Helping children with the *Steps to Cope* intervention

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Abstract

Purpose – *The purpose of this paper is to summarise the findings from two projects in Northern Ireland which investigated the feasibility of adapting an existing adult intervention, the 5-Step Method, for children affected by parental substance misuse and/or parental mental illness. The structured brief psychosocial intervention is called Steps to Cope and can be delivered as an individual or group intervention.*

Design/methodology/approach – *The two projects recruited and trained 57 practitioners from across Northern Ireland, 20 of whom went on to use the Steps to Cope intervention with a total of 43 children.*

Findings – *It appears possible to adapt the intervention for children; to train practitioners, some of whom are able to use the intervention with one or more children; and for the intervention to benefit children in line with the five steps of the intervention targeting areas such as health, feelings, information, coping, support, and resilience. However, there are organisational and practical barriers to delivery which need to be overcome for the intervention to be more widely implemented.*

Originality/value – *Steps to Cope is a unique intervention for this population and the findings discussed here suggest that the model has potential in an area where support for children in their own right is lacking.*

Keywords *Qualitative, Children, Resilience, Intervention, Parental mental health, Parental substance misuse*

Paper type *Research paper*

The *Steps to Cope* project is a collaboration between the *Taking the Lid Off* Partnership in Northern Ireland (ASCERT, Barnardo's, and the SE H&SC Trust) and the UK Alcohol, Drugs and the Family Group. Thanks to Gary McMichael (ASCERT); the *Taking the Lid Off* partners and the other members of the UK Alcohol, Drugs and the Family Group (Alex Copello, Akan Ibanga, Jim Orford, and Richard Velleman) for their support of this work, with particular thanks to Jim Orford and Richard Velleman for their helpful comments on a draft of this paper. Grateful thanks are also extended to all the children and practitioners who participated in both projects. The first project was funded by the Public Health Agency, the South Eastern Health & Social Care Trust, and the *Taking the Lid Off* Partnership. The second project was funded by Alcohol Research UK.

Background

Estimates for the UK suggest that there are approaching five million children under 16 affected by parental substance misuse (Manning *et al.*, 2009). Other estimates suggest that 30 per cent of adults with mental health problems, and around 200,000 adults receiving treatment for substance misuse problems, have dependent children (Ofsted and Care Quality Commission, 2013). These are also problems which commonly co-exist and it has been estimated that over three-quarters of a million children in the UK live with an adult who has an alcohol or drug problem and a concurrent mental health condition (Manning *et al.*, 2009).

There is a wealth of research which describes how children can be affected by parental substance misuse and parental mental illness (Adamson and Templeton, 2012; Advisory Council on the Misuse of Drugs (ACMD), 2003; Aldridge and Becker, 2003; Cleaver *et al.*, 2011; Cogan *et al.*, 2004; Houmoller *et al.*, 2011; Reupert *et al.*, 2012a, b; Stallard *et al.*, 2004; Templeton, 2013). Overall, the evidence is unequivocal that children can be extremely burdened, in both the short- and the long term, by their experiences and by the worry they hold for their parents and their family. All domains of individual and family life can be affected. Many children take on caring roles within the family, while others may be cared for temporarily or permanently by other family members or local authorities (Forrester and Harwin, 2011). Other issues are also often present, such as domestic abuse and social disadvantage, which can further compound how children may be affected (Cleaver *et al.*, 2011; Templeton, 2013). A major contribution to the literature in recent years has been an understanding of the protective

factors and processes which it is believed can create "resilience" in a child, thereby reducing the risk of negative outcomes (Cleaver *et al.*, 2011; Sawyer, 2009; Templeton, 2013; Velleman and Templeton, 2007). This has important implications for the development of interventions and services.

Children have a wide range of needs, including wanting to understand what is happening and what is wrong with their parent(s), to feel safe, for their parent(s) to get better, and to meet others who are "like them" (Adamson and Templeton, 2012; Cogan *et al.*, 2004; Reupert *et al.*, 2012a, b; Stallard *et al.*, 2004). However, they also face barriers in accessing support, such as isolation, fear, the secrecy which often surrounds the problems, blaming themselves for the problems, mistrust of professionals, and maintaining loyalty to their parents and fearing separation from them. While there has been a growth in the number of services and interventions developed to support children and families where there is parental substance misuse or parental mental health problems (Drost *et al.*, 2010; Forrester *et al.*, 2008; Goodyear *et al.*, 2009; Hamill, 2008; Harwin *et al.*, 2011; Templeton, 2014; Templeton *et al.*, 2011), there remains a lack of evidence-based support for children in their own right, more so in the area of parental substance misuse.

The needs of children affected by parental drug misuse, parental alcohol misuse, and parental mental illness have been prioritised in Northern Ireland where the research reported here was undertaken. With regards to parental drug misuse the key driver has been the ACMD's Hidden Harm report which highlighted for the first time in the UK the plight of this large group of children (ACMD, 2003); the Northern Ireland response has been extended to cover parental alcohol misuse. National and local action plans outline how to develop a response for these children who have been identified as some of the most vulnerable in Northern Ireland (e.g. Department of Health, Social Services and Public Safety, 2008). The aims of the *Hidden Harm* response dovetail with the six outcome areas of the over-arching *Our Children and Young People* strategy (Department of Health, Social Services and Public Safety, 2006). The needs of children affected by parental alcohol misuse have also been prioritised within Northern Ireland's *New Strategic Direction for Alcohol and Drugs* (Department of Health, Social Services and Public Safety, 2011). The response to families where there are mental health problems is centred on the *Think Child, Think Parent, Think Family* approach recommended by the Social Care Institute for Excellence (Social Care Institute for Excellence, 2009) which recommends a multi-agency, holistic response.

Steps to Cope is a new intervention for children living with parental substance misuse and/or parental mental health problems. It has been developed and introduced in Northern Ireland in response to the recognition of the needs of this group of children in national policy agendas. *Steps to Cope* has been adapted from a brief structured intervention for adult family members, the 5-Step Method, affected by a relative's substance misuse (Copello *et al.*, 2010a; Templeton, 2010), and extended to include children living with parental mental health problems. The 5-Step Method, and hence also *Steps to Cope*, is grounded in theoretical models of stress and coping which liken the experience of those affected by the substance misuse of a relative to living with other chronic and stressful everyday life events and adversities (such as cancer, dementia, or acquired brain injury) (Orford *et al.*, 2010, 2013). In so doing this non-pathological approach is a significant departure from other ways of conceptualising the families of substance misusers as dysfunctional or deficient in some way (Orford *et al.*, 2010, 2013). Furthermore, the model is also unique in concentrating on the needs of family members in their own right rather than, for example, viewing the family member as a vehicle through which to engage the problem user. The adaptation of these theoretical foundations into a practical intervention consists of five main building blocks: namely, stress, strain, information, coping, and support. There has been a lengthy programme of research into the effectiveness of the 5-Step Method which has demonstrated positive outcomes in a number of areas such as health and coping (Copello *et al.*, 2010b; Velleman *et al.*, 2011).

As with the adult 5-Step Method, the *Steps to Cope* intervention guides a professional through five steps to support children (listed below) and is supported by a workbook (given to practitioners when they attend the *Steps to Cope* training course). Practitioners are asked to work through the steps in order although within this core structure there is scope for flexibility according to, for example, individual need, and the number, length, and frequency of intervention sessions needed. The intervention is intended for delivery over a number of

individual sessions between a practitioner and a child, although it is possible to deliver the sessions in a group format or by telephone. Two projects, undertaken in Northern Ireland between 2011 and 2013, have considered the application of *Steps to Cope* with this population, and it is a summary of these two projects which are presented here.

The five steps of the *Steps to Cope* intervention:

- Step 1: What is living with this like for me?
- Step 2: Information about addiction and mental health problems.
- Step 3: Coping with addiction or mental health problems in your family.
- Step 4: Using support.
- Step 5: Further help.

Methodology

Both projects collected a range of qualitative data and these findings are the focus of this paper. The second project included the collection of some quantitative data but this was extremely challenging, and so this paper focuses on the qualitative findings from the two projects. The following qualitative data were collected:

- Professional logs, which recorded basic information about the child and summarised the intervention sessions, were completed each time a practitioner delivered an intervention ($n = 31$).
- Qualitative data, including brief interviews and/or a drawing exercise, according to the preference of the child (Wall and Templeton, 2011) and completed workbooks (shared with the research team with the child's permission), were collected from a sample of children in both projects with varying data available according to how a child wished to provide feedback. In total, 20 children shared their workbooks with the research team (wholly or partially completed), interviews were conducted with six children and five completed the drawing exercise. Practitioners approached children they had worked with to see if they would be willing to meet the researcher during one of her trips to Northern Ireland; interviews tended to brief and to be conducted at the office where the practitioner worked (or another venue such as a school), in some cases the child asked the practitioner to join the interview.
- Qualitative data were collected, using interviews (telephone or face-to-face: $n = 28$) and group discussions ($n = 16$), from practitioners in both projects (some provided feedback on more than one occasion). All practitioners were approached about interviews, and interviews were completed with those with whom it was possible to arrange interviews during the time frame of that phase of the project.

Interviews were audio-recorded unless the interviewee did not agree to this or the researcher felt that this would be inappropriate (e.g. where it was hard to engage a child in an interview). The researcher took detailed notes during interviews; these were written up afterwards with the addition of verbatim quotes from notes or recordings. Analysis was thematic, informed by the aims of the project, the components of the theoretical model and the steps of the intervention, and grounded in the experiences of the participants.

Inclusion criteria

The inclusion criteria for children were that they were aged 12-18 years old, lived with (or had regular contact with) the parent(s) with the alcohol, drug, or mental health problem, and had sufficient capability to take part in the study. Children were excluded if they themselves had serious alcohol, drug, or mental health problems, or were living with high levels of risk that would make participation difficult or unsafe. Children gave informed consent, following standard guidelines, for their participation.

Participants – practitioners and children

A total of 57 practitioners (21 in the first project and 36 in the second project) from a wide range of organisations across the five Health and Social Care Trust areas in Northern Ireland were recruited (five practitioners from the first project continued their involvement in the second project). There was some attrition across both projects, with eight and five practitioners dropping out of each project, respectively, following training. The main reasons for drop-out were health or other personal reasons, change in job, or recognition that it would not be possible to deliver the intervention. Additionally, it was extremely difficult to keep in touch with several practitioners following training; for example, some changed contact details or did not respond to (often numerous) telephone calls or e-mails. Communication about the collection of research data was also difficult. It is unclear why communication was so difficult although it might have been because those practitioners were less sure about the potential for the intervention in their role or were unable to identify a child to work with.

Across both projects 20 practitioners (13 in the first project and ten in the second) delivered the intervention with at least one child (three of the ten practitioners in the second project had also delivered at least one intervention in the first project). The majority of the interventions were individual with one group intervention delivered in each project (ten children in the first project and seven in the second project). A total of 43 children from across Northern Ireland (23 in the first project and 20 in the second project) participated in the two projects (Table I). Table I shows that the majority of children affected by parental substance misuse were dealing with maternal alcohol misuse, a large number had been dealing with their parents' problems for ten or more years, and a number were affected by both parental substance misuse and parental mental health problems (most commonly depression) involving one or both parents. Practitioners used their professional judgement to identify and approach a child about the intervention, working with both existing clients and new referrals. Practitioners were able to discuss possible cases with the authors.

Findings

Feasibility of the intervention

The findings show that an adaptation of the adult intervention can be developed for children, that practitioners can be trained, and that some of those trained can subsequently use the intervention. Practitioners explained the value which they thought the intervention brought to their work, highlighting both the framework and structure of the intervention but also the flexible way in which it could be used. Several reflected on the way that the intervention mirrored how they worked with children, but that having a structured intervention offered a clear framework for supporting this vulnerable population. For example, one practitioner said that the intervention helped her to think about how to approach issues with the child which she had been unsure how to tackle.

Table I Characteristics of children who received a *Steps to Cope* intervention

	Project 1 (n = 23)	*Project 2 (n = 20)*
Sex	Female = 15 Male = 8	Female = 10 Male = 10
Age	Age range 12-17 years, mean 15 years	Age range 10-17 years, mean 15 years
BME status	22 White (one White Asian – refers to how the young person or the practitioner defined this)	18 White (White British/Irish)
Parental substance misuse	13 living with PSM (12 with alcohol, one with drugs), nine with maternal problems (alcohol in eight cases)	19 living with PSM (eight with alcohol), 11 with maternal problems (paternal for five and both parents for three)
Parental mental health problems	18 living with PMH problems (17 with maternal problems)	14 living with PMH problems (maternal for seven and paternal for five)
Length of time living with the problem(s)	Range 3-14 years. Ten had been living with the problems for ten or more years	Range 3-16 years. Nine had been living with PSM for ten or more years, six had been living with PMH problems for ten or more years

Note: $n = 43$

How the intervention helped children

A summary of the qualitative findings is presented, considering each of the five steps of the intervention in turn. A small number of illustrative quotes are included.

Step 1. Children had the opportunity to think about what it is like to live with these problems, what they found stressful and how things affect different parts of their lives. What children wrote in their workbooks showed how varied, complex, and distressing their situations are. There appeared to be three main ways in which Step 1 supported children, namely:

1. Being able to tell their stories, and exploring and discussing their situations. For many, this was the first opportunity they had had to talk about their experiences.
2. Being able to name, understand, and discuss their feelings, and make connections between their feelings and experiences.
3. Realising that these are not uncommon problems; they are not alone and there are many others out there living with similar problems.

> I didn't really understand it so I didn't know what to feel […] [it's given] me the chance to be open […] [the sessions] were very very helpful […] I felt like I had somebody to talk to […] [it] helped me to become more positive (Girl, 14, maternal alcohol and mental health problems).

> I think actually breaking down at the start what it was actually like for him, I don't think anyone had ever asked him that before […] almost a sense of relief that he's been able to talk about it (Community Support Worker).

> […] it's made him think about talking a bit more to people, it's very much a secret within the house, and now he will talk a bit more and he will say things that he would never have said before (Worker at young peoples' alcohol and drug service).

Step 2. This step provided children with the opportunity to ask questions about their parents' problems. Some of the children asked powerful and challenging questions, such as: If he loves me as much as he says he does, why doesn't he stop?; Will she ever stop drinking?; If she keeps drinking what age will she die?; Why do they take drugs or drink? The findings suggest that the children valued learning and understanding more about addiction and mental health problems. Furthermore, many gained awareness about their own health and other problems (e.g. sleeping, worrying, alcohol/substance [mis]use, or mental health problems) and how they may be associated with the parental problems. Significantly, some children were able to recognise and understand that their parents' problems were not their fault:

> I have learnt that mum suffered from these things. I found all the information useful. It helps me to talk about things I find hard (Girl, 14, maternal drug and mental health problems).

> […] sometimes she felt that it was her fault because of her mother's drinking, and she just felt very angry as well […] as we worked through the steps as well she was able to see that it wasn't her fault, she had a better understanding (Worker at young peoples' alcohol and drug service).

Step 3. This step allowed children to think about how they respond to the parental problems, and to consider what worked or did not work for them and what they might want to do differently. The content of the workbooks illustrate the challenging situations which children faced, the decisions which they made about coping, and the practical and emotional dilemmas which they grappled with, demonstrating that (as suggested in the academic literature) they are not "passive victims" but very much "active agents" in trying to deal with the complex, confusing, chaotic, frightening, and unpredictable environments in which they find themselves:

> […] the way I [used to] cope with it was to shut myself off whereas now I'm kinda downstairs a lot more with the family and we've been going out places and stuff like that […] so it's helped like bring everyone together […] just even like go on day trips or watch movies together, stuff like that (Girl, 14, maternal alcohol and mental health problems).

> I've seen a big change in her […] she was able to see that her methods of coping weren't appropriate […] she was able to look at what she was doing […] and come up with alternatives […] she hasn't drunk alcohol now in about 4 months (NIACRO worker).

Step 4. Children were supported to think about their support networks, what support means for them and who they do, or could, turn to for help and support. Some appeared to find it helpful to

realise, more than they had before, that there were people out there who they could turn to. This seemed to facilitate some of the children feeling less alone with their problems, which is potentially important given the isolation experienced by many of them, the time it can take before many seek or accept help, and the difficulties in sharing and disclosing what they are living with:

> […] she did start to talk to friends about it […] and she found out that they had similar [experiences] so she found that very useful, and so she has become more open (Hidden Harm worker).

> […] it made me realise I've got plenty of people there for me (Girl, 14, paternal alcohol problems and maternal mental health problems).

Step 5. The final step of the intervention was an opportunity to reflect on the work which had been done, what the child felt they had achieved and gained from the work, and to think about further support or other needs. In the workbook children were given the opportunity to tick a list of items which summarised some of the key aims of Steps 1-4. Many of the children who shared their workbooks completed this exercise and their responses are summarised in Table II, showing that many of them felt that the intervention had been helpful in a number of ways. In addition, children were invited to share through drawing (or writing if they did not want to draw) how they felt *Steps to Cope* had helped them with one example presented in Table III.

Children and practitioners were further able to reflect on, overall, how the intervention had helped them. There were examples of children being less angry or more confident, as well as a small number who reported a positive impact in terms of their own substance use or mental health. In a small number of cases the work seemed to impact upon the wider family, for example by a worker facilitating sessions which brought the young person and members of their family together (primarily the parent with the substance use problem) and facilitating dialogue between them:

> […] we talked about it together which we had never done before […] we went through the book together so my mum understood how I was feeling […] it was a bit weird because we'd never done that before but I think it was a good thing […] I guess [she responded] the best way that she could've […] she was telling me that it's not my fault and stuff like that […] (Girl, 14, maternal alcohol problem).

Table II What children gained from *Steps to Cope*

Goal	*Number of responses*
I do not feel so alone	15
I am feeling it's not my fault	14
I am not feeling so embarrassed or ashamed	10
I understand more about addiction and or mental health issues	17
I am coping better	13
I have someone who can help me	17

Note: $n = 17$

Table III In her own words (Girl, 14, maternal alcohol and mental health problems)

Before	*After*
"Before I started meeting with [Jane], I didn't like talking about any problems I had and often bottled my issues up, this always ended up in the same result. I would end up breaking down and often didn't realise why I was so upset as I was used to blocking things out. I found it hard trusting people, including friends which had quite a negative impact but I [saw] this as a way of protecting myself, as I was always used to people letting me down" (girl wrote this using a purple pen)	"Since I've started working with [Jane] I've become more open. I know that I have to learn to trust people because not everyone is going to let me down. I can talk about my problems more easily and this has had a very positive impact on my life. I have also learnt to sort out my problems because avoiding them does not help the situation. I think the booklet is the main reason I have progressed so much, in my own state of mind" (girl wrote this using a red pen)

Discussion

It has been possible to train a large cohort of practitioners, a number of whom were able to test the intervention with children. Practitioners seemed to find the steps relevant and straightforward, with many able to work through the steps in order, and the workbook is an important part of the intervention. Some flexibility seems to be important where children are also facing other issues, where their circumstances are more chaotic and when engagement is hard. Overall, the findings from the two projects are promising in showing that the framework of the adult intervention and the theoretical foundations on which it is based are suitable for children, and can be applied to children living with parental mental health problems.

The findings are encouraging in suggesting that children can benefit from *Steps to Cope* in a number of ways which are in line with the five steps and which have been seen with the adult intervention, although it is hard to attribute change directly or solely to the intervention. Given the circumstances in which many of the children lived, where secrecy and mistrust often dominate, and that many of the children had been living with the problems for many years and had received no specific help, it is important to highlight that one of the things which they seemed to find most helpful, and which the practitioners agreed was crucial, was having a safe space to discuss their feelings, fears, concerns, and hopes with a trusted professional. It is possible that the relationship between the child and the practitioner is an important part of the intervention, and future work could consider the impact of therapeutic alliance.

How *Steps to Cope* seems to help children mirrors findings from other interventions which have been developed to support children (sometimes with their families) living with these problems (Drost *et al.*, 2010; Riley *et al.*, 2008; Templeton, 2014; Templeton *et al.*, 2011). An Australian study with children of parents with a dual diagnosis (substance misuse and mental illness) identified four themes to come from their data: the meaning of family, understanding the parent and their illness, coping, and support (Reupert *et al.*, 2012a, b), themes which mirror the *Steps to Cope* framework. A Canadian study evaluated a psycho-education and support programme for children of parents with mental illness (Hamill, 2008), with children naming eight things which they found helpful about the programme, features which are again similar to those which children and practitioners found helpful about *Steps to Cope.* Research in this area has also identified that it is important for children to be better informed about and have a better understanding of their parents' problems (Cogan *et al.*, 2004; Grove *et al.*, 2013; Reupert *et al.*, 2012a, b; Stallard *et al.*, 2004) which, again, aligns with *Steps to Cope*. Information and understanding can help children to feel less responsible for, or to blame for, their parents' problems, and can also facilitate communication between parents and children about the problems, although Stallard *et al.* highlights the importance of pitching the information correctly, as too much information could overwhelm and overburden children.

The findings also suggest that *Steps to Cope* might target the factors and processes which are thought to facilitate resilience in this group of children, thus maximising their protection from the potential harms associated with parental substance misuse and mental illness (Cleaver *et al.*, 2011; Sawyer, 2009; Velleman and Templeton, 2007). Further research is needed to understand what areas of resilience it is most important to target (e.g. psychological or behavioural components), and whether there are differences according to key variables such as gender or age (Cleaver *et al.*, 2011), living with alcohol or drug problems (Russell, 2006) or mental health problems (Cleaver *et al.*, 2011), maternal or paternal problems (Scaife, 2007), and how many risk factors or protective factors a child is exposed to (Templeton, 2013). Such work also needs to bear in mind that an individual's resilience may change over time, with factors or processes operating positively or negatively at different developmental or life stages (Velleman and Templeton, 2007). Finally, resilience cannot be taken at face value, nor can it be assumed that a factor or process will be protective for every child. For example, something which may operate positively and suggest resilience, such as doing well at school, may mask problems in other areas while something which may be perceived negatively, such as taking on a caring role (maybe at the expense of school attendance or performance), may be viewed positively by a child because it protects them and/or their family from harms in other areas (Mordoch and Hall, 2002; Sawyer, 2009).

Limitations

Despite the encouraging findings both projects faced challenges in the delivery of the intervention and there are a number of additional limitations to the data. Less than half of those who were trained went on to use the *Steps to Cope* materials, and some of this group found it hard to engage children and work through the full intervention. Overall, it seemed to take time for practitioners to identify and engage children to work with. Several expressed frustration at not being able to work with children for the project while others lacked the time and capacity to use the materials, or suggested that the intervention was not appropriate to their role (e.g. they work with children in crisis or have limited time with a young person). The learning from this aspect of the project is that careful consideration must be given to whether *Steps to Cope* is best viewed as a universal or targeted intervention, and which services and practitioner disciplines are best targeted in thinking about the continued roll-out of the work.

There was variation in how the *Steps to Cope* materials were used. While many practitioners maintained fidelity to the model and were able to follow it as intended, some held the structure of the model in their head without using it overtly as "an intervention", and others used "bits" of the materials and did not follow the full structure of the intervention. Working in this way can be important in terms of engaging children although it raises challenges for research and evaluation. There is a need for further research to record this work, the fidelity of the components that are used to the model, whether such work can still be classed as *Steps to Cope*, and the impact of using the materials in this way. Some practitioners suggested that it is difficult to engage children in a structured and time-limited intervention, preferring to work in a less rigid way. However, the evidence from the two *Steps to Cope* projects indicates that children can both engage with and benefit from more structured input. In fact, for this group, many of whom live in chaotic and unpredictable environments and where structure may be absent in the family, the provision of structured support can be of enormous benefit.

There was an example of group work in each project, something which can bring specific benefits to children (Goodyear *et al.*, 2009; Templeton *et al.*, 2011), and further work could explore this in more detail along with considering other ways in which the materials can be used such as web-based (e.g. Drost *et al.*, 2010) or DVD and online (Grove *et al.*, 2013) materials. However, while such approaches have their advantages, not least the size of the potential target audience, the importance of face-to-face support with peers, and/or trained practitioners must not be lost.

Some quantitative data were collected in the second project but this aspect of the work was very challenging and given the small data set findings have not been reported here. Future work must find a way to successfully collect data on quantitative outcomes associated with the intervention, and this must include a long-term follow-up as the qualitative findings reported here relate to the short-term only.

The majority of the children in the project were White Irish or White British and more likely to be affected by maternal problems; it is unknown whether this is representative of the population of children in Northern Ireland who are dealing with such problems although it is known that there are challenges in reaching out to children from black and minority ethnic groups (Adamson and Templeton, 2012). Future work needs to consider how to engage broader populations of children, such as younger children, those from minority ethnic groups or those with literacy problems. Additionally, given that many children had been living with the problems for many years, and had not received support, consideration must be given to how children can be identified and encouraged to engage with services sooner, and to providing support which is not time-limited and which can offer support to children, on their own or in combination with other interventions and support, in the longer term.

Conclusion

Steps to Cope appears to be a useful tool for a range of practitioners who, already skilled in working with vulnerable children, value the structure, and focus which the intervention gives them for working with this population. The intervention has potential in an area where there are few evidence-based approaches and where support for children and in their own right is lacking.

The research reported here also suggests that the intervention (the adult version of which focuses on substance misuse) can support children affected by parental mental health problems. Overall, given the circumstances in which many of the children live, where secrecy and mistrust often dominate, and where many had been living with the problems for many years and had received no specific help, the findings reported here suggest that *Steps to Cope* has the potential to become a widely used tool, both in Northern Ireland and elsewhere.

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