshop (Appendix C). Questionnaires were designed to assess whether the training programme met its objectives, with questions matched to the expected outcomes of the training. As responses were anonymised, it was not possible to match individual users' pre- and post-test questionnaires.

Limitations

- Despite multiple attempts from the OnePlusOne research team to contact the practitioners who attended the training, there were no responses from practitioners. Therefore, there was no follow up with practitioners to assess how or whether they were using the skills that they had learnt during the training in their day-to-day practice. We observed significant increases in knowledge and confidence following training. We were not in a position however to assess to what degree this translated into practice.
- Similarly, there was no follow up with parents who may have received support from practitioners. Without this kind of follow up we cannot be certain of the impact that the training has had on the parents who engage with the practitioners.

- It was not possible to conduct a paired t-test analysis on the pre-post data because practitioner feedback forms were anonymised. This reduced statistical power when analysing the findings.

Findings

The impact of the training on practitioner knowledge and competencies

A total of 285 practitioners attended training sessions in six localities: East London (65); Leeds (52); Bristol (55); Norwich (30), Birmingham (43), and South East London (40). As summarised in Table 1, practitioners were drawn from several specialities that support families and individuals, including health, social care, family work, and therapeutic services. The majority of participants were female (87%), white British (71%), and were near evenly distributed across age groups (18-35 = 26%; 36-45 = 34%; 46-55 = 26%; 56+ = 14%).

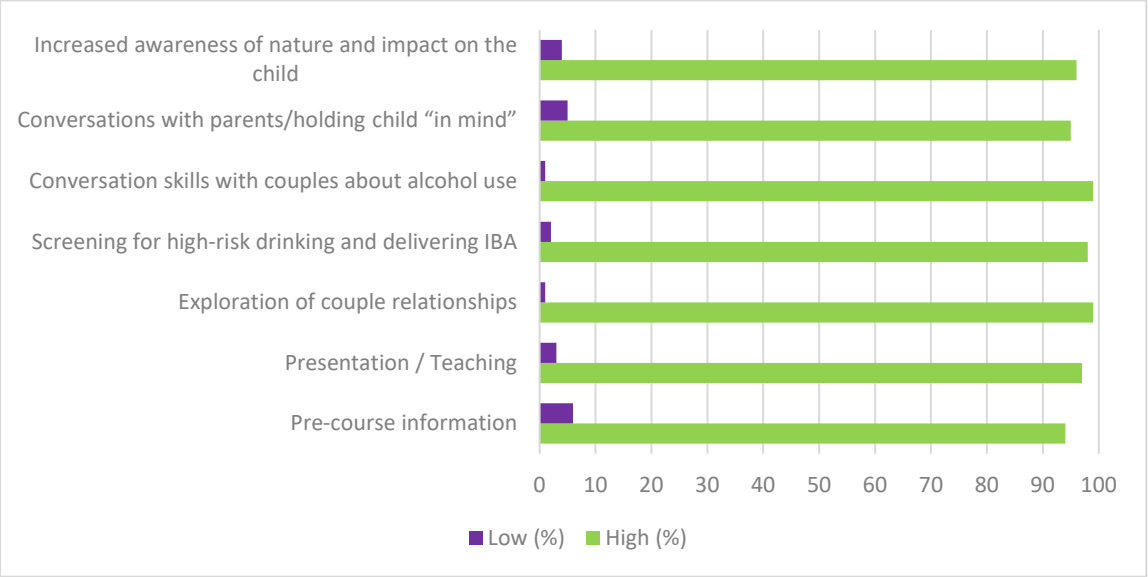
Of the 285 participants across the six training sessions, 215 returned pre-training evaluation surveys and 207 returned post-training evaluation surveys, with varying degrees of completion.

Table 1. Sector in which participants work

Sector	Respondents (%)
Family work	24
Therapeutic work (e.g., psychotherapy, counselling)	16
Alcohol/ drug treatment service	18
Health service	10
Social care	16
Family justice	2
Education	1
Other (e.g., substance misuse, gambling, domestic abuse, housing support)	8

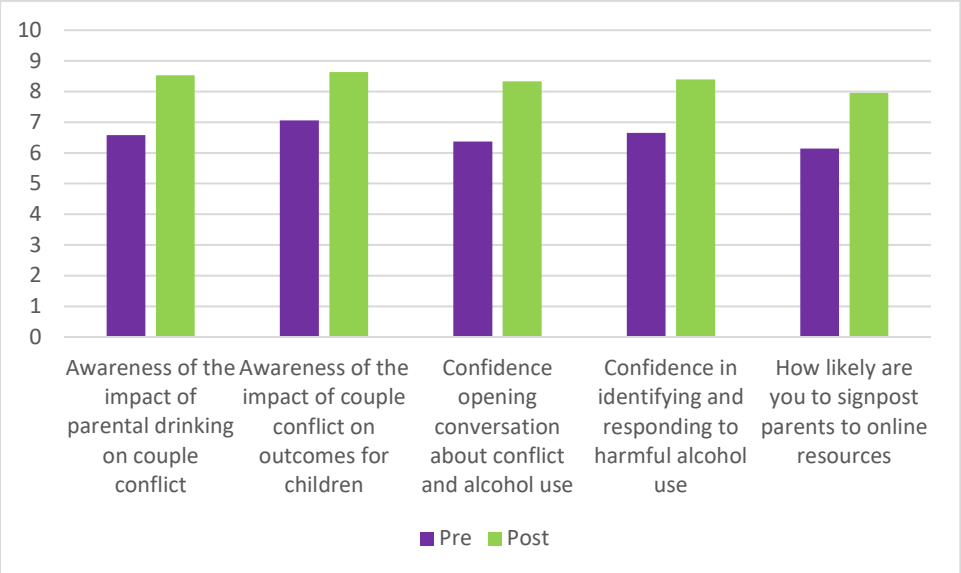
Practitioners were either very satisfied (35%) or satisfied (55%) with the course overall and reported high levels of satisfaction with each aspect of the course, as demonstrated in Figure 1.

Figure 1. Participants' satisfaction with different aspects of the training



Practitioners also reported improvements in their knowledge and confidence around problematic alcohol use and the couple relationship. As shown in Figure 2, analysis of mean scores showed that practitioners reported statistically significant improvements in their knowledge about the impact of drinking on couple conflict and the impact of couple conflict on children. There were also significant improvements in their confidence in opening up conversations about alcohol and conflict and in identifying and responding to harmful alcohol use.

Figure 2. Changes in practitioners' knowledge, understanding and confidence



It was also possible to turn the individual items of the questionnaire into a scale that assesses an overall measure of practitioner knowledge and skills based on average scores[1]. As Table 2 indicates, there was a statistically meaningful improvement in practitioners' self-reported knowledge and confidence following the training.

Table 2. Mean scores for practitioner knowledge and skills scale pre- and post-training

Practitioner self-assessment	*Pre-training Mean (SD)*	*Post-training Mean (SD)*
Score on practitioner competence scale	5.56(1.43)	8.37 (1.08)*

*statistically significant difference in mean scores (p<.001) (d=0.57)

Overall, according to practitioners' accounts, the training had a significant positive effect on their knowledge and competencies around supporting individuals and families in which harmful alcohol use is having a negative effect.

Comments from feedback forms illustrate how practitioners were thinking of using the learning from the course, for example, many of them spoke about an increased focus on the couple relationship when dealing with conflict "*use the resources, links, websites, youtube clips with parents*" and also in using the resources with parents and sharing the resources with other practitioners on their team "*share info from training with my team; raise awareness of OnePlusOne parents platform with team and small percentage of clients to whom this may be suitable*".

2.3 Conclusions

In view of the numbers of practitioners recruited to the workshops, the training demonstrated that there is a considerable interest amongst frontline practitioners in training of this kind. Utilising the combined expertise of Adfam and Tavistock Relationships proved to be an effective means of creating a training course which has been successful in raising practitioners' awareness of the impact of drinking on couple conflict, in raising practitioners' awareness of the impact of parental conflict on children's outcomes, and in increasing practitioners' confidence in speaking to parents about conflict and harmful alcohol use.

[1] Scale analysis of the pre- and post-training items showed sufficient internal consistency to be treated as a single scale (α>.80)

3. The 'Coping with Stress and Alcohol' digital platform for parents

The second strand of the programme involved the 'Coping with Stress and Alcohol' website which hosted the 'Coping with Stress and Alcohol' short course for parents. The course was based on an established therapeutic intervention - Couple Coping Enhancement Training (Bodenmann & Shantinath 2004), which focuses on helping couples to cope with stress - and was designed to reduce alcohol use as a coping strategy.

The site also provided a supplementary practitioner guide designed to support practitioners in using the digital resource with their service users.

3.1 Development of the resource

The content of the digital resource was grounded in the literature on stress, dyadic coping, and problematic alcohol use, with modules adapted from both CCET and OnePlusOne's How to Argue Better training programme for practitioners working with parents in conflict (HTAB; Coleman et al. 2013). In development, the resource was tested with four individuals – three who misused alcohol and one adult child whose parents misused alcohol.

A number of changes to the resource were made in response to usability testing feedback, these included:

- Multiple text edits for behaviour change, user understanding and service direction.
- Modified evaluation questions to ensure they didn't spill onto multiple pages.
- Videos published entirely on Vimeo, to prevent the YouTube problem of recommending playlists at the end of each video.
- More 'general' alcohol support content (e.g., 12 steps).
- Improved signposting for both an alcohol user, their partner, and any children.
- New navigation buttons being added to interactives, so that users can return to their pathway without closing down the tab.
- Significant User Interface changes to the activity navigation after users had trouble using the orange bar for navigation.
- Clearer signalling around the use of "quiz" questions.
- Floating buttons were scrapped after users were confused about when to complete questions.

Behaviour change principles were applied throughout the entire site and course. To ensure that these had been implemented as accurately and effectively as possible, an independent behaviour change expert was invited to complete an audit. The results of the audit mostly confirmed our use of behaviour change theory, with some recommendations for improvement around goal setting, content tweaks for clarity of messaging and improved calls to action.

A practitioner guide was developed in response to requests from practitioners for the opportunity to develop their skills through a digital platform as face-to-face training was curtailed due to the Covid-19 pandemic. This had not been part of the original proposal.

Theoretical underpinnings

The digital resource draws on theories about how relationships work (e.g., Vulnerability-Stress-Adaptation model) and approaches to helping individuals change patterns of behaviour through Behaviour Modelling Training (BMT) and Digital Behaviour Change Interventions (DBCI). The theories and their application are summarised in Figure 3.

Figure 3. The Theoretical underpinnings of the 'Coping with Stress and Alcohol' digital resource

Vulnerability-Stress Adaptation model (VSA)

The theory: The VSA is an influential and comprehensive theoretical model based on a review of 115 longitudinal studies representing over 45,000 marriages (Karney and Bradbury 1995). The VSA model helps us to understand the impact of stressful life events in the context of individuals' past histories and the methods they use to adapt in these circumstances. Some of these adaptations help to support the relationship whilst others may undermine it.

Our application: The content was designed to help users understand the strengths and vulnerabilities each partner brings to the relationship; how their respective strengths and vulnerability influence how they respond to the stressful events encounter, such as alcohol use; and how they can adapt their behaviours to support one another them during this time.

Behaviour Modelling Training (BMT)

***The theory*:** Drawing on social learning theory (Bandura 1977) BMT uses visual demonstrations of behaviours to help learners acquire new knowledge and skills. It provides opportunities for feedback and social reinforcement to participants as they practice skills to maximise the likelihood of adopting new behaviours.

Our application*:*

Video clips based on tried and tested BMT techniques were used to promote behaviour change. These reflected the different components needed to support behaviour change:

- **Attentional** - Observing ideal behaviours from least difficult to most difficult.
- **Retentional** - Memorising the new skills.
- **Reproduction** - Practicing the observed skills.
- **Motivational** - Positive reinforcements for demonstrating the newly learned skill.

Digital Behaviour Change Interventions (DBCI)

The theory: Digital behaviour change interventions employ digital technologies to encourage and support behaviour change. They can include techniques such as, nudges, gamification, and goal setting.

Our application:

The resource used the COM-B model of digital behaviour change (Michie et al. 2011) that recognises that behaviour comprises:

1. **Capability -** Knowledge, skills, stamina
2. **Opportunity -** Time, resources, prompts, support
3. **Motivation -** Motives, desires, impulses

The resource also drew on evidence-based programmes designed to strengthen couple relationships, including:

Couple Coping Enhancement Training (CCET): CCET is a training resource designed to teach couples how to cope with stress both individually and together, through dyadic coping. Developed by Bodenmann and Shantinath (2004) in Switzerland, it has never been trialled in the UK and was originally designed to be delivered by psychologists or other specialists although recent adaption tested delivery via DVD (Bodenmann & Shantinath 2004; Bodenmann et al. 2014).

How to Argue Better (HTAB): HTAB is an evidence-based training programme devised by OnePlusOne that provides practitioners with the skills, knowledge, and resources to work with parents experiencing conflict in their relationship (Coleman et al. 2013).

Content

The digital resource comprised three modules each utilising BMT videos (with actors), psycho-educative information pieces designed to help users understand the impact of stress and alcohol use, graphics and activities. Each module ends by encouraging users to set a goal to change their behaviour. Further details are provided in Table 3.

Table 3. The 'Coping with Stress and Drinking' digital resource modules

Modules	Sections	Description
Section 1	• What is stress? • How stress comes about • Major events and daily hassles • How does stress affect you? • Inside and outside stress • Stress and relationships • Where does your stress come from? • Coping with stress together • How 'my' stress becomes 'our' stress • Recognising stress • Talking about stress • How to talk about stress • Supporting each other	Focusing on stress and coping, this section aims to enhance the dyadic coping skills of parents. It includes psychoeducational resources developed from the CCET programme and an animation demonstrating the importance of sharing stress.
Section 2	• Arguing better • How conversations get out of hand • The 5:1 magic ratio • Where you're at – sliding scale of happiness • A situation – BMT video demonstrating harmful and helpful arguments	Section 2 aims to help parents develop skills in communication and managing conflict. It starts with a self-assessment tool for parents to reflect on how they are getting on in their relationship 'right now'. It includes: a graphic to explain why arguments happen; BMT videos to demonstrate an argument going badly and then going better; extensive psychoeducational resources to explain 'How to Argue Better'

The supplementary practitioner guide outlined the theoretical underpinnings of the resource and provided step-by-step instructions on how to use the resource with service users.

3.2 Programme delivery

The website reflected OnePlusOne's Click Relationships platform style. In line with digital behaviour change best practice, parents worked through the content in a linear fashion, incrementally building on their learning and practising increasingly complex skills. Parents were invited to complete pre-resource questionnaires before progressing onto the actual content and once users had worked thorough all pages of the resource, they were invited to complete a post-test questionnaire. Although it was possible for parents to work through the resource independently, the intervention was primarily designed for practitioners to refer parents to the resource and to provide ongoing support to parents as they worked through it. This reflected practice knowledge around the challenges of engaging and

sustaining the involvement of parents at risk of alcohol dependence in such a behaviour change programme.

A three-month delay in the award of the grant had a significant impact on the delivery schedule for the digital resource, which was developed from scratch. As practitioner training, which largely drew on existing content, went ahead in the Spring/ Summer, a disconnect emerged between the launch of the digital intervention and the frontline practitioner training. As a result, the training did not address the digital intervention in the level of detail originally envisaged, and we were not able to target and engage practitioners in a supported referral approach. This had an inevitable impact on take-up for the resource, as we know from previous projects that a blended practice model works well.

To address this gap and increase uptake to the intervention, OnePlusOne engaged Local Authorities within the Innovation Fund areas and had discussions with managers about the intervention to encourage take-up. During these discussions and follow up calls there was real engagement with the purpose of the intervention and who it was targeting, however, with the lack of the vital bridge to the practitioner on the ground, this did not result in increased uptake.

As we had initially identified, the practitioner training, and bridge that this provides between the intervention and the user was the real missing link. At this point, we applied for an extension in order to develop targeted training and arrange for this supplementary training to be carried out in Haringey. The goal of this training was to encourage Family Support Workers (FSW) in the area to use the resource with their service users. The intervention was well received; however, it was delivered in the first week of March 2020, therefore due to Covid-19 restrictions these practitioners were not able to use the resource with service users face-to-face as intended.

In a final attempt to reach practitioners and encourage use of the resource with their service users OnePlusOne produced the supplementary digital practitioner guide, this was also in response to demand from Practitioners due to Covid-19 restrictions.

Delivery challenges

- Delays in roll out of the funding. The initial plan was to have the digital resource available at the time that Adfam and Tavistock rolled out the frontline practitioner training. As noted above, due to funding delays OPO were not able to start work on the digital resource until later in the grant period and the resource was not available for use until 3 months after the initial frontline practitioner training. This resulted in a lost opportunity to direct practitioners to the resource for use with their service users and low take-up of the resource by parents.
- Other attempts to reach parents through a supported practitioner model were thwarted. Firstly, by our inability to work directly with practitioners in the

Innovation Fund areas and secondly by the introduction of the Covid-19 restrictions shortly after training Family Support Workers.

- For behaviour change to be effective it is important that there is identification and personalisation. The person needs to 'see' themselves in the thing they are interacting with, and this is achieved through providing interactive content. Due to limitations with the platform we were not able to create the kinds of meaningful personalised interactions that would affect behaviour change – so we removed them. This may have limited the effectiveness of the resource.

3.3 Evaluation of the 'Coping with Stress and Drinking' digital resource

Ethical procedures

Ethical concerns were taken into consideration throughout the development and delivery of the training, the digital resource and the evaluation. The process was guided by OnePlusOne's research protocol in conjunction with the British Sociological Association's and the British Psychological Society's guidelines. The parents that were recruited by healthcare practitioners to use the digital platform were given an information sheet and gave informed consent digitally, on the Click Relationships platform, before starting the digital resource. All information sheets and consent forms can be found in Appendix B.

Evaluation approach

Users who accessed the original release of the digital resource completed pre- and post-test questionnaires (Appendix D) consisting of the following scales:

- **Alcohol Use Disorders Identification Test** (AUDIT; Babor et al. 2001): The AUDIT is a 10-item screening tool developed by the WHO to assess alcohol consumption, drinking behaviours, and alcohol-related problems. A score above 8 indicates hazardous or harmful alcohol use.
- **Perceived Stress Scale-4** (PSS-4; Cohen et al. 1983): A 4-item scale designed to measure "the degree to which individuals appraise situations in their lives as stressful" (Cohen et al. 1983, p. 385). The items focus on events in the past month. When coded, a high score indicates high levels of perceived stress.
- **Dyadic Coping Inventory** (DCI; Bodenmann 2008): We utilised six-items from the supportive dyadic coping subscale of the DCI, which measures how one partner provides problem- and/or emotion-focused support that assists their partner in coping. A high score indicates high levels of dyadic coping. The original DCI is a 37-item measure, which we determined to be too long for a digital resource evaluation. The six items were chosen following guidance from the author of the scale.

To assess whether the user found the content helpful we included a single-item question at the end of each page of content using a 1=*'not at all helpful'* to 5=*'very helpful'* scale.

To understand users' experiences of the digital resource we planned to conduct semi-structured interviews with parents who visited the site. However, in light of the lack of users progressing through the entire resource we made the decision to conduct a case study to describe in more depth one user's experience of the 'Coping with stress and alcohol' resource.

Findings

Analytics

Google Analytics were used to monitor indicators of the resource's reach and engagement, these include length of time on page, how much of the resource parents consumed.

'Coping with stress and alcohol' digital resource

A total of 1,826 users had 2,585 sessions with the 'Coping with stress and alcohol' digital resource. This generated 6,639 unique page views overall. The goal funnel in analytics indicates that the main drop off was on the introduction page (87.3%), which describes the content of the course as focused on stress and worry. Beyond this, we see a further 66.7% drop-off at the point of being asked (pre) questions. Possible reasons for the high drop off rates on the introductory page are discussed further below.

On average, users spent around one minute on pages relating to "coping with stress", and around 2:35 on pages relating to "coping with drinking". A total of 1,545 users registered to use the resource.

Nine users completed the pre-questions and of those that did, six users completed the post-questions. However, of those six, four were practitioners from one organisation and two were independent users.

Parents' experiences of using the digital resource

Due to the engagement challenges noted earlier, just one interview was conducted with a parent who used the digital resource. The themes from the interview are presented as a case study below to illustrate the user's experience of using the resource, what worked well and not so well, and what changes the parent made as a result.

Case study of a parent who used the digital resource

Background

Katie[2] age 37. Couple experiencing high levels of relationship conflict. Been together 15 years, two children (1 girl (11), 1 boy (15)). They can't seem to get along and are arguing a lot. This has got worse since lockdown. They are struggling to change their ingrained behaviours. They both get

[2] Katie is a pseudonym.

defensive as they know they are going to argue. They have tried various routes for support, including couple counselling and searching for resources online. Katie felt that none of these approaches were effective for her and her partner and described the cost of counselling an added pressure on the relationship. Neither of them has a support network, someone to talk things over with and get a fresh perspective.

Engagement with the digital platform

Katie came across the 'Coping with stress and alcohol' site by chance whilst searching for online support. Although her issues weren't related to alcohol, she felt that the focus on stress could be useful and she could see a link between stress and alcohol. The resource seemed more approachable, relevant, and easy to follow than others she had come across.

What worked well?

Katie found the resource very useful, finding that it normalised conflict and reflected how they behaved in their relationship/ how families behave. She thought that the way it pitched the relationship between partners worked well, "*… he comes home from work and the way that he reacted meant that she has another glass of wine. You're not going to drink 3 bottles of wine, but you will have another glass when that happens*…"

Katie thought it was well structured and in bite sized chunks. Enjoyed the interactive things that reflected how you were feeling as it "*hammered it home*"; "*Nice to tick things off… makes you feel like you've achieved something*." "*There were things that you were reading, that you went "oh"… it was interesting to read.*" This was felt to be more "*approachable*" than some of the other resources out there. The fact that the resource was free, always available and easy to use were also important. She contrasted this with the financial commitment involved in signing up to counselling which had felt like an added pressure and made it "a big deal".

Challenges

Katie found it difficult to navigate the site as it switched between OPO and the Click relationships platform. She thought that the resource was difficult to find "*It isn't that useful to find unless you're really fed up in your current relationship and are googling things…"*. It can also be difficult starting to use the skills you see in the videos because "*as soon as something becomes emotional, that's it!*"

Partner engagement

Katie sent links to her partner, but he did not engage, and she went through the resource on her own. Neither have they discussed the resource as they struggle with communication. She was positive about working through the theory on her own as "*it's quite a vulnerable thing*" but suggested that having things you could do together would be useful as a conversation starter, although she recognised you might need more guidance with those conversation, because although it's a bit hand holding it pushes you through that together.

Lack of partner engagement has made it difficult. For example, she has been trying to use the "*speak for yourself*" with her partner but he has laughed at her *"He doesn't acknowledge what I've said and that's all you want… you don't have to agree with it you just have to see that yes that's got you upset." "If the other person doesn't play the game, what do you do?"* Reflecting on this Katie noted that they have very little quality time due to her partner's work schedule and something that outlines 'how' to speak and listen in short time frames would be really helpful.

Impact of the resource

Katie found the emotional v. practical support concept very useful. She is aware of her own tendency to offer practical advice before listening "*It's the mum in me I want to fix everyone's problems again".* She described a recent incident in which her husband came home from work and wanted to talk about a bad day, and her reaction was to try and fix it. Later that night she reflected on the fact that maybe he just wanted to talk, and she should have listened "*I said to him the next day… which is probably the first time I've ever said it and not just thought it… I probably should have just let you talk to me about that thing instead of trying to solve it for you… so that did work quite well."*

Katie has started using "I feel…" and finds it really useful. "*As soon as I start doing that, it helps. Even if he's not doing it.*" She notes that this has made her feel more conscious about how she actually feels and focussing more on how she manages herself. For example, one night they were arguing, but instead of their usual routine of "*following each other around*" to continue the argument, she made herself a hot drink, and played mindfulness brain training games on her phone "*actually I'm pleased with how I managed myself… that's a real big mind shift for me*." Concluding that "*it could have been a huge argument, and it wasn't.*"

The programme made her realise that both partners need to take responsibility for their part in the relationship. In the past, she would take responsibility for both of them, but now realises that he needs to carry his load as well, "*There's a difference between doing it for you and being supportive.*" Katie notes that her partner is struggling with this change in behaviour from her as he is used to her doing everything for him. *"I don't know where I would be now if I hadn't found the videos and the programmes and it makes you feel very trapped and isolated… but you watch the videos and you think 'everybody's going through the same thing and I'm not terrible' and it's a confidence boost because you've found something that can help you… when you're in that situation it's really helpful."*

When asked whether the resource had impacted her alcohol use Katie reflected that she didn't drink in the same way anymore and was more mindful about her alcohol use. *"It has improved… I will have a drink with a nice meal of a weekend… so what I do now is I buy one of those mini bottles and I will have that with a roast dinner… or a takeaway." "I don't have a bottle of wine in the fridge, because what I was doing it was a self-harm thing, I was so miserable, and I would just drink it and I would feel worse… I'm only drinking because I'm miserable I'm only drinking for negative reasons." "Because of the video… I was like that's exactly what I do, I feel miserable, so I pour another drink. It wasn't a problem for me because I'm a lightweight and I can't drink much anyway, but it's the pattern and the mentality of it that I went, yeah, it's a really slippery slope."*

Sources of support

Would recommend this resource to others. Katie has been really proactive in looking online for support and feels like it's really tricky to get what you want. She believes people use the internet because it's anonymous but it's tricky to find things that are similar to our resource and that don't require you to go face-to-face and lose anonymity.

3.4 Evaluation of the digital practitioner guide

Practitioners were asked to complete a post-resource feedback form (Appendix E) to assess whether the digital practitioner guide was effective in increasing practitioner knowledge and confidence in understanding the impact of stress and dyadic coping on the couple relationship, conflict and communication, and supporting couples to use the skills developed through the digital resource. We are not able to report on these findings as no practitioners completed this feedback form. We also used Google Analytics to monitor indicators of the guide's reach and engagement, these include length of time on page, how much of the guide practitioners consumed, and number of click throughs to the parent site.

Findings

Analytics

Practitioner guide

The practitioner guide received 1,306 visits in total indicating moderate reach. For those that stayed to read the guide, the average time on the page was 1 minute, which suggests that most users neither engaged with the guide nor used it with parents. Over two-thirds (69%) of users did not scroll past half-way and only 15% of the users scrolled down through the entire guide. Only 17% of total users (*n*=85) clicked the link to view the parents-and-drinking resource, indicating low engagement with the guide and lack of connection between the practitioner and parent resources. Of these 85 practitioners, eleven downloaded the parent information sheet suggesting they intended to use the resource with parents. However, this is not reflected in the data collected on the parent's platform. Nine practitioners accessed the feedback form, but none were completed.

Semi-structured interviews

Three interviews were conducted with practitioners in order to gain some insight into their views about the digital resource. One had been involved in the DWP's Reducing Parental Conflict training. None of them had used the resource with parents.

Barriers to using the resource

All three practitioners spoke about the barriers that they experienced in using the various resources rolled out as part of national schemes, as well as the 'Coping with Stress and Alcohol' resource in particular. A notable barrier was the number of emails that practitioners receive offering alternative resources, meaning that practitioners can overlook otherwise useful resources.

> *"I think the difficulty is, there's often new things coming along or new resources or things that would be really helpful and there's a bit of fatigue around that."*

Practitioners also spoke about services being overwhelmed with complex cases and time pressures, leaving them short of time to learn about and then go through new resources

with parents. For example, if alcohol is a problem then practitioners may get in a drug and alcohol specialist rather than provide support themselves using a novel resource.

"sometimes that might be, well, they're saying alcohol is an issue, I'll wheel in the alcohol worker, rather than try and work through something with them because I've got 101 other things to do"

Practitioners also discussed the possible barriers for the parents that they work with, for example, one reflected on the resistance of parents she worked with in using an established intervention independently. When probed further this practitioner noted that it was difficult for parents to maintain motivation and highlighted the importance of making the resource as easy to work through as possible. Not having the mental or physical time to use the resource was also a reason that parents had given in the past for not engaging with resources, despite being encouraged by practitioners.

"I haven't got time. I've been dealing with the children… And it's setting aside some time that actually they can do it without the children about… But they just, that still comes back, oh, I didn't have time and I didn't really understand it, how to do the login."

Other observations were around the messaging of the site. Whilst none of the practitioners indicated that the messaging was unclear or confusing for parents, one practitioner felt that the resource struck a good balance between discussing alcohol and stress but that the alcohol aspect was more in the context of a coping mechanism. Whilst her colleague stated that she felt the site was focussed heavily on alcohol and not enough on stress. Different interpretations of the site's message may help to explain the high drop off rates on the entrance page.

"initially, I thought it was going to be just down that avenue, but actually, after completing it, it's more a case of the drink aspect is quite brief on it, in the sense of you can do the course. Its more stress based, and the drinking is more of a, I suppose, coping strategy that some people might go down the route of."

"a colleague I spoke to recently, she felt that it was obviously drink… She felt it was ironically it was more drinking related than what she thought it was going to be, while I felt it was more based on the stress and the drink

Facilitators to using the resource

When probed about the most effective means of engaging practitioners with the resource, one practitioner noted that an A4 sheet that highlights how the resource could be used with different parents of different levels of need, in bullet points would be useful. This is important as particularly following Covid-19, practitioners are stressed, and demands have gone up.

"I think an A4 crib sheet saying, this could be part of an intervention if you're working with family on a high level of need, if you're working with families on a lower level of need, or you may want to just disseminate it…"

This practitioner also noted that a webinar or online training would also be a useful way to introduce practitioners to the resource.

"It's all changed so much since Covid-19. I've noticed that more people are likely to attend online trainings now than they would have traipsed across the city to a face-to-face meeting…it's actually quite a good time to have an hour webinar to attend."

The practitioners who had gone through the resource themselves were positive about its features, commenting on its usability and accessibility, the clear messaging around stress and alcohol, and how they had found it useful for themselves.

"First of all, it seemed very usable. So, I thought the layout was nice. It seemed very easy to navigate. So, it was quite clear where you could go to do certain things or look at certain things. So, I thought that was very helpful. It was quite straightforward… the language isn't too daunting. There's nothing too overtly scientific or tricky or complicated about it… I would feel comfortable signposting people towards it if they felt that would be helpful for them or they wanted to look at it. ‘‘

"… between me and the CEO, when we completed it, when we went through it, we were both actually quite reflective on our own situations. Not in the sense of the drinking aspect, but I think the stress aspect."

How the resource could be used with parents

Practitioners saw the resource as potentially useful for different levels of need with their service users, delivered either as standalone or blended practice depending on level of need.

"I imagine further up the scale of need you'd need to embed it within an intervention, but lower down the scale of need it would be a useful resource to disseminate, and for practitioners to feel confident to disseminate."

One practitioner suggested that families working with social care may need more than a digital resource to facilitate changes in behaviour, although she could see practitioners using it with parents as a means of opening up conversations about relationships. Indeed, one of her colleagues is thinking of using the resource in this way. Another practitioner noted that due to the sensitive subject matter of conflict and alcohol use it would be best placed used in a face-to-face setting with parents with an experienced practitioner.

3.5 Limitations of the evaluation

Insufficient numbers of parents using the resource

Despite the many attempts that we have outlined, we were not successful in getting parents to access the digital resource. This means that we were unable to conduct meaningful quantitative analysis on the pre- and post-test questionnaires to measure the impact of the resource. We were also, therefore, only able to interview one parent about their experience of using the resource and what difference, if any, using it made to their relationships and to alcohol use.

Limited practitioner responses to the practitioner guide feedback form

Although a large number of practitioners accessed the practitioner guide, they did not complete the feedback form at the end of it. This may be due to practitioners not using the guide in full.

No comparative evaluation

Had parents used the resource, the findings would have been constrained by the repeated measures design of the evaluation. In other words, we would only have been able to comment on the impact on parents from before and following use of the resource as opposed to comparing the impact of our intervention against the impact of no intervention or a different resource.

3.6 Conclusions

Although a large number of users did not progress beyond the introductory page, of those that did the majority (67%) went on to complete the resource, suggesting that the course effectively sustained engagement amongst users who made it past that first page. This is echoed by feedback from the case study parent, who found the resource engaging, accessible and easy to use, as well as comments from practitioners.

Evidence from our case study suggests that the course was effective in teaching conflict communication skills as well as increasing mindfulness about alcohol use. The user from our case study noted that the resource was very accessible and normalised her experiences, offering a means of understanding her interactions with her partner. This resulted in positive changes to how she dealt with conflict in her relationship and a shift in her thinking about the relationship.

Although we lack insights from potential users about why there was so little engagement with the resource, experience from other projects suggest one reason may be because practitioners were not providing a supported referral. Anecdotal evidence also suggests that the messaging may not have been sufficiently clear. For example, people who wanted to use it for alcohol may have been deterred by the stress focus and vice versa.

Formative feedback from two practitioners that we spoke to suggests that the resource is appealing in terms of content and messaging, but that the overwhelming number of

resources available to practitioners means that even seemingly useful resources are not picked up. This highlights the need to ensure resources are marketed in an engaging way to practitioners. Perhaps utilising co-production and co-design to ensure that practitioners are involved and 'on board' before the resource is launched.

Although the resource was originally designed with a view to supported referral from practitioners, the positive feedback from the case study user, who found the resource independently, suggests it could operate as a standalone intervention if we are able to find ways to signpost users to it. It is less clear what role a stand-alone practitioner guide has, given its moderate reach and relatively low engagement.

4. BCT-AD training for counsellors

4.1 About the BCT-AD training

Sticking to the evidence base identified by NICE (2011), BCT-AD is a brief therapy of up to 20 sessions based on behavioural principles, drawing on Randomised Controlled Trial Studies of efficacy as well as best practice in behavioural, cognitive, emotionally focused, systemic and psychodynamic couple therapies designed to treat relational distress (e.g., Fals-Stewart, Klosterman, Yates, et al. 2005; Fals-Stewart, O'Farrell, Birchler, et al. 2004; O'Farrell & Fals-Stewart 2006). An adaptation of Couple Therapy for Depression, originally designed to work with distressed couples generally, as well as addressing depression-specific factors, the model is easily adapted for the treatment of other chronic conditions in which distressed couple relationships play a part, such as alcohol abuse, obesity, cardiovascular disease and diabetes, amongst others.

BCT-AD focuses on the relational aspects of alcohol dependence and looks for the bi-directional causal and maintaining factors in the relationship that are contributing to the problematic use of alcohol. The approach also encourages couples to improve their communication, to tolerate their differences, think about what might be blocking change, how their conflict and alcohol dependence is affecting their children, how to problem solve together, and to work as a team to prevent alcohol misuse.

The model focuses on factors that reduce stress and increase support within the couple, using the relationship as a resource for recovery and relapse prevention.

Theoretical underpinnings

The therapeutic stance taken in BCT-AD is based on a pragmatic balance between working with couples to change what they can, explore what is blocking those changes, including the function of alcohol misuse in the relationship, and helping couples find ways of coming to terms with what cannot be changed. There is also an emphasis on harnessing the relationship as a resource to enable change, particularly in relation to alcohol misuse and in understanding childhood trauma and attachment disorder.

The therapy aims to enable practitioners to first assess couples and, where it is safe to proceed, guide them to reduce damaging interactions, change unhelpful cognitions and perceptions, create closeness and understand each other's vulnerabilities better. There is an emphasis on improving the couple's coping abilities in terms of ordinary and not-so-ordinary stresses and triggers, which may contribute to alcohol misuse and that arise in the course of everyday living. Improving communication and emotional openness will, in turn, improve behaviour – and how couples manage the business of parenting their children, affecting their children's well-being and development, is very much part of the process.

Content of the BCT-AD training for practitioners

The training consisted of four days of face-to-face training, comprising didactic teaching, film clips, role-play by trainees, role-play by trainers, small group discussions, large group discussions and homework (plus feedback). On Day 4 trainees were filmed delivering a role-play session with actors playing a couple with alcohol misuse problems. This filmed role play was then assessed by the trainee as to what aspects of the model they have used/would use in future and then marked by their Tavistock Relationships supervisor.

Following the training participants received 15 sessions of online group supervision. This was extended due to Covid-19 restrictions preventing on-going work in some cases, now due to end December 2020.

Day 1: Introduction to Couple Therapy and Alcohol Dependence

1. Outline aims and structure of the course including project origins, funders, stake holders, initiative rationale linked to impact of alcohol misuse on families and children.
2. Understanding the services trainees are working in.
3. Background and Introduction to BCT-AD: The model, who is it for, competency required to pass, and training aims.
4. Introduction to alcohol dependence and couple relationships: dyadic conflict and alcohol related problems, linked to children's outcomes; dyadic conflict and patterns of interaction; addictive behaviours and assessing alcohol dependence (using AUDIT; Babor et al. 2001).
5. The Relational Aspects of Alcohol Dependence: interactional models; patterns of interaction between couples; the model's focus on the relationship as client.
6. Measures – how to use and work with measures with a couple: Couple Satisfaction Index (CSI: Funke & Rogge 2007); Patient Health Questionnaire-9 for depression (PHQ-9: Kroenke et al. 2001); Generalised Anxiety Disorder-7 for anxiety (GAD-7: Spitzer et al. 2006); Strengths and Difficulties Questionnaire to think about impact on children (SDQ: Goodman 1997).

Day 2: The Therapeutic Relationship – assessment, engagement, balance, acceptance and tolerance

1. How to work with couples during the duration of treatment: how can they help the couple understand their relationship difficulties better and learn to spot when distress is building that may lead to alcohol misuse.
2. Assessment, risk, and contra-indicators to working with couples/BCT.
3. Formulation:
    - How to engage couples in therapy and co-creating a treatment plan.
    - How to create a safe space where disclosure is possible, whilst acknowledging the limits of confidentiality around risk.

- Identifying themes for the work, how the couple have become polarized in their difficulties, communication and physical relationship likely to have broken down, conflict, misunderstanding and isolation that leads to alcohol misuse.

4. Jacobson and Christensen's 6 questions (1996) to facilitate formulation.
5. Revising couple perceptions: techniques and interventions and the couple therapist's role.
6. Promoting acceptance and building tolerance: creating empathic joining between a couple when talking about emotional vulnerability is likely to have broken down between them.
7. How to use genograms with couples in relation to thinking about attachment patterns and addictive behaviours. Using genograms to facilitate tracing how emotions and stress were handled in families of origin, differences between the couple in relation to this and how these differences may be reflected in their current intimate relationship.

Day 3: The Couple Relationship - Improving Interactions

1. Revision of genogram homework; encouraging the couple to make links.
2. Attachment patterns in adult relationships; Linking attachment styles to management and containment of feelings; Use of alcohol in relation to attachment anxieties; Linking attachment styles to difficulties in parenting.
3. Working with anger, Mentalization Based Techniques (MBT) and promoting change. What might be blocking change and reducing alcohol and addictive behaviours? What might anger be defending the couple against confronting or coming into contact with? Are there losses that need to be mourned?
4. MBT techniques with couples to contain conflict and anger 'in the room'; to promote thinking, clarify misunderstanding, think about the couple's impact on each other and lessen anxiety.
5. Communication Skills: how to help a couple to better connect and feel validated by the other and their relationship. Introduction to communication exercises (such as the communication wheel (Bernstein 1984)/speaking and listening exercises for couples). What are the barriers to good communication? How to broaden communication for couples to encompass new understanding and empathy.
6. Talking about sex, working with resistance in the couple and the therapist (As in all these aspects of the model, encouraging trainees to refer on to other specialist services if necessary, once BCT is completed).
7. Coping with stress in the individual and the couple relationship including an exploration of the rationale for a focus on coping for couples with addictive behaviours, dyadic stress and coping (e.g., Bodenmann 1997) and how they may be different for the two individuals within the couple relationship. How to create a 'couple coping style'.

Day 4: The Couple Relationship – changing behaviour, problem solving, endings in therapy

1. Reviewing the course so far and relating this to trainees' services.
2. Behaviour exchange exercise: how to encourage, set and work with feedback from couples.
3. Operant conditioning and reinforcement erosion in relationships.
4. Caring behaviours exercise: how to encourage, deliver and work with feedback.
5. Setting homework for couples to complete between sessions; Increasing homework compliance: growth in couple confidence to tackle problems in a different way, using their relationship as resource.
6. Problem solving as a couple: Gottman (Wilson & Gottman 2002), Christensen (Christensen & Heavey 1999; Jacobson & Christensen 1996) and Baucom (2017) – problem solving methods.
7. Relapse: using the relationship as resource/toolkit, troubleshooting the future, looking for warning signs and how to tackle them as a couple, using the tools from this treatment. Revising what has changed, what 'work' is yet to happen, thoughts and plans for the future for the couple and their children.
8. Endings in therapy with a couple: unplanned endings/planned endings, therapist's stance and techniques.
9. Ending the course for trainees – next steps which may involve setting up a couple service, offering support from Tavistock Relationships, the need to find training cases to bring to supervision and starting work.
10. Discussion of on-going supervisory element of the course and how to pass revised

4.2 BCT-AD training programme delivery

Tavistock Relationships trained practitioners on BCT-AD in London, Leeds and Bristol between June and November 2019. Twenty-nine practitioners attended the four-day training, across the three centres (30 were registered, but one dropped out the day before the training began). The practitioners were from a range of professions, including family support workers, alcohol service workers, counsellors, and psychotherapists. The majority were working in alcohol services, while a small number were working in private practice. The training was delivered by senior trainers from Tavistock Relationships who had many years' experience of delivering similar trainings (e.g., Couple Therapy for Depression). Trainees were then tasked with returning to their services and identifying a suitable number of training cases in order to fulfil the training requirements.

Following the training, participants were offed fortnightly supervision, conducted in groups via Zoom. Supervision was either for 60 or 90 minutes, depending on group size (3 or 4 supervisees). Supervisees were required to return reflections on learning during each supervision sessions to their supervisor. The initial offer was 15 supervisions, but this was extended until December, due to restrictions imposed by Covid-19 and trainees' difficulties in finding couple referrals in their services. Supervisees were expected to bring their training cases to supervision and aspects of the model in relation to these were explored. Supervisors worked with the same supervisor throughout. It is anticipated that over one third of trainees will pass the competency criteria to deliver BCT-AD following the end of

supervision. Over the course of the programme 12 practitioners withdrew from the programme following the training.

Delivery challenges

Trainees encountered a range of difficulties in recruiting a sufficient number of couples to work with. This was due to a number of reasons, including:

- Alcohol services are not set up to work with couples, despite it being widely acknowledged that relationships can be utilised as a resource to aid recovery and forming part of NICE guidance.
- The precarious nature of the services in which the alcohol service practitioners are working (with funding being withdrawn for many and several redundancies and resignations amongst the cohort).
- The chaotic lives of the service users being replicated at some level within these services (this view is coming from the managers of these services we have spoken to). For instance, the difficulties experienced by service users was understood in supervision to be, at times, mirrored in trainees' difficulties in putting boundaries around their work and training requirements. It was curious how 'knowing your limits' became an often-repeated phrase to supervisees and seemed hard to achieve, much as they were seeing in their clients around alcohol misuse.
- The lack of clinical training (and training for many who have been service users themselves) for practitioners working in this sector.
- Managers not thinking ahead about where to get referrals for the staff on this course (several said they would have done it differently, contacting social care/probation services etc if they could have this time again).
- Impact of restrictions imposed by Covid-19 meant that many services stopped working clinically with couples altogether resulting in further attrition of trainees being able to complete their clinical training cases.
- Many practitioners struggled to find time to complete this training, alongside their 'day' jobs.

4.3 Evaluation

Ethical procedures

Ethical Approval for the project was overseen by Tavistock Relationships' Ethics Committee; all clinical staff were bound by the professional and ethical procedures of their employing organisations.

Evaluation approach

At the end of the four-day face-to-face training, evaluation forms were collected from the trainees on Survey Monkey (Appendix F). Feedback on participants' experiences of fortnightly supervision sessions was collected at the end of July/early August 2020 after the practitioners had attended a minimum of ten supervision sessions. Among 17 practitioners who stayed in the programme, 12 responded to the survey, which consisted of rating five questions on a 5-point scale about their experience of the supervision and a non-compulsory open-ended question of their comments (see Appendix G).

Responses to the training and supervision questionnaires were analysed using descriptive statistics (e.g., frequencies) and comments were analysed using a content analysis approach.

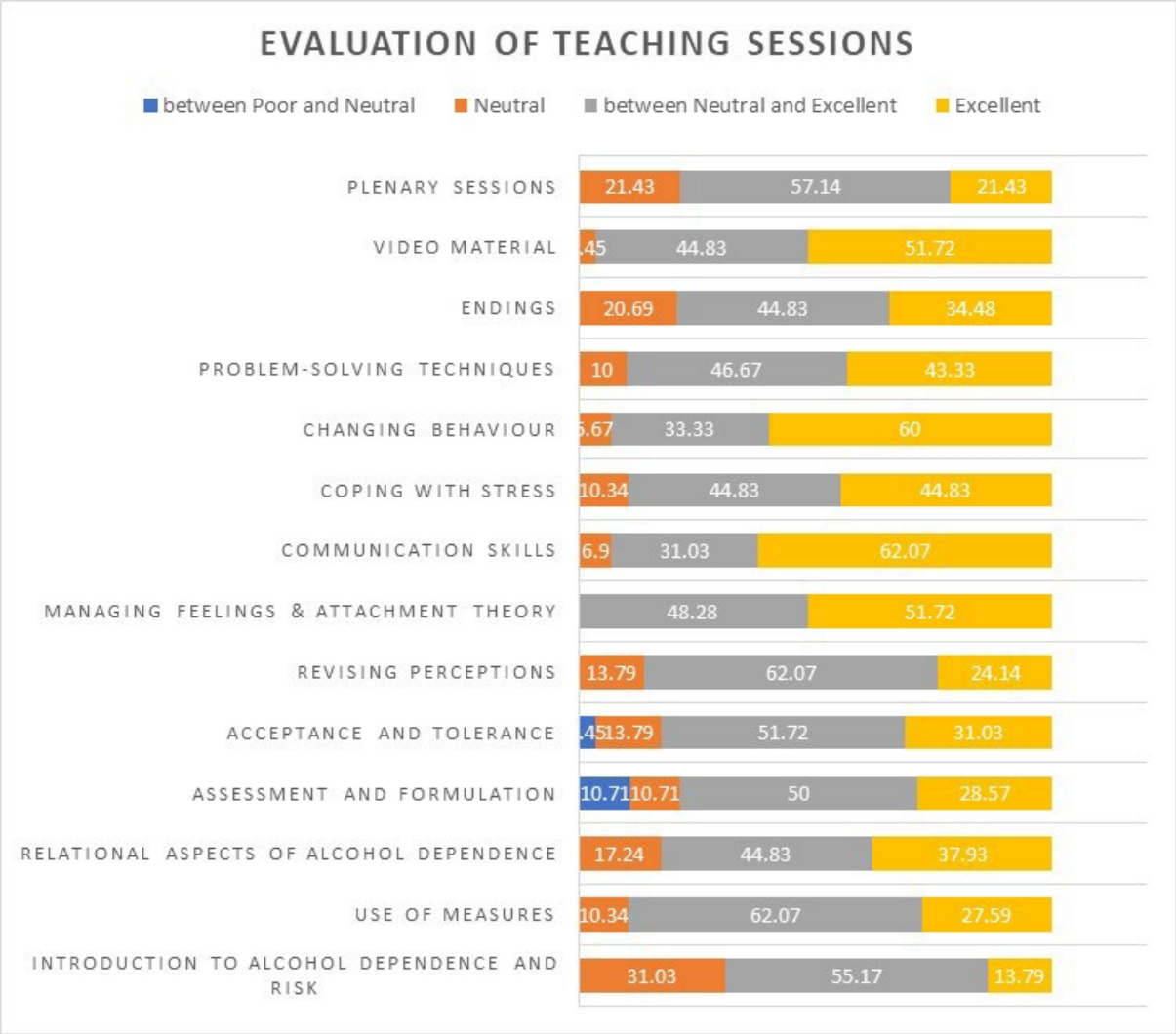
Findings

A total of twenty-nine participants and one observer (11 from London, 12 from Bristol and 7 from Leeds) completed the BCD-AT end of training evaluation forms on Survey Monkey. These show that the majority (60%, n=16) of the participants were very satisfied with the training, a further 40% (n=12) were "completely satisfied", 7% (n=2) "satisfied", and none were "dissatisfied".

Teaching sessions

Participants were asked to rate 14 different aspects of the teaching. Sessions rated most highly were those on 'changing behaviour', 'communication skills', 'managing feelings', and 'attachment theory'. The most poorly rated sessions were those on 'assessment and formulation' and 'acceptance and tolerance'.

Figure 4. Feedback on the teaching sessions



The most liked aspects of the training

Twenty-six participants provided comments on the training. Out of these, 13 (50%) participants noted that the training was well designed and delivered by experienced trainers and facilitators. For example, "*Loved the experience and the knowledge of trainers. Great range of course materials*", "*Relaxed ways of delivery*", "*A good balance of theory and discussion time*", and the trainers "*used the knowledge of their own professional lives and those of the participants to enrich the programme which brought it to life*".

Eleven (42%) participants enjoyed the group discussions which allowed participants to share and learn experiences with each other. For example, "*Range of skills in the room – great discussions and opportunity to explore different perspectives*", and "*…discussion time. There is a wealth of different experience in the cohort which enriched the learning".*

The role plays were particularly liked by 10 participants (38%). For example, "*Role plays were very helpful*", "*Role plays. I think being video[e]d – though challenging – will be very useful (especially rating myself and then having the supervisor rate me)*".

There was also appreciation (*n*=4) of the skills and techniques that they had learnt from the training. For example, "*MBT techniques and exercises that we can offer couples. Formulation supports all the work*", "*Learning specific skills and techniques*", and "*Listening to examples of interventions and how to ask questions etc.*" Reflecting the high ratings on the questionnaire, three participants also commented on the value of the communication skills element, "*Communication skills – made me realise how much more … it is in working with couples*" and "*Communication wheel, tools*" and three also commented on the attachment theory content, e.g., "*looking at genograms and attachment styles and how this impacts on their current relationship, dynamics and alcohol*".

Areas of the training that could be improved

Areas for improvement identified by participants, based on 26 responses, included, a suggestion that the training should be longer/ more days (ten participants). For example, "*A lot of information to take in, possibly split over 5 days*", "*more time to explore tools*", "*Sex role playing session was too rushed – unable to give feedback or receive feedback*", and "*It was a fast learning pace, not enough time to process*". Six (23%) participants suggested including more role plays, e.g., "*More role playing to practice the exercises and learnings*", "*Video or live role play of a couple of interventions*", "*demonstration how formulation is done. Role play maybe*", and "*Formulation – did not understand. Would have been facilitators to role play that rather than supervision*". Five (19%) participants commented that they would prefer some changes of the format in the training. For example, "*I really struggle with concentrating for long periods of time on PowerPoint*", "*Probably aim for less content and more elucidation of skills/concepts. Less doing more thinking/reflecting*", and "*For it to be more interactive*".

Impact of the training

The majority of participants reported an improved understanding (60%; *n*=18) or a great deal improved (37%; *n*=11) understanding of alcohol dependence on relationships following the training; 3% (*n*=1) did not report any improvement of understanding. Similarly, the majority of participants reported they had improved (23%; *n*=7) or had improved a great deal (77%; *n*=23) their understanding of couple dynamics following the training.

A total of nineteen (79%) participants noted in their comments that they had gained the knowledge of how to work with couples. For example, "*Focus on the relationship between – always return to this. To support couples to improve communication and empathic joining have this aim in mind*", "*To listen and take time to think before moving on with the couple*", "*Couples relationships quite complex. Need to be sensitive and diplomatic to be able to balance the emotions*", and "*Remember the couple is the client. Focus on relationship*". Five (21%) participants stated that they were now the confident in working with couples, e.g., "*Confidence in working with couples in a specifically therapeutic way linked to alcohol*

dependence" and "*Confidence I can work with couples*". Three (13%) participants pointed out the importance of couple therapy. For example, "*The importance of working with the couple, rather than just the partner/family member or substance user, and how each impact on each other*" and "*The importance of couple work when resilience building and supporting substance prevention*".

Suggestions for future BCT-AD practitioner training courses

Participants highlighted a number of ways the training could be improved (based on 23 responses). Eleven (48%) participants suggested providing more content, including "*To bring in something more around talking about the children*", "*More homework*", "*Maybe more of a cultural aspects, how this may work with different communities*", "*More work around formulation and offering more clear examples*", and "*I feel it would have been beneficial to use a case example from day one throughout the training, possible use of the one we had for the recording session"*. There were also comments around opportunities for "*more group discussion*", and "*more practice in group for the whole process eg: assessment, individual sessions and future sessions*".

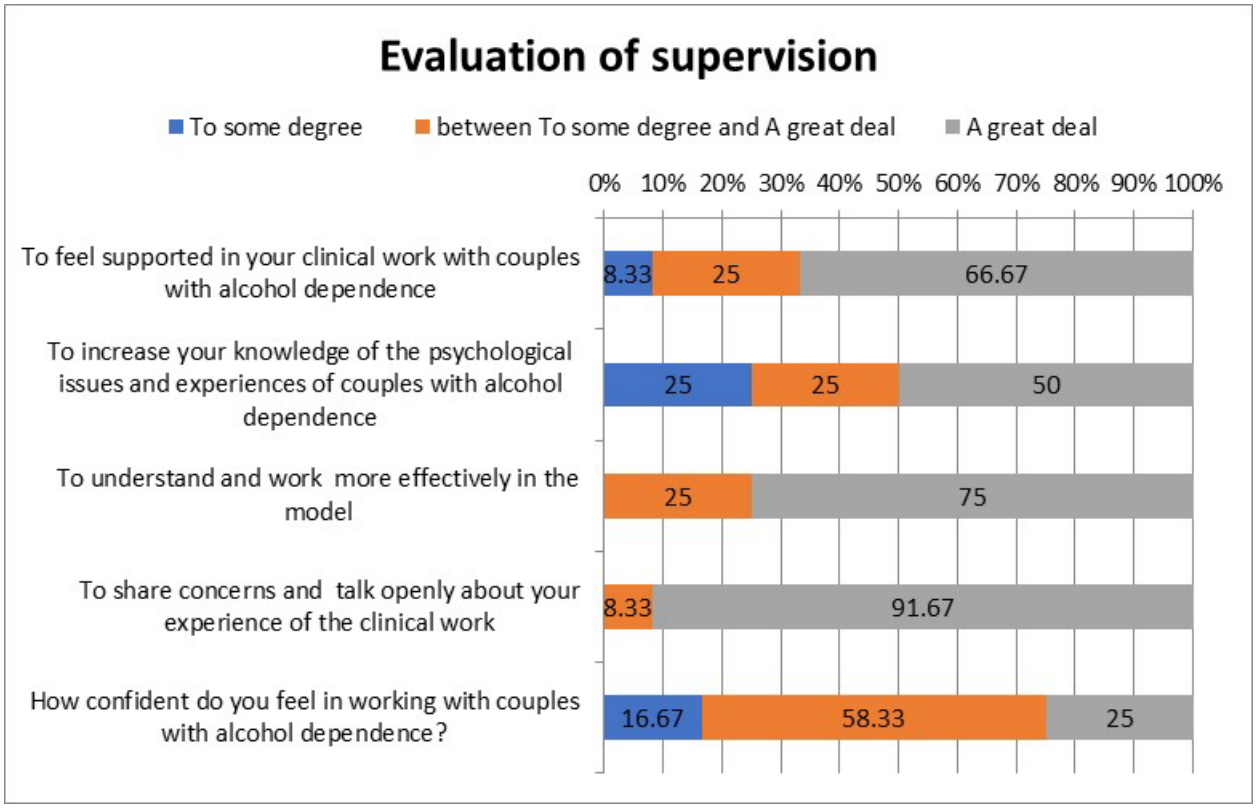
Some (*n*=5; 22%) participants suggested the course should be longer. For example, "*It would be better if [we] had more days on training, so that we could've put our learning into role plays*" and "*Maybe add another day*". There were also comments about the need for a clearer introduction to the training at the start (*n*=3; 13%) so there was a clearer overview of the course e.g., "*I think explain a little more about the model at the beginning. It would have helped me to have a vague shape of it in my head to build on as time went on*".
Other participants (13%; *n*=3) mentioned the value in separating role plays from the learning, e.g., "*The video role play to be separate not when learning is continuing as there was no time for a debriefing after*" and "*Maybe have the video role play as a separate item as it was difficult to come and go out of the classroom and concentrate when returning mid-session*".

Evaluation of the supervision sessions

Twelve practitioners responded to a survey, which consisted of rating five questions on a 5-point scale (where 1="*Not at all*" to 5= "*A great deal*") about their experience of the supervision and an open-ended question inviting their comments.

As Figure 5 shows, more than half of the practitioners felt that the supervision group helped a great deal in their clinical work, knowledge, effectiveness, and sharing concerns.
Responses were least positive around how confident participants felt in working with couples with alcohol dependence - with 25% feeling 'a great deal' of confidence, 58% feeling 'between some degree and a great deal' and 17% feeling confident just 'to some degree'.

Figure 5. Feedback on the supervision sessions



Eight practitioners provided further comments. In general, these practitioners felt that the supervisor was very supportive, and the supervision group provided a place to talk openly about any issues that arose in their therapy sessions. For example:

> *"It is a fantastic place to speak frankly about how things are going, whether this is good or bad. The supervisor is very experienced and always has a solution for any issues that we have. I feel that the group is very supportive and has helped me tremendously."*

> *"I found this slow at first but as it went on the support became stronger. I felt that I could bring any issues I had including not feeling confident in some areas of the work and also around the huge challenges I faced throughout the process with a lack of support in other places that made the work really difficult."*

> *"Really enjoyed hearing the others in the groups work and how they progressed with their couples. The supervisor's wealth of knowledge that implemented the model more into my mind when working with couples and also the confidence to do this.".*

Semi-structured interview findings

Three practitioners who attended the BCT-AD training and successfully recruited parents to attend therapeutic sessions, took part in semi-structured interviews, providing more detailed insight into the training, supervision and implementation of BCT-AD.

Echoing the training feedback forms, the practitioners were positive about the materials and delivery of the training, but also found that there was a lot to take in over 4-days with little time to consolidate learning.

"we did a couple of days, a little break, and then another couple of days… I wonder if actually we could have done with that fourth day being something like a three-month follow-up as a means to trying to cement some of the things that had been taught"

"The training contained lots of helpful information and was delivered by experienced therapists which offered both a strong theoretical framework and practice experience. The opportunity to work with actors on a role play exercise, though slightly anxiety-provoking, was a valuable part of the training and gave a good run-in to how it might be to work with couples in practice. The feedback given by supervisors was thoughtful, meaningful and gave me a good indication of what skills to develop".

In terms of supervision, the two practitioners found the supervisor highly experienced, the supervision of a high quality, and valued hearing the experiences of others in the group setting.

"The shift to working therapeutically with couples was challenging but felt contained by effective and helpful supervision. Fortnightly sessions felt like a proportionate amount and once or twice it was necessary for me to contact my supervisor outside of these sessions when she was responsive and helpful. I feel that in a relatively short time, I have built strong working relationships with my supervisor and fellow supervisees and this, in turn, has supported my practice. Supervision sessions feel safe and afford me the opportunity to talk openly about what I am experiencing in the couple work so that I can effectively deliver the model".

However, there were concerns that the supervisions were quite stretched for time.

"… It never quite felt enough time really and I think it puts lots of pressure on everybody, including the supervisor in terms of trying to get through the sessions and to do all the other bits alongside as well. It's quite pressurised."

These pressures were echoed more widely across the project, in terms of managing the conflicting priorities of delivering the project and managing the day-to-day challenges of working in terms of the demands "*of what practitioners have been dealing with, particularly*

in terms of lockdown, the COVID crisis etc … I'm not sure that's really been fully appreciated".

Suitability of the training to different practitioners

One of the practitioners drew on a background in family therapy and trained at a systemic level and was used to working with couples in a therapeutic session.

"I had done some couples work with a colleague in another organisation… This coincided really with interparental conflict, or reducing parental conflict rather, work starting off as a whole."

This practitioner suggested practitioners without this kind of experience may find it difficult to switch from individual to couples' therapy.

"It's quite a different skill set, I think, from working to an individual to working with couples. I think there's a lot more to juggle in the room and, as good as the training was, I'm not sure it really equips enough people. Supervision, too… I'm not sure it really addresses that effectively."

One of the practitioners acknowledges that a barrier to practitioners' success in engaging and achieving their desired goals in the project was the time gap between attending the training and referrals coming through. This delay (sometimes up to six months) meant that the skills learnt during the training were not 'fresh' in practitioner's minds and required additional work on the part of often already strained practitioners.

"the struggle has been, because referrals have been so slow and difficult, you come into the work four, five, six months after doing the training and therefore trying to have some fidelity to the model and what you've been trained is actually… It's not difficult exactly, but it takes a bit of extra work"

This barrier was anticipated by Tavistock Relationships through maintained contact with practitioners about the need for referrals and had managers co-sign the application for training to say that they would ensure support for the trainee and referrals coming through.

Barriers to parental engagement

When asked about potential barriers to parents engaging with the intervention one of the practitioners reflected that there was a general reluctance to engage in couple therapy, on the part of service users, for a variety of reasons, including *"something about the stigma of alcohol use and the potential shame around it which leads people to seek individual treatment as opposed to couple or joint treatment".*

Another practitioner suggested that "*commissioners don't think systemically and don't see*

relational work as a stand-alone option, despite the evidence, so it really is a cultural issue."

This practitioner described the way in which the male partner (the high-risk drinker) in a couple he had been due to see, opted to do "*some individual work and he was very happy to be doing that… His partner, who was female, wanted to do the couple work, but he wouldn't engage in it."* The practitioner also described some of the practical challenges, particularly amongst those with young children, when work and other priorities are competing for attention.

Strengths of the intervention

Despite these barriers, this practitioner successfully worked with two couples using the BCT-AD approach, initially face-to-face and utilising Zoom due to the restrictions put in place due to the Covid-19 pandemic. Both practitioners noted that the use of Zoom had actually acted as a facilitator to parents engaging with the therapy:

"a couple I've worked with have sought to call in via Zoom individually [joining the sessions via different Zoom accounts] initially because they felt that was more helpful to them, to have that space. So, they felt that they could be separated out a little bit and that was more helpful to them."

"I have been able to work face-to-face with one couple who started after the strictest lockdown measures eased and I have found this more comfortable and accessible than working remotely via Zoom. However, working with zoom and being able to be seen and heard at a time of family stress was particularly important for some, especially during lockdown when family life might have felt more strained."

A strength of the intervention that acted as a facilitator for parents was the focus of BCT-AD on the positive steps that individuals can take to change their drinking behaviour, rather than on the individuals' negative drinking behaviours, thus removing some of the stigma around drinking clients' habits.

"it isn't on the individual so much or their drinking, you're seeing it as a symptom as opposed to the problem unto itself and again… I think that's something that's quite liberating as well rather than being a stick to beat people over the head with"

One of the couples that this practitioner worked with had responded very well to the BCT-AD sessions and had demonstrated positive steps forward in their relationship despite difficulties arising in their relationship.

"I think their relationship is in a different place, as in a more positive place, as a result."

"they keep finding a value in it and it has created shifts for them. So, it clearly is effective for them and I think it has allowed them to see and challenge some of their patterns of behaving and interacting with one another."

Another practitioner described the progress a couple had made as a result of the intervention:

"The female partner in the couple felt belittled in her role and for the first time ever was able to speak openly about this. Her male partner was able to listen and give her positive feedback on the spot. I guess that might have been achieved for her in individual work but I think the power of doing this as a couple generated a real shift…The couple talked about their past relationships and think about patterns linking back to their upbringing, patterns that they inhabit now that relate back to their parents' conflict where alcohol played a role also.

They could discuss things with more light and less heat and I could pick up if one of them felt wounded as it happened and we could sort it out. He needed to talk about the legitimacy of being a step parent and up until now had not found a language to talk about it… They could begin to have a dialogue about stuff and I'm not sure where else they could have done it…'

One of the practitioners reflected on the usefulness of the BCT-AD intervention in benefitting the children of clients that they worked with.

"Parents could join to work together for the sake of their children who were suffering from the conflict between them. This idea united them as they want the best for their children, and it helped them accept that working together to reduce conflict made sense. It provided a useful grounding for BCT-AD."

"One couple I worked with were scapegoating their child, who the school reported as behaving badly. The model provided me with a framework to put that to one side and focus on their conflictual relationship that I felt was contributing to the child's problems at school."

This practitioner commented on the useful tools contained within the intervention, that helped both the practitioner delivery of the model and the parents receiving it.

"In training, I was excited to implement the model with couples and I have found it a useful framework in which to do the work. In particular, I have found some of the suggested exercises helpful in supporting couples with their communication. One couple were frequently in conflict during the first few sessions and found it difficult to balance expressing themselves with actively listening to the other. The communication exercises (listening exercise and communication wheel) offered a containing way for each of the couple to take

up space in the session and perhaps help them both feel held and contained by me instead of potentially being in competition for showing "how bad" the other was".

Evaluation limitations

For the reasons cited in the delivery challenges section above, it has unfortunately not been possible to collect sufficient data from training cases seen by the practitioners who attended the BCT-AD training. This limits the conclusions we can draw about the impact of the BCT-AD training on practitioners and on parents who participate in the therapy.

4.4 Conclusions

Overall, participants were positive about the BCT-AD training. They were satisfied with the training experience, felt that they had increased their understanding on alcohol dependence on relationships, and couple dynamics. The teaching sessions were well-received, and none of the participants rated any aspect of the teaching as poor. More than half of the participants rated the teaching of "*managing feelings & attachment theory*", "*communication skills*", "*changing behaviour*" and "*video material*" as excellent. These ratings were reflected in the comments provided by the participants at the end of the form. The majority of the participants reported that they had improved their knowledge of how to work with couples and were positive about the design and delivery of the training. Areas for improvement noted by participants included adding more time for the training and supervision and more role plays.

Although the training was viewed positively, participants' confidence in working with couples experiencing alcohol dependency was somewhat low. This may be a result of the difficulty in finding couples to work with in some services which prevented trainees being able to embed the model within their practice and competency, something that can be achieved over time. As noted by one of the practitioners who was interviewed, and feedback from the Tavistock Relationships staff who delivered the training, that may reflect lack of experience in couple work, a need for further training, or the time-lag between training and working with couples.

The findings show that there is appreciable appetite among workers in alcohol services for training to work with couples, and couple distress, in the context of alcohol dependence. More than a year on from the last of the three trainings in BCT-AD, Tavistock Relationships are still receiving requests from alcohol service practitioners about the training. However, it is also apparent that services are not set up in such a way to facilitate such work.
It is also the case that relatively few of those working in alcohol services have sufficient counselling training to be able to work with couples in the way set out in the BCT-AD model. Until and unless services are commissioned to work specifically with couples, and until services place more emphasis on the core counselling skills of their staff, it is hard to see this situation changing.

Where practitioners have been able to work with couples in their services using the BCT-AD model the feedback has been positive. An interview with one of the practitioners who had managed to recruit two couples to engage in BCT-AD reflected that although there were substantial barriers to engaging parents, such as a reluctance to engage in couple therapy and stigma around alcohol dependency, they noted that when couples did attend sessions the outcome was positive.

5. Summary and conclusions

5.1 What have we learnt?

Frontline practitioner training

Overall, practitioners saw significant improvements in their knowledge and confidence in working with parents where alcohol use is a problem, in their knowledge and confidence around problematic alcohol use and the couple relationship, and the impact of couple conflict on children. There were also significant improvements in their confidence in opening up conversations about alcohol and conflict and in identifying and responding to harmful alcohol use. While the absence of follow-up data means that we cannot gauge the impact of the training on practice, feedback forms suggest that practitioners saw value in the resources that had been discussed during the training and intended to use them in their practice.

'Coping with Stress and Drinking' digital resource

Reach and engagement with the resource was disappointing. Of 1482 unique users who came to the resource's title page only 295 went on to the '*Is this for me?*' page to obtain further information. However, the majority (67%) of users who progressed beyond the introductory page went on to the rest of the resource, suggesting that the course effectively sustained engagement amongst users who made it past that first page. This is echoed by feedback from the case study parent, who found the resource engaging, accessible and easy to use, as well as comments from practitioners, who also found the content and messaging appealing.

Feedback from our case study indicates that the content helped to normalise experiences and provide a means of understanding interactions in couple relationships. It also demonstrates that it is possible for a user to learn techniques to manage conflict and communication in their relationship through modifying their behavioural responses.

We lack insights from potential users about why there was so little engagement with the resource. Experience from other projects highlights the importance of practitioners providing a supported referral. Without practitioners referring parents to the resource in this project, were no mechanisms in place to drive parents to it through, for example, different social media channels. However, the positive feedback of the case study user highlights potential for this to be a standalone resource if we are able to find ways to signpost users to it.

In addition, feedback from practitioners suggests that the messaging may not have been sufficiently clear. For those who did find their way to the resource, one barrier to engagement may have been confusion about the target audience for the resource, and

whether the stress messaging was too prominent. One practitioner that we spoke to highlighted that her and a colleague had differing views on what the resource focussed on most, something that was backed up by our analytics in which drop off was highest on the page where users were able to read what the resource was about.

Practitioners were positive about the different ways in which the resource could be used with parents, depending on level of need. However, they also talked about the challenges of staying on top of the volume of new resources being shared with them, meaning that even seemingly useful resources are not picked up. This highlights the need to ensure new interventions are marketed in an engaging way to practitioners. Perhaps utilising co-production and co-design to ensure that the right groups of practitioners are involved and 'on board' before the resource goes out itself.

BCT-AD training

Overall, participants were positive about the BCT-AD training. They were satisfied with the training experience and felt that they had increased their understanding of alcohol dependence on relationships, and couple dynamics. The teaching sessions were well-received, and none of the participants rated any aspect of the teaching as poor. Areas for improvement noted by participants included adding more time for the training and supervision and more role plays. As noted by one of the practitioners who was interviewed, more experience in couple work, further training, less time-lag between training and working with couples and more couple referrals generally are needed in this sector.

The findings show that there is appreciable appetite among workers in alcohol services for training to work with couples, and couple distress, in the context of alcohol dependence. Where practitioners have been able to work with couples in their services using the BCT-AD model the feedback has been positive. However, challenges in recruiting parents suggest that services are not set up in such a way to facilitate such work. In addition, relatively few of those working in alcohol services have sufficient counselling training to be able to work with couples in the way set out in the BCT-AD model.

5.2 Learning from the challenges and limitation

There were multiple challenges in rolling out the 'Coping with stress and alcohol' digital resource for parents, which persisted throughout the course of the project. In the first instance, the frontline practitioner training was rolled out before the resource was ready which made it difficult to ensure that practitioners acted as the referral link to the resource. Timing aside, we may have been more successful at securing practitioner engagement if we had better understood how a digital resource might sit within their existing workflows. For example, we had limited understanding of practitioners' needs, what resources they would consider sharing, and what digital services they were actually using.

Other attempts to work with practitioners were also thwarted. Despite support from managers we were unable to form bridges with practitioners on the ground in Innovation Fund areas. We trained a cohort of Family Support Workers in Haringey to share the resource with families, but they were unable to do this as the COVID-19 lockdown was imposed shortly after their training. However, discussions with professionals (e.g., Public Health England, Westminster forum) and managers in Local Authorities, pointed to significant interest in the digital platform. Practitioners interviewed about the resource were positive about its potential and could envisage using it in different ways depending on parents' level of need.

Previous projects addressing interparental conflict and communication have demonstrated significant reach and engagement when resources are placed in trusted online platforms for independent use and when resources are shared by and used with a trusted practitioner. For example, our 'See It Differently' (Good Things Foundation & OnePlusOne 2020) resource, which was a digital resource designed to reduce parental conflict and improve communication, was placed on trusted social media platforms and achieved a reach of 834797 views. When used by trusted practitioners in community settings, the same resource achieved positive impact on parents' conflict and communication behaviours.

Similarly, our 'Me, You and Baby Too' (Hirst & Reynolds 2020) resource achieved extensive reach when placed on a trusted app, Baby Buddy, and when used in a blended practice with practitioners we received positive feedback from practitioners not only about parent awareness and behaviour change, but also the integration of resources into their existing interventions. Connecting parents to the 'Coping with stress and alcohol digital platform' in the future is likely to involve identifying key groups of practitioners, such as public health professionals, working with our target audience of parents.

5.3 Conclusions and recommendations

The I-CADeP programme as a whole provides a continuum of support for couples struggling to varying degrees with conflict and problematic drinking. Good take-up, engagement and satisfaction with frontline training and the more specialist BCT-AD training illustrates an appetite amongst practitioners to develop their capacity to support couples caught in cycles of alcohol misuse and conflict. We were not able to gauge the extent to which practitioners were able to implement what they learned, although practitioners did state they intended to use their learning to inform future practice

Low take-up for the digital platform and the difficulties practitioners faced in recruiting couples to undertake the BCT-AD programme both indicate the challenges in engaging target parents. Putting to one side many of the practical obstacles that both strands encountered, there may also be issues around how alcohol misuse and couple relationship difficulties are framed and owned which compounded recruitment difficulties, both for potential service users and services themselves.

Digital offer

Digital support is attractive because it is accessible, flexible and anonymous. COVID-19 makes digital support even more timely as individuals and families face greater isolation, stress, and obstacles to obtaining face-to-face support. Experience on other projects indicates that online resources such as these have an important role to play in providing support but connecting with target audiences can be challenging (e.g., Good Things Foundation & OnePlusOne 2020; Hirst & Reynold 2020). Our experience on this project suggest this is even more difficult when combining the issues of couple conflict and alcohol use.

Next steps are to explore viable options to support parents to use the resource individually or with a practitioner. The former means identifying trusted online locations in which to place the resource and signpost parents. The latter means identifying practitioner groups working with our target audience. That might mean, for example, public health professionals or others providing universal support who are well-placed to signpost individuals to the resource. It may also mean developing a more targeted training offer focused on defined groups of practitioners, as we sought to do with Family Support Workers, who will actively support parents in engaging with the resource as opposed to solely signposting.

As well as being clearer about which groups of practitioners are best placed to work with our target groups, the findings also highlight the importance of adopting a co-production approach with practitioners. For example, we are applying this learning to our Foetal Alcohol Spectrum Disorder project which we are rolling out in close collaboration with a midwifery team. By engaging practitioners to have conversations with parents-to-be about alcohol whilst also placing the resource in a place where these parents-to-be go (a webpage that all parents-to-be in the local authority area are referred to and need to access for up to date info) we are maximising reach to our target audience and offering a stepped universal early intervention.

Reaching a broader audience of practitioners means, in part, addressing the ways in which they can feel overwhelmed by the volume of resources coming across their path. Remedies could include working more closely with umbrella organisations, such as practitioner bodies, to curate targeted lists of resources with simple crib sheets explaining relevance and use. Brief webinars or other live online training could also be offered, which would minimise the impact on practitioners' time.

Future research

Future research could address the following questions:

- What impact did the frontline training have on practitioners' practice and the parents with whom they work?
- What were BCT-AD trained practitioners' experiences of using the approach with couples? What impact did it have on couples they worked with?

- What could be done to address systemic barriers in services to working with couples as opposed to individuals presenting with harmful alcohol behaviours?

In term of the digital resource:

- To what extent does the resource improve users' ability to cope with stress, manage conflict and reduce modify alcohol use?
- Is it possible to reach our target audience of parents by putting the resource on trusted online pages, supported by a marketing strategy that drives parents to the resource?
- Is it possible to increase practitioner engagement with the resource, and use with parents, through greater co-production and synergy with training?
- Are there other groups of practitioners, such as public health professionals, who are better placed to signpost parents to a resource? What are the best ways to identify and work with such practitioners?

Conclusions

The I-CADeP programme as a whole sought to provide a continuum of support for couples struggling to varying degrees with conflict and problematic drinking. The findings from this project point to both the opportunities and challenges involved in delivering such support. The former, such as the appetite for training amongst practitioners and the role for a digital resource highlight the value in continuing to develop a broad offer. The challenges, however, highlight the need to think creatively as to how to overcome obstacles such as system level changes in NHS services and reaching those parents most likely to benefit from a digital intervention. The learning from this project provides some useful insights into how to begin to address those challenges and continue to develop much needed support for families.

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Appendices

Appendix A. Logic Model for the Evaluation of the Digital Resource

	Indicators	**Means of verification**	**Assumptions**
Goal / impact • Improved well-being for children of alcohol dependent parents (this is a long term goal/ impact and one that we will not be able to assess in this short 1 year period)	•	•	•
Outcomes • Parents more able to cope together with stress (dyadic coping) • Parents reduce use of destructive conflict behaviours • More effective communication • Reduction in harmful drinking • Parents aware of nature and consequences of IPC (i.e., on them, on partner, and on child) • Practitioners able to recognise IPC and able to facilitate discussions with parents	• Reduction in self-report stress and increase dyadic coping • Changes in self-report/ identification of conflict styles • % increase in effective communication behaviours • % increase in perceived partner support • % increase in attentive parenting	• Post-test questionnaire (compare to pre-test) • Qualitative follow-up interviews with parents • Post-course questionnaire	• We will have access to parents for follow up interviews (including appropriate time scales) • Functionality of the digital tools to collect appropriate data • Engagement of practitioners to refer users • Retention of users (high risk of attrition due to alcohol use)
Intermediate results • Parents are aware of the relationship between drinking and stress • Parents understand how they react individually to stress and their individual conflict & communication styles • Parents aware of effect of stress on relationship and how to communicate stress • Parents motivated to change relationship behaviours • Practitioners aware of association between IPC and impact on child	• Uptake of digital intervention following referral • Active engagement with goal setting • % Agreement/ knowledge answers to questions about the knowledge and understanding that they have taken from each session • Increase from pre-post training awareness (practitioners)	• Touch point end of session questions • Analytics to monitor and measure engagement with the digital tool. • Active goal setting and revising at beginning of each session	• Functionality and usability of digital tools. • User engagement in intervention & data collection • Practitioner engagement with training
Outputs • Practitioners trained to identify IPC and alcohol use, and make appropriate referrals	• Practitioners engaging with practitioner platforms • % practitioners acquired necessary skills & knowledge	• Data analytics • Pre-post training questionnaires	•

Appendix B. Information sheets and consent form

Consent form

Your name:	**Your contact details:**
Consent taken by:	**Date:**

The research

OnePlusOne have developed the Coping with Stress and Alcohol programme, a resource for couples for whom stress in their relationship is associated with alcohol use. We are now following up with people who have used the resource and are doing some research to learn more about your experiences of using the resource.

How we would like to use your interview

We would like to understand your experiences better. The information you give us will be made anonymous (we will not use your real name), but we might want to use the information you give us as a case study for publication online.

How we store your data and for how long

We keep a complete policy that explains this in detail (Our Research Data Retention Procedure and Data Processing by External Suppliers policy). In this policy, we outline how we process all research data, including recorded audio interviews – which a staff member at OnePlusOne will happily discuss upon request. In summary, all data can only be accessed by members of the research team at OnePlusOne, and we will not share personal data with any external parties. These audio recordings fall into the permanent preservation category and will be transferred to an archive after three years from project completion; however, participants are able to request that their data is deleted at any time, when data is deleted it must be non-recoverable. All data, audio and transcriptions, will be stored on secure servers in the UK.

□ *I agree to take part in an interview with OnePlusOne*
□ *I agree to this interview being recorded.*
□ *I agree to the things that we discuss being used by OnePlusOne for their evaluation report to be submitted to the DHSC and DWP.*
□ *I agree to OnePlusOne keeping my details in their private database for a maximum of two years from the publication date.*
□ *I understand that all data will be made anonymous and my own contributions will not be able to be identified from others.*
□ *I understand that OnePlusOne will not pass my personal details to anyone else.*
□ *I agree to OnePlusOne contacting me in future, only about this research.*
□ *I understand that I am free to withdraw from the interview at any time without having to say why.*

Signed: _____

Date: _____

Appendix C. Frontline Practitioners: Pre- and Post-training questionnaires

Reducing the impact of inter-parental conflict on children in families affected by alcohol dependence: pre- and post- questionnaire

East London training – 28th February & 1st March

Your role:

Prior to attending this training course:

On a scale of 1 – 10 (where 1 is not at all aware):
How would you rate your awareness of the impact of parental drinking on couple conflict?

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

On a scale of 1 – 10 (where 1 is not at all aware):
How would you rate your awareness of the impact of couple conflict on outcomes for children?

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

On a scale of 1 – 10 (where 1 is not at all aware):
How would you rate your confidence in opening up a conversation about conflict and harmful alcohol use with parents?

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

On a scale of 1 – 10 (where 1 is not at all aware):
How would you rate your confidence in identifying and responding to harmful alcohol use?

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

On a scale of 1 – 10 (where 1 is not at all likely):
How likely are you to signpost parents to online resources?

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Reducing the impact of inter-parental conflict on children in families affected by alcohol dependence: pre- and post- questionnaire

East London training – 28th February & 1st March

Your role:

Having attended this training course:

On a scale of 1 – 10 (where 1 is not at all aware):
How would you rate your awareness of the impact of parental drinking on couple conflict?

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

On a scale of 1 – 10 (where 1 is not at all aware):
How would you rate your awareness of the impact of couple conflict on outcomes for children?

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

On a scale of 1 – 10 (where 1 is not at all aware):
How would you rate your confidence in opening up a conversation about conflict and harmful alcohol use with parents?

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

On a scale of 1 – 10 (where 1 is not at all aware):
How would you rate your confidence in identifying and responding to harmful alcohol use?

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

On a scale of 1 – 10 (where 1 is not at all likely):
How likely are you to signpost parents to online resources?

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Appendix D. Coping with stress and alcohol platform measurement instruments

Audit

1. How often do you have a drink containing alcohol? Never

Monthly or less
2 to 4 times per month
2 to 3 times per week
4 times or more per week

2. How many units of alcohol do you drink on a typical day when you are drinking?

0 to 2 3 to 4 5 to 6 7 to 9 10 or more

3. How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?

Never
Less than monthly
Monthly Weekly
Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

Never
Less than monthly
Monthly Weekly
Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of your drinking?

Never
Less than monthly
Monthly
Weekly
Daily or almost daily

6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?

Never
Less than monthly
Monthly Weekly
Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking? Never

Less than monthly
Monthly Weekly
Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never
Less than monthly
Monthly
Weekly
Daily or almost daily

9. Have you or somebody else been injured as a result of your drinking?

No
Yes, but not in the last year
Yes, during the last year

10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?

No
Yes, but not in the last year
Yes, during the last year

DCI (short form)

This scale is designed to measure how you and your partner cope with stress. Please indicate the first response that you feel is appropriate. Please be as honest as possible. Please choose the response that best fits your situation.

1-Never/ very rarely 2- rarely 3- sometimes 4- often 5- very often

When my partner is stressed...
I show my partner I understand how they are feeling.
I let partner know that I am on their side.
I listen to my partner and give them space and time to talk about what really bothers them.
I tell my partner that their stress is not that bad and help them to see the situation in a different light.
I look at the problem with my partner and try to help them find a solution.

What do you think of your coping as a couple?
I am satisfied with the support I receive from my partner and the way we deal with stress together works for us.

PSS-4

The questions in this scale ask you about your feelings and thoughts during THE LAST MONTH. In each case, please indicate your response by choosing the number that represents HOW OFTEN you felt or thought a certain way

1-Never 2-Almost never 3- Sometimes 4-Fairly often 5-Very often

1. In the last month, how often have you felt that you were unable to control the important things in your life?

2. In the last month, how often have you felt confident about your ability to handle your personal problems?

3. In the last month, how often have you felt that things were going your way?

4. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

Appendix E. Coping with stress and alcohol practitioner guide feedback form

'Coping with Stress and Alcohol' practitioner guide evaluation questionnaire

Now you have read the 'Coping with Stress and Alcohol' guide, we would like you to answer the following questions to help us assess how useful this resource is. Each statement offers a numerical scale for you to use to report your current knowledge and confidence.

1. What is your work email address?
2. What is your employing organisation?
3. How did you find this resource?

	Strongly disagree - 1	Disagree-2	Neutral-3	Agree-4	Strongly agree - 5
I understand how different types of stress can impact relationships.					
I am aware of how dyadic coping can improve a couples' ability to cope with stress and reduce alcohol use.					
I understand how stress can influence drinking behaviours.					
I feel confident in supporting couples to develop their ability to communicate their stress.					
I feel confident in supporting couples to develop their empathetic listening skills to improve dyadic coping.					
I feel confident working alongside couples to help them improve their ability to cope with stress together.					
I am aware of the different types of destructive conflict.					
I feel confident providing support to couples in developing constructive communication skills.					

9. What did you find most useful about the handbook?

10. What did you find least useful?

11. Do you have any other comments on the content of the handbook?

We would like to speak to you to better understand your experience of using the 'Coping with Stress and Alcohol' practitioner guide and parent resource. If you are happy for us to contact you in two months for a short telephone interview, please tick this box.
Thank you for taking the time to answer these questions. Your responses will help us to improve our resources going forward.
For more information on our treatment of your data and all personally identifiable information that we collect or hold go to: https://clickrelationships.org/data-protection-and-privacy/

Appendix F. BCT Post-Training Evaluation Questionnaires

Q1 *How satisfied were you with this training?*

Dissatisfied

Satisfied

Very satisfied

Completely satisfied

Q2 *The training input has improved my understanding of the impact of Alcohol Dependence on relationships:*

Not at all

Yes

Yes, a great deal

Q3 *This training input has improved my understanding of couple dynamics:*

Not at all

Yes

Yes, a great deal

Q4 *Evaluation of teaching sessions:*

Rate the following on POOR (1), between POOR and NEUTRAL (2), NEUTRAL (3), between NEUTRAL and EXCELLENT (4), EXCELLENT (5)

Introduction to Alcohol Dependence and Risk

Use of Measures

Relational aspects of Alcohol Dependence

Assessment and formulation

Acceptance and Tolerance

Revising perceptions

Managing Feelings & Attachment Theory

Communication Skills

Coping with Stress

Changing Behaviour

Problem-Solving Techniques

Endings

Video Material

Plenary Sessions

Q5 *Overall, what take home messages will you go away with today?*

Q6 *What were the aspects of the course that you liked the most?*

Q7 *What were the aspects of the course that you thought could be improved?*

Q8 *Please share any suggestions you may have for future BCTAD Practitioner training courses*

Q9 *Would you be happy for us to use your comments on our publicity if it were anonymised?*

Appendix G. BCT-AD Supervision evaluation form

Self-Reflection on Supervisory Learning Rating Scale

Behavioural Couple Therapy for couple conflict and alcohol misuse

Name:	**Supervision date:**

Briefly list up to 5 aspects of learning that you gained from today's supervision.

Points might vary from understanding more about working with couple dynamics to understanding part of the model, that might not have been clear to you from the original training.

You may want to comment on your experience of working in a group and discussing clinical cases.

There is no right and wrong, this is simply a record of the growth of your learning through each supervision. Can you please send this form to your supervisor after each meeting. We do not anticipate you spending more than 15 minutes on this.

1.

2.

3.

4.

5.

End of Supervision Evaluation Questions

Q1 *Please rate the following questions according to the extent you feel that the BCT-AD supervision group has helped you*:

1 (Not at all); 2; 3 (To some degree); 4; 5 (A great deal)

To feel supported in your clinical work with couples with alcohol dependence

To increase your knowledge of the psychological issues and experiences of couples with alcohol dependence

To understand and work more effectively in the model

To share concerns and talk openly about your experience of the clinical work

How confident do you feel in working with couples with alcohol dependence?

Q2 *Do you have any other comments about the supervised element of the training?*