Introduction

I have chosen to evaluate the helpline of the National Association for Children of Alcoholics (NACOA) for my third year special study module. First, I will discuss the global issues facing children, such as their needs, the problems that occur when those needs are not met and their rights as human beings. I shall then proceed to discuss the special case of children of alcoholics. In order to understand the plight of these children it is important to first have an understanding of alcoholism, codependency, the way in which families of alcoholics adapt to the situation and the particular problems for these children. I will discuss children's own protective factors, how we can increase these and what services are available. I shall then introduce the National Association for Children of Alcoholics, their helpline and the evaluation I have performed. I will then discuss the results with regard to my own experience within the organisation, and working on the helpline.

Children's Needs

During childhood, the human physical, psychological and emotional development is in a state of extreme vulnerability and malleability. Children have very demanding needs that must be fulfilled to enable successful development. Not only must the parent feed, clothe and protect the child from the environment, but a successful parent must also provide the scaffold that will enable that child to develop psychologically and emotionally.

The quality of a parent-child relationship has a profound and lasting influence on the child's psychological development. According to Pringle (1975), successful parenting provides a sense of security, companionship and belonging. It also provides a sense of purpose, direction, achievement and personal worth for the child. Parents mediate between the child and the world at large, providing a "buffer, filter and a bridge". Successful parenting lays the basis for adjustment of the individual within society and develops the child's capacity for integration, co-operation and creativity.

Pringle (1975) also identified four major needs which are important for the healthy development of the child:
1) Love and security - a stable, continuous, dependable and loving relationship with parents is needed for the child to gain the realisation of his/her own personal identity, worthwhileness, self-approval and self-acceptance.
2) New experiences - pre-requisite for mental growth and intellectual development.
3) Praise and recognition - provides the strong incentive required for overcoming the difficulties, conflicts and set-backs of emotional, social and intellectual learning.
4) Responsibility - allows the child to gain personal independence, freedom of decision and maturity.

The child's egocentric view of the world and limited life experience results in a distorted perception, causing fears and fantasies in response to threatening situations. Emotional problems can occur at the time or later in life. The majority of literature on this subject was developed before the 1980's, for example, Bowlby's theories on attachment and maternal deprivation which were developed in the 1950's.

Bowlby's 'Attachment Theory' (1951) stated that human infants develop a unique relationship with their mother's during the first 6 months of life. Disruption of this bond leads to serious, irreversible behavioural problems in later life. 'Maternal Deprivation' (1956) was described as being deprived of one's mother during the first 5 years of life. He argued that contact with mother during the first 5 years of life is critical for establishing normal social development in a child. His 'Continuity Hypothesis' stated that damaged infancy led to damaged childhood and resulted in damaged adulthood. This damage was a direct result of maternal deprivation during the first 5 years of life and was irreversible. The extreme case of this is when the child fails to develop a sense of social responsibility and conscience, interfering with that child's capacity to form meaningful relationships with others. This syndrome is termed 'affectionless psychopathology'.

The role of mother as primary carer, however, may be due more to social norms rather than to any child rearing deficiency on the part of men. Research by Schaffer & Emerson (1964) showed that father-child relationships can also be very important for the child. This depends on who is more sensitive to the child's needs. In other instances, a child may form multiple attachments to both parents if they are both responsive to the child's needs.

Parke & Swain (1980) observed that in a traditional nuclear family, fathers seem to have a particularly important role in play interactions that enable the child to develop social skills. Lamb (1977) observed that mothers and fathers hold their children for different reasons; mothers for caretaking and restricting, and fathers for play or because the child wants to be held. This difference seems to be a function of the amount of time spent with the child and not any biologically pre-determined dichotomy between motherhood and fatherhood roles. What is important for the child is that all of these needs are fulfilled.

Problem Parent-Infant Relationships

An inability to fulfil the child's need for love and security, new experiences, praise, recognition and responsibility may cause serious problems for that child.

These feelings may outwardly manifest themselves as vandalism, violence and delinquency. Several studies ;Robins (1966), West (1969), Wolfgang et al (1972) and West and Ferrington (1974), have shown a link between home background, a child's educational achievements and antisocial behaviour. They have shown that neglect often results in the child feeling rejected and unloved, and that this can lead to anger, hate and a lack of concern for others.

In young children, insufficient sensory stimulation can retard or impair development and intellectual growth. The most important factor in promoting intellectual growth is the quality and quantity of the child's speech environment; the reciprocity of speech between the child and adult is essential. However, less contact with adults adversely affects acquisition of verbal ability which affects response to formal education i.e. reading and writing. The result of under-stimulation is therefore limited language skills, boredom, frustration and restlessness. On the other hand, the result of over-stimulation in young children is uncontrollable excitement, tenseness, exhaustion and disturbed sleep. For each individual there is an optimal level of stimulation and a marked excess leads to stress, frustration and maladaption (Millen, 1964; Sargeant 1963; Selye 1966)

Pringle (1970) recognised that emotionally neglected or disturbed children need more praise and recognition but often receive less. If a child is neglected by it's parents, then it's level of achievement will decrease and the child is then neglected by other adults as well.

"*the quality of family relationships, the emotional climate of the home, together with parental interest and encouragement are of paramount importance also in helping able children to realise their potential*" (Pringle, 1970)

Pringle (1986) also recognised that under-satisfaction of a child's emotional needs engenders a sense of failure and under-confidence in tackling new situations, tasks or relationships. There is no incentive to achievement and there is a total destruction of self-respect. Over-satisfaction of these needs, for example parents overcompensate for lack of attention by over-praising. In this situation the child will either be satisfied with results of too limited an effort and will not do his/her best or the child may ignore undeserved praise. This devaluates all praise and it then becomes ineffective as an incentive. It's a vicious cycle - failure, discouragement, disapproval, further failure.

Too much responsibility may be perceived as a burden. The child may decide to shoulder it , but the price can be high in terms of anxiety and the child may become a "mini adult" (Henriques, 1989) leading to a loss of innocence, permanent seriousness and false maturity. Or the child may refuse to accept it and spend much time and ingenuity in devising ways of avoiding responsibility. If denied the opportunity to exercise responsibility, however, the child will fail to develop a sense of responsibility for himself, for others or for material objects. When this is coupled with a lack of training in self-control and in planning ahead then the child will tend to be impulsive, unwilling to postpone immediate gratification of impulses and be contemptuous of the rights of others i.e.. irresponsible.

"*Parental mental disorder is most likely to be followed by behavioural disturbance in the children when the parent exhibits long standing abnormalities of personality....the involvement of the child in the symptoms of the parental illness does seem to be crucial...children in families where both parents are ill or where the parental illness is accompanied by break-up of the marriage seem to be especially at risk*". (Rutter, 1966)

The most common fields of disturbance of children whose parents have a chronic physical or mental illness are (Cameron, 1955):

1. Primary habit disorder: Disorder of micturition, defecation, eating, sleeping or speech.
2. Secondary habit disorder: Gratification or tension habits.
3. Motor disorder: Hyperactivity, ticks, habit spasms or any other motor disorder.
4. Disturbed relationships: Aggressive manifestations, disturbed relationship with mother, father, siblings or peers.
5. School or work disorder.
6. Conduct disorder (symptoms include socially unacceptable behaviour): Lying, truanting, wandering from home, stealing, disobedience, destructiveness, fighting or sexual disorders.
7. Psychic disorder (neurotic symptoms): Anxiety, depression, hysterical or obsessional symptoms.
8. Functional somatic disorder (somatic symptoms where no organic pathology is thought to be present): Abdominal symptoms, headaches, fainting attacks or hypochondria's.
9. Allergic diathesis: Hay fever and allergic rhinitis, asthma, eczema or urticaria.

Rutter (1979), however, concluded that delinquency attributed to early experience by Bowlby was more often attributable to immediate stress within the family home. He then added (1981) that other factors were often involved as well e.g. physical and emotional neglect in general and the lack of any positive relationships with others.

Children's Rights

The way in which parents and adults respond and behave towards children varies across the globe and is influenced by many things. Factors such as cultural mores, economic positions, health conditions, historical precedence and social conditions play an important role.

The socialisation process by which children develop into unique individuals also affects their sense of being a part of their cultural community. The level at which children feel a sense of belonging varies according to the status bestowed upon them. The construction of children as the property of adults or subjects in need of protection by adults, has been the primary belief of British society. This is rooted in beliefs that there are fundamental differences between adults and children, and that involvement in adult life is a burden not suitable for young people and children. (Tarr 1998)

Recent legislative developments are leading us to begin to listen to children more seriously and allow them to participate in decisions made about and for them. Over the last ten years, steps have been taken to create a legal framework within which we can work with children.

Newell (1991) describes the effect of the Children Act (1991) which came into force on 14 October 1991, bringing the law relating to children and families into one piece of legislation. In seeking to redefine the balance between securing children's safety and the responsibility and rights of parents to bring up children within their families, the act adopts as its guiding principle the welfare of the child. This act states that before making any order concerning children '*A court shall have regard in particular to the ascertainable wishes and feelings of the child concerned'*.

The UNO publication on the UN Convention of the Rights of the Child (1989) explains that this convention advocates the right of every child to self-determination, dignity, respect, non-interference and the right to make informed decisions. Once a country has ratified the convention, as the British Government did in December 1991, it is obliged under international law to comply with its principles and standards. This includes measures such as:
"*.....effective procedures for the establishment of social programs to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment...*"

The National Commission of Inquiry into the Prevention of Child Abuse defines child abuse as:
"*...anything which individuals, institutions or processes do or fail to do which directly or indirectly harms children or damages their prospects of a safe and healthy development into adulthood.*"

In theory, the pronouncements of the UN Charter are at variance with the current British law. To date, the British government has not adequately fulfilled the obligations set out in this charter. However, its adoption marks an important move forward in that there now exists a set of minimum standards for children and they are recognised as a group to whom human rights law applies.

Alcoholism

The COFACE and EUROCARE report to the European Union about alcohol problems in the family has identified three types of problem drinking:

1. Intoxication
2. Regular excessive consumption
3. Alcohol dependence (Alcoholism)

Whilst it is recognised that each of the three can cause serious problems for the family, the most serious is alcoholism. I shall only consider this.

Literature in the area of addiction and alcohol uses many terms to describe a problem that has far reaching consequences for many in our society today. Alcoholism has such negative connotations that many professionals in the field, such as doctors and psychiatrists, opt for less controversial terms because they are less value laden. The use of such terms as "problem drinker" or "alcohol dependence syndrome", however, detract from the emotional and

social impact of this disease. For example, "problem drinking" implies a purely behavioural disorder which could be remedied simply by altering drinking behaviour.

Studies have shown the problem to be greater than imagined. The Alcohol Concern publication 'Measures for Measures' stated that one in 25 people in Great Britain are dependent on alcohol with 6% of men and 2% of women drinking at very risky levels. National statistics from 'Social Trends' have shown that heavy drinking by both men and women has risen over the last decade. The percentage of men in Great Britain drinking above the government's recommended level rose from 25% to 27% between 1984 and 1994/5. In that period, the percentage of women drinking above the government's recommended level rose sharply from 9% to 13%.

Holiday periods have always been difficult times for families, however, with alcohol sales increasing significantly over the Christmas period families of alcoholics have even more to be concerned about. The Brewers and Licensed Retailers Association Statistical Handbook for 1996 stated that in December 1995, beer sales were up by 17% over the yearly average, wine sales increased by around 53% and sales of spirits by 105%.

Alcoholism is an addiction to alcohol. In the medical literature this is referred to as the Alcohol Dependence Syndrome. The International Classification of Diseases 10th edition (cited in Kumar & Clarke, 1998) describes it as ' a cluster of cognitive, behavioural and psychological symptoms'. The elements of this syndrome are:

1. The subjective awareness of a compulsion to drink.
2. A narrowing of the drinking repertoire.
3. Primacy of drinking over other activities.
4. Increased tolerance to alcohol.
5. Withdrawal symptoms, 'bad nerves', shakiness, and blackouts through to the delirium tremens.
6. Relief from or avoidance of withdrawal symptoms by further drinking.
7. Rapid reinstatement of syndrome on drinking after a period of abstinence.

The course of the alcohol dependence syndrome can be traced using the Jellineck chart (See appendix 1)

Current government guidelines cite 21 units for men and 14 units for women as the maximum weekly intake of alcohol. Drinking more than this, however, is common. Medical literature estimates that approximately 30% of men and 10% of women on general medical wards have a drink problem serious enough to cause withdrawal symptoms during their stay as an inpatient. These figures are thought to be even higher on trauma wards where withdrawal is often missed.

Many possible causes of alcoholism have been postulated. Current thinking suggests a multifactorial aetiology, probably some combination of the following factors:

- Genetic factors
- Environmental factors
- Biochemical factors
- Personality
- Psychiatric illness
- Excess consumption in society

The most controversial belief about the aetiology of alcoholism is the disease concept. In the 1930's, Bill Wilson and Dr Bob Smith of the USA devised a model to help alcoholics to stop drinking and lead normal lives. They were the founding members of Alcoholics Anonymous and were themselves recovering alcoholics. They devised the disease concept of alcoholism. (Alcoholics Anonymous)

The Alcoholics Anonymous program is a 12-Step program that considers alcoholism as a primary disease. That it is it's own disease causing it's own symptoms, not a symptom of some other disease. Recovery depends upon total abstinence from alcohol and all mood altering substances. This program has been recognised as a viable form of treatment due to it's success in helping many alcoholics to stop drinking and maintain sobriety.

In Britain, however, the medical community has never really been convinced that alcoholism is a disease. In fact, it's been given very little thought in the way of service provision and not really considered to be a medical problem. The mainstay of treatments has always been social and psychological approaches. These, however, do not acknowledge or take advantage of the scientific advances made in the biology of alcoholism and could distort the range of services being developed.

Chick (1998) explained that although a biological basis for alcohol dependence has not been established, geneticists now calculate that 40-50% of the explanation for alcohol dependence is attributable to genetic factors. The role of neurotransmitters is also being explored. Dopamine is thought to contribute by way of the reward pathway, which is stimulated by the consumption of alcohol. Serotonin is also thought to be linked as it indirectly affects mood stability and increases impulsive and aggressive behaviour when stimulated by alcohol.

Ohims (1980) described a study which discovered a substance that is closely related to heroine – Tetrahydrosioquinline (THIQ), in the brains of chronic alcoholics. Numerous studies have replicated these results.

Normal, social drinker:

Alcohol	Acetaldehyde	Acetic Acid	H O + CO	Lungs & Kidneys	Eliminated

Alcoholic drinker:

Alcohol	Acetaldehyde	Acetic Acid	H O + CO	Lungs & Kidneys	Eliminated
		Dopamine	THIQ		

Ohims (1980) stated that THIQ has been shown to be manufactured in the brain, and it only occurs in the brain of the alcoholic drinker. It doesn't happen in the brain of the normal, social drinker. THIQ is highly addictive, more addictive than morphine and is a very good painkiller. Animal studies have shown that once THIQ is injected into a monkey's brain, it stays there. The monkey can be kept alcohol free for as long as 7 years, and yet when the brain is studied the THIQ is still present.

The THIQ hypothesis certainly explains how an alcoholic who has been sober for years can revert back to the point at which he left the Jellineck chart after just one drink. This suggests that the only truly effective path to recovery for an alcoholic is abstinence from alcohol. The first step, however, is breaking the denial and educating both the alcoholic and the family. The family must be involved in the treatment for either the alcoholic or themselves to achieve recovery.

Addiction is a family illness. As the family of the alcoholic adapts to the addiction, the disease follows a parallel course in family members (See appendix 2). The denial of the alcoholic and family of the problem compounded by the shame surrounding the secret, make it very difficult for any member of the family to ask for help. The people who need help are not being identified, so the need is perceived as less than it is in reality.

Codependency

Stafford and Hodgkinson (1991) described codependency as the way in which family systems and individual psychology are affected by a person who is chemically dependent or affected by a similar addictive problem. It is a learned behaviour which results from adapting to dysfunction in a family. Codependency is passed from one generation to the next through rigid rules and irrational belief systems.

In addition to the presence of chemical dependence, there will usually be two significant factors in homes where codependency patterns are evident. The parents will, either emotionally or physically, not be there for the children and the children will be there for the sake of the parents.

These are the families where there is a lot of covering up and pretense. Nothing is what it seems and there is no acknowledgment of painful realities. Stafford (1992) described such homes as shame-based family systems that give rise to the following unspoken family rules:

Don't Talk
Don't Trust
Don't Feel

Such families tend to produce children who may grow up with low self-esteem, a diffuse sense of identity, and a desperate need to control others in order to feel secure. More often than not, these symptoms are heavily disguised and the codependent person may appear to be happy, mature and successful. The facade is most likely to crumble in mid-life through the development of addictions, compulsions and depression.

"*Rules and beliefs that are functional in a war zone become a problem when we no longer live in it.*"
(Hilary Henriques, Codependency Lecture - 1989)

Family Systems

The family as a system adapts itself to cope by codependent patterns of behaviour to find ways to balance the effects of the drinking parent's behaviour. It does so by prescribing certain rigid roles for family members to play. The family members often 'become their roles', seeing them as essential to survival and playing them with the same compulsion, delusion and denial as the dependent plays his/her role as drinker.

System Dynamics Of The Alcoholic Family

(Table taken from "Another Chance" by S. Wegscheider - 1981. p.86)

Role	Motivating Feeling	Identifying Symptoms	Pay Off For Individual	Pay Off For Family	Possible Price
Dependent	Shame	Chemical use	Relief of pain	None	Addiction
Enabler	Anger	Powerlessness	Importance; righteousness	Responsibility	Illness; "martyrdom"
Hero	Inadequacy; guilt	Over-achievement	Attention (positive)	Self-worth	Compulsive drive
Scapegoat	Hurt	Delinquency	Attention (negative)	Focus away from dependent	Self-destruction; addiction
Lost child	Loneliness	Solitariness; shyness	Escape	Relief	Social isolation
Mascot	Fear	Clowning; hyperactivity	Attention (amused)	Fun	Immaturity; emotional illness

Wegscheider (1981) explains that the destructiveness of these roles for the person who plays them does not lie in the nature of the role but in the fact of role-playing at all. The family members who play the roles cannot be honest with either themselves or others. Instead, they must send double messages, an overt one from the role-self and a covert one from the real, hurting self. These can be just as unhealthy coming from a family member as from the dependent.

According to Greenleaf (1981), codependent patterns in the family create confusion for the child with regard to its identity. When a child grows up around parents who have no concept of the proper boundaries between individuals, he/she continues to perceive identity as something that is shared. Independence is to be avoided, since it leads to feelings of abandonment and betrayal. These are burdens too heavy for any child to bear and so may grow up with low self-esteem, a diffuse sense of identity, and a desperate need to control others in order to feel secure.

These family roles occur in all troubled families, even occasionally in healthy families in times of stress - and stress is a part of our everyday reality. In families dealing with the presence of an addict, however, the roles become more rigidly fixed and are played with greater intensity, compulsion and delusion.

Problems For Children Of Alcoholics

The National Association for Children of Alcoholics' quantification study estimates that over two million adults - 5% of the population - grew up with parents who drank too much.

In 'Under the Influence', Alcohol Concern have roughly estimated that approximately 7% of parents are problem drinkers, leading to an estimate of 1 million children in the UK currently living in a family in which parental drinking is a problem. Added to this is the fact stated in 'Measures for Measures' that alcohol misuse is a factor in 40% of domestic violence incidents, and that marriages where one or both partners have a drink problem are twice as likely to end in divorce as marriages where alcohol problems are absent.

The NSPCC library indicates that in 1995, there were 35,152 children on child protection registers in England, Wales and Northern Ireland. The NSPCC embargo 'A Cry for Children' reported that over the course of four months in 1997, the NSPCC Child Protection HelpLine took 2,234 calls about child abuse and neglect. Parental Misuse of alcohol was mentioned in 23% of calls about neglect. It was also reported in 13% of calls about emotional abuse, 10% of calls about physical abuse and 5% of calls about sexual abuse.

Children's helplines have shown that children of alcoholics feel guilty and confused about their home life. They desperately try to keep the family secret and tell lies to cover up about their parent's drinking. They feel to embarrassed to take friends home and gradually isolate themselves from their peers. They feel different, frightened, alone and that nobody could possibly understand.

Some examples of what children say on the helplines:

- "*Everything revolves around Mum's drinking. We pretend it's not happening. I can't stop thinking about what's happening when I'm not there. Sometimes I think I'm going mad*." Paul, 15. (NACOA HelpLine)
- "*Dad drink's and hits Mum. I took an overdose last week - I wanted to die. I can't talk to Mum because it would only add to her problems. It's all my fault*." Cindy, 15.(ChildLine)
- "*Dad gets drunk every day, he hits me and Mum....we don't provoke him...he broke my arm once. If I have bruises he locks me in the house and stops me going to school. He says that if we ever tell anyone he will kill us... I'm scared...it's getting worse*." Tracey, 12.(ChildLine)
- "*Mum says Dad is drinking again. Dad says he isn't...I'm confused. I'll just try harder to work it out*." Tasha, 7.(NACOA HelpLine)

For children of alcoholics the home environment very often is characterised by inconsistent parenting, with unpredictable rules and limits; chaotic or tense family environments; parental violence or spouse abuse; unpredictability; poor communication, with unclear messages and broken promises; loneliness and isolation as family members attempt to hide the problem and reduce the potential for shame and embarrassment by withdrawing into itself.

In his review of international literature, Orford (1990) showed that many studies worldwide concluded that there were much higher rates of alcoholism among the relatives of alcoholics than apparently occurs in the general population. This was also found by Goodwin (1971) in his review two decades earlier.

Studies by Marcus (1986), Ervin et al (1984) and Fine et al (1976) have shown that the children of alcoholics and addicts suffer from a range of psychological problems which affect their capacity to learn. In addition they can also display difficult and disruptive behaviour. These children are often found to be more isolated, less able to maintain attention, more fearful, liable to emotional upset and more preoccupied with inner thoughts than with the world around them.

Cermak (1986) identified the more common risks involved in being raised in an alcoholic / addict family as:

1. Fetal alcohol syndrome (FAS),
2. Alcohol and drug related birth defects,
3. Hyperactivity,
4. Stuttering,
5. Eating disorders,
6. Contact with the foster care system,
7. Child physical and sexual abuse,
8. School phobias and dropouts,
9. Runaways,
10. Contact with the juvenile justice system,
11. Teenage pregnancy and prostitution,
12. Post traumatic stress disorder (PTSD),
13. Early drug and alcohol abuse.

Velleman (1992) concluded in his recent literature review concerning the intergenerational effects of alcohol that:

- There is considerable evidence that children who grow up in a home in which one parent abuses alcohol are at higher risk of developing a number of childhood problems and disorders than comparison children. The risk appears to be even greater for conduct disorders. The evidence is equivocal regarding the likelihood of a problematic adulthood adjustment, and appears to depend on the source of the sample. The risk of developing

alcohol problems appears greater than in the general population, however, the research in this area appears biased and may exaggerate this risk. Adjustment in other areas may be problematic especially with reference to feelings of control, depression and relationships. The existing literature is suggestive, however it is extremely sparse and requires further research.

- There is also considerable evidence that children who grow up in a home which has a discordant atmosphere are at a higher risk of developing a number of childhood problems and disorders than are comparison children. Evidence is clear that antisocial behaviour and conduct disorders are particularly likely outcomes for boys. There is also evidence that adults who were raised in a discordant atmosphere are still at high risk of developing a variety of problems once they reach adulthood.

- Both alcohol related and discord related parental problems raise the risk of a child (especially a boy) developing a conduct related disorder. These problems have a poor prognosis. This is important because alcohol related parental problems are very likely to be associated with discord, hence children in these relationships will be exposed to both risk factors.

- Of these two risk factors current evidence suggests that parental discord is the more deleterious, both for the developing child and adult.

- It is not known *HOW* having a problem drinking parent or having a disharmonious household causes these problems.

- There is a variety of biases in the research – ill defined terminology, conceptual lack of clarity and sex bias.

- "Family disharmony" is an imprecisely defined concept. This incorporates at least 4 separable aspects : who the discord is between, how it's made apparent, what it's about and how long did it last.

- A variety of global research methodologies were described and all of these methods were shown to have their drawbacks.

A major drawback of existing literature is that many problems in adult life are not sufficiently problematic to cause the individual to seek help. Also, some qualities developed by growing up in an alcoholic family may be viewed by others as desirable and indicative of good adjustment. For example, the Hero child develops the characteristics of self-sufficiency, success and perfection. These are qualities that were developed as coping mechanisms for that child which were protective at the time. In adult life, however, self-sufficiency and the need to control everything and everyone creates problematic relationships.

The Self-Help movement created a large body of literature which often takes the form of anecdotal evidence as opposed to empirical research. I believe, however, that it would be a mistake to totally disregard this information. Many adult children of alcoholics remember their childhood with the greatest clarity, and for many the nightmare does not disappear with time.

"*My strongest childhood memory is one of fear. My father was a huge man and always angry...He would sit up drinking late at night. My brother, sister and I were terrified of being beaten...*' Tim, 53.(NACOA HelpLine)

Life stories by people in the various self-help groups, e.g. AlAnon, Alateen and ACA (Adult Children of Alcoholics), indicate a pattern of characteristics which many adult children of alcoholics identify with. These are:

1. We guess at what normal is
2. We have difficulty following projects through from beginning to end
3. We lie when it would be just as easy to tell the truth
4. We judge ourselves without mercy
5. We have difficulty having fun
6. We take ourselves very seriously
7. We have difficulty with intimate relationships
8. We over-react to changes over which we have no control
9. We feel different from other people
10. We constantly seek approval and affirmation
11. We are either super responsible or super irresponsible
12. We are extremely loyal even in the face of evidence that loyalty is undeserved

13. We look for immediate as opposed to deferred gratification
14. We lock ourselves into a course of action without giving serious consideration to alternative behaviours or possible consequences
15. We seek tension and crisis and then complain about the results
16. We avoid conflict or aggravate it: rarely do we deal with it
17. We fear rejection and abandonment, yet we are rejecting of others
18. We fear failure, but sabotage our success
19. We fear criticism and judgment, yet we criticise and judge others
20. We manage out time poorly and do not set our priorities in a way that works well for us

(Codependency Leaflet – NACOA)

Evidence suggests that adult children of alcoholics experience difficulties in later life and that the sex of the alcoholic affects this outcome. While about equal numbers of resilient and problematic children come from families with an alcoholic father, in a study by Werner (1986) it was shown that the majority of children of alcoholic mothers failed to make a successful adjustment by the age of 18. There is evidence, however, that many adult children of alcoholics grow up to be well adjusted despite the difficulties encountered in childhood (Velleman, 1993) or perhaps, some argue, because of the coping skills they have developed.

Protective Factors And Resiliencies

The degree to which children are able to shelter themselves from the negative impact of parental alcoholism may vary enormously.

"*Whether we have succeeded in becoming whole persons depends a good deal on the families in which we grew up. Whether we can remain whole and continue to develop our potentials will depend on the families (or other intimate living networks) that we have created ourselves*." (Wegscheider, 1981 p 44.)

The research on children of alcoholics has been focused on 'at risk' children, including those who face the mental illnesses or addiction of their parents. Researchers found, however, that while these children are at a higher risk of developing more problems than the general population, a great percentage become healthy, competent young adults. In other words, they were resilient to the difficulties experienced in childhood.

Jerry Moe, children's programme director at the Sierra Tuscan treatment centre, Arizona, describes the core characteristics of resilient children are social competence, problem-solving skills, autonomy and a sense of purpose and future. This is important, as these characteristics can be taught to children and thus protect them from the negative impact of their parental alcoholism. Moe cites information, skill building and attachment/bonding as key components in the prevention of problematic adjustment.

Many researchers and therapists such as Drs Steven and Sybil Wolin, see difficulties encountered in childhood as both a danger and an opportunity. The Wolins describe this as the Challenge Model. Over time, the self-protective behaviours used by children in response to troubles develop into lasting strengths called resiliencies. This describes a cluster of strengths which are mobilised in the struggle with hardship. These include:

Insight
Independence
Relationships
Initiative
Creativity
Humour
Morality

The Wolins describe three developmental stages for each resiliency. In children, resiliencies appear as unformed, non-goal orientated, intuitively motivated behaviour, e.g. insight is sensing. In adolescents, these behaviours sharpen and become deliberate, eg. insight is knowing. In adults, they broaden and deepen, becoming an enduring part of self, eg. insight is understanding.

The National Association For Children Of Alcoholics have compiled a range of leaflets for those dealing with children of alcoholics and for the children themselves. Important things for children to remember are:

1. You are not alone.
2. There are people and places that can help.
3. It's not your fault that your parent drinks too much. You didn't cause it: alcoholism is like an illness.

4. Don't try and water down your parents alcohol or pour it away. It won't work. You can't stop your Mum or Dad drinking: it's up to them to get help.
5. You can feel better even if your parent doesn't stop drinking.
6. Don't argue with someone who is drunk: it may make things worse. Your Mum or Dad may say or do things they normally wouldn't.
7. Do remember that feeling afraid and alone is the way lots of people feel when they live with alcoholic parents.
8. It's okay to hate the problems caused by drinking but love your parents.

Children can be helped by 'safe' people, people who will listen without judging and will validate their experiences. Moe stresses that saying to the child 'I hear you and I believe you', significantly helps children from high-stress families. While 'safe people' cannot change the parental addiction or solve the family's problems, they can make a difference to a child by:

Listening
Observing
Validating
Educating
Empowering

"*I hate it when my Dad is drunk, but I do love him. I wish I could make it better but now I know I can't. Now when he gets drunk, I just call Grandma or my Uncle Jim and they come and look after me*." Jessie, 11. (NACOA HelpLine)

Services Available

The Government has a key role in ensuring appropriate organisations can work together and in ensuring that the many planning services are fully equipped to take account of the needs of children of alcoholic parents. The needs should be addressed in Children's Services Plans and Community Care Plans. There should be specific guidance on how local service providers should view their obligations under children's legislation and, where necessary, ensure that resources are available to respond to identified needs.

Services aimed specifically at children of alcoholics are few and far between. There are, however, a growing number and there is much discussion as to how to develop additional services. Existing services include:

- Alcohol agencies with services for young people
- Services specifically for children of alcoholics
- Family services run by alcohol or combined drug and alcohol services
- Alcohol service for parents e.g. Alcohol Recovery Project
- Joint working between schools, social services, GP's, youth services and alcohol services.
- Information: leaflets, books, tapes
- Helplines
- Alateen
- Services offered by other agencies to children of alcoholics

Many services that can help are not being utilised by those who need them. An Alcohol Concern news release indicates that alcohol advice agencies are only seeing a fraction of the people who need help, that is around 10,000 people with drink problems every day. Two thirds of those who go for help are men. Many agencies, however, still do not regard the family of an alcoholic as legitimate clients in their own right.

Child and Family counselling services, run by the Health Service, can only be offered with parental consent. The irony is obvious, how can a child of an alcoholic obtain parental consent for counselling? There is also a problem with generic services for children as they may not recognise or have an awareness of the problems caused by parental alcoholism.

Currently existing services which need to be targeted with education and training on how to recognise and support children of alcoholics are:

- Specialist alcohol services
- Services provided by non specialist alcohol agencies, for example:
    - ⇒ Schools
    - ⇒ Special needs support services
    - ⇒ Youth workers

- ⇒ Young people's counseling and advice services
- ⇒ GP's and Primary Health Care Teams
- ⇒ Nurses, Midwives and Health Visitors
- ⇒ Social Services Departments
- ⇒ Criminal justice
- ⇒ Guardians ad Litem ("act as the voice of the child in legal proceedings, such as adoption and Child Protection cases)
- ⇒ Services which encounter parents

Adult children of alcoholics can utilise many resources in the form of literature, self-help groups or professionals to aid their recovery.

The National Association For Children Of Alcoholics

The National Association for Children Of Alcoholics (NACOA) was founded in 1990 to address the plight of children growing up in families where one or both parents suffer from alcoholism or a similar addictive problem. This includes children of alcoholics of all ages, many of whose problems only become apparent in adulthood.

NACOA was established with four broad aims:

1. To offer advice, information and support to children of alcoholics
2. To reach professionals who deal with children of alcoholics in their everyday work – educating them as to the specific needs of children of alcoholics
3. To raise the profile of children of alcoholics in the public consciousness.
4. To promote research into the phenomena of children of alcoholics

In 1992, NACOA commissioned a small national survey of a representative sample of adults in the UK which indicated there was in excess of 2 million adults in the country who perceived they grew up in families where the parent(s) drank too much. The survey also showed that approximately 100,000 people felt that the charity would definitely be of help to them. This was the first time an estimate based on a representative sample had been conducted in the UK and therefore the first time the true scale of the problem had been exposed. At present, a more extensive survey with 4,000 respondents is underway, the results of which are expected in Autumn 1999.

NACOA provides a free helpline service to children of alcoholics of all ages which receives between 2 and 50 calls each day. The need to monitor and evaluate calls, in order to identify and subsequently provide caller-led services, was discussed in relation to this project and has been implemented and developed in 1999.

I first became involved with NACOA three years ago when I enrolled on a training course to work on the helpline. I have since become deeply involved with the charity, and the people and work are now close to my heart. I began the process of this evaluation in the autumn of 1998 when it had become clear that such a study would be invaluable to the charity. The time allocated by the university for a special study module has allowed me to undertake the task of evaluating the helpline and consolidating my knowledge of the issues surrounding children of alcoholics.

Aims and Objectives

The main aim of this evaluation was to quantify and evaluate all calls to the NACOA freephone HelpLine during the period of 1 April 1998 to 31 March 1999. This would allow NACOA to identify and subsequently provide caller-led services. The evaluation objectives were:

1. To quantify the number of callers to the HelpLine.
2. To quantify and characterise the callers in terms of who was calling, for example, what percentage of calls were from concerned professionals etc.
3. To quantify and characterise the callers into age categories. What percentage of callers were under 18 years old etc.
4. To characterise the nature of the environment and experience of a child of an alcoholic in terms of, the age of the child, the family structure, who in the family experienced the problems and the degree of external support to the problem received.
5. To quantify the number of information packs sent, resources searched for and calls returned.

In addition to providing the above information, this evaluation has provided the basis for future evaluation.

Method

Using backdated logged calls from the period of 1 April 1998 to 31 March 1999, the final sample consisted of 813 calls from four separate months. The months chosen were April 1998, July 1998, September 1998 and January 1999. These four months are a sample of the trend of calls over the whole year, however, are not truly representable of the year. The sample includes a very busy period, a quiet period and more average months.

The variables analysed were:

- Where the caller was calling from
- Whether an answerphone message was left
- Whether it was their first call to NACOA
- Had the caller told anyone else before
- The type of caller eg. Child of an alcoholic, professional etc
- The sex of the caller
- The area the call was from
- The age of the caller
- The marital status of the caller
- The work status of the caller
- Whether the caller has any children
- The family circumstances of the caller
- The living circumstances of the caller
- How the caller found out about NACOA
- What action was taken by NACOA

The Chi test was used to determine whether the actions of NACOA were dependent upon the sex of the caller.

The backdated calls were logged on the new call card (see appendix 3). This call card was designed and piloted with live calls before being used for the transcription of backdated calls. The data was then keyed into the database. During both the transcription of calls and the keying in of information both the call card and database were under constant evaluation and updating. The call cards were used for all calls from 1 January 1999.

The main problem with using backdated calls was incomplete information. Although the information may have been imparted at the time of the call, it may not have been logged. The information gathered depends upon the way calls are handled. The policy of the National Association for Children of Alcoholics is to listen or to ask questions that are directly relevant to the callers query, e.g. which area the caller lives in so we can search for services in their area. Questions are not asked so we can fill in the call card.

The aim of this policy is to give the caller control over the information they wish to impart without feeling threatened by lots of questions. All callers remain anonymous until they choose to give a name. The helpline is a listening service that also provides information in a non-threatening manner.

Results

The results of this evaluation will be tabulated with a brief description of their significance. The tables correspond with the above list of variables.

Table 1 - Was the call an answerphone message or a live call

Message	April 1998	July 1998	September 1998	January 1999	Total	Percentage
Answerphone message	51	29	40	81	201	24.7%
Live call	73	45	40	51	209	25.7%
Silent call	5	1	9	10	25	3.1%
Dropped call	47	36	61	169	313	38.5%
Return call	0	0	0	4	4	0.5%
Abusive call	3	17	9	3	32	3.9%
Incomprehensible	3	4	18	4	29	3.6%
Total	182	132	177	322	813	100%

Mode	Live call	Dropped call	Dropped call	Dropped call	Dropped	

Table 1 is based on all logged calls during April, July and September of 1998, and January 1999 resulting in a total of 813 calls. Nearly 25% of calls were logged as answerphone messages, with a further 40% logged as dropped calls. This indicated the desperate need for more volunteers and extended hours of service. The logging of days and times in the future will enable us to open the helpline during the hours of greatest need, and satisfy the maximum demand with the resources available at this time. This will enable us to decide whether staying open for longer in the evening is more efficient than opening on the weekend.

The following tables of data will be based on the answerphone messages, live calls and return calls resulting in a total of 414 calls. The dropped calls, silent calls, abusive calls and incomprehensible calls will not be included as it was not possible to collect any information regarding the caller.

Table 2 - Who called

Type of caller	April 1998	July 1998	September 1998	January 1999	Total	Percentage
Child of an alcoholic	39	15	20	31	105	24.1%
Anonymous	49	35	40	63	187	42.9%
Carer	0	0	1	5	6	1.5%
Family member	4	8	6	17	35	8.0%
Friend	3	5	2	7	17	3.9%
Professional	10	8	8	9	35	8.0%
Student	1	1	2	3	7	1.6%
Addict/Alcoholic	6	2	5	9	22	5.0%
Other	15	1	3	3	22	5.0%
Total	127	75	87	147	436	100%
Mode	Anon	Anon	Anon	Anon	Anon	

The total for Table 2 is larger than expected as the categories are not mutually exclusive and callers can be logged under more than one category, e.g. Professional and Family member.

It is interesting to note that only 24.1% of callers presented for themselves as children or adult children of alcoholics. A further 21.4% of callers presented as advocated for children of alcoholics in the form of carers, family members, friends and professionals. These statistics indicate the need to raise awareness of the plight of children of alcoholics and to target this particular group of people.

In some cases, the caller presented as the alcoholic/addict themselves. 5% of calls to the NACOA helpline were from alcoholics concerned either about themselves or their children. Those presenting with concern for their children were recovering alcoholics and were often very concerned about the effect their drinking had on their children. The large majority of callers (42.9%), however, did not reveal why they were calling and were thus logged as anonymous.

Table 3 – What was the sex of the caller

Sex of caller	April 1998	July 1998	September 1998	January 1999	Total	Percentage
Female	95	52	64	95	306	**73.9%**
Male	29	15	14	41	99	**23.9%**
Not Known	0	7	2	0	9	**2.2%**
Total	**124**	**74**	**80**	**136**	**414**	**100%**
Mode	Female	Female	Female	Female	Female	

The overwhelming percentage of female callers, almost 74%, probably reflects the fact that women are more likely to ask for help. It also reflects a small percentage who are female adult children of alcoholics and have married alcoholics. They present with concerned for their own children as well as the fact that they are repeating the pattern of their childhood.

The figures in Table 3 indicate a need to target men. General education and raising of awareness may achieve this, but it is probable that these figures will not change drastically until society is more encouraging of men to ask for help.

Table 4 -Which area did the caller call from

Area called from	April 1998	July 1998	September 1998	January 1999	Total	Percentage
South Central	4	6	7	4	21	**5.1%**
South East	7	5	4	10	26	**6.4%**
Midlands	13	10	7	0	30	**7.2%**
Scotland	10	1	9	20	40	**9.7%**
Northern Ireland	0	0	0	0	0	**0%**
North West	2	0	1	12	15	**3.6%**
Wales	4	5	3	3	15	**3.6%**
South West	8	9	11	13	41	**9.9%**
North East	6	7	8	9	30	**7.2%**
Anglia	4	10	1	6	21	**5.1%**
London	6	0	12	14	32	**7.7%**
Not Known	60	21	17	45	143	**34.5%**
Total	**124**	**74**	**80**	**136**	**414**	**100%**
Mode	NK	NK	NK	NK	NK	

The area categories that NACOA used are those used by the national postal address books. This system allowed callers to be allocated an area category and this was calculated by postal address or telephone area code. The small number of area categories allows for easier handling of the data and for a single broad area to be targeted at a time.

The large percentage of Not Known in Table 4 indicates the number of callers concerned with confidentiality and anonymity. This number reflects the callers who do not want information sent to them and do not want to be contacted by the organisation. This stresses the importance of a non-threatening HelpLine. If questions were asked then many of these callers may not continue calling and so they would withdraw from a major source of support.

Almost 10% of calls were from the South West which is where the office is based. This reflects the effect of targeting local alcohol advice services, health centres, counselling services and schools. Scotland, however, also represents nearly 10% of calls. This may be a reflection of the high incidence of alcoholism in Scotland and the need for services for children of alcoholics. Many organisations throughout the country, including the media, have information about NACOA. The calls from Scotland are not consistent, therefore, it is likely that they follow some form of advertising campaign or press release local to the area.

The other areas represent between 3.6% and 7.7% of the calls. The total lack of calls from Northern Ireland, however, indicates a desperate need to advertise. This is an area well known for its high level of alcoholism and thus the need for NACOA is greater.

Table 5 – What age is the caller

Age of caller	April 1998	July 1998	September 1998	January 1999	Total	Percentage
0 – 7 years	0	0	0	0	0	**0%**
8 – 11 years	8	2	2	2	14	**3.4%**
12 – 18 years	19	8	6	13	46	**11.1%**
19 – 35 years	34	0	3	22	59	**14.2%**
36 – 49 years	19	1	1	10	31	**7.5%**
50 + years	3	5	0	3	11	**2.7%**
Not Known	41	58	68	86	253	**61.1%**
Total	**124**	**74**	**80**	**136**	**414**	**100%**
Mode	NK	NK	NK	NK	NK	

The largest percentage in Table 5 is the Not Known category. This indicates a disappointing trend in call logging for the volunteer to tick unknown for any data that is not directly given. The age categories were designed to be broad so that age of a caller could be inferred from other information. More training is needed for volunteers using the call cards.

Despite the fact that less than 40% of callers were allocated an age category, 15% of callers were logged as being under the age of eighteen. This is encouraging as it illustrates that children are calling and there is a particular need within this age group. There is also a need to raise awareness of the issues for these children and to specifically target this age group.

Almost 25% of callers were over the age of eighteen and were presenting either for themselves or others. Those presenting for their own problems illustrates the devastating effect that being a child of an alcoholic can have. These people are still having problems in their adult life and some are still having problems when they are over the age of fifty.

Table 6 – Is this the callers first call

Callers first call	April 1998	July 1998	September 1998	January 1999	Total	Percentage
First call	50	7	24	27	108	**26.1%**
Ongoing call	34	6	5	12	57	**13.8%**
NK	40	61	51	97	249	**60.1%**
Total	**124**	**74**	**80**	**136**	**414**	**100%**
Mode	First call	NK	NK	NK	NK	

Again the largest percentage in Table 6 is Not Known. The category of Ongoing Calls represents 13.8% of calls and is an indication of the support that can be offered by the NACOA HelpLine. Ongoing callers often call many times, either intensively over a short period of time or sporadically over a long period of time.

Table 7 – Has the caller told anyone else

Told before	April 1998	July 1998	September 1998	January 1999	Total	Percentage
Told before	15	0	4	8	27	**6.5%**
Told no one	8	8	35	24	75	**18.1%**
NK	101	66	41	104	312	**75.4%**
Total	**124**	**74**	**80**	**136**	**414**	**100%**
Mode	NK	NK	NK	NK	NK	

Table 7 illustrates the point that many callers have never spoken to anyone else about their problems. I'm sure that over time this number will increase as this information was not always logged before the use of the call card. Only 6.5% of callers had told someone else about their problems. This is a very small number. Also, a proportion of those callers reported not being believed when they had approached someone as a child.

Tables 8, 9, 10, 11, 12, 13 and 14 (please see appendix 4) have such high percentages of Not Known that it is impossible to interpret the results. One thing that is clear is the need for training the volunteers fill in the call card correctly. In the past, before the call cards were used, calls were logged in an unstructured way. Much information, therefore, has been lost as it was not logged at the time of the call. Now that the call cards are being used I would expect more information to be logged and next year that data should be available for analysis.

Table 15 – Action taken by NACOA based on live calls and answerphone messages

Action - 1	April 1998	July 1998	September 1998	January 1999	Total	Percentage
Listen	65	16	34	30	145	**24.4%**
Journalling	3	0	0	0	3	**0.5%**
Find resource	19	20	5	36	80	**13.5%**
Self help group	32	10	7	15	64	**10.8%**
Information pack	37	36	27	37	137	**23.1%**
Info on addiction	6	1	3	6	16	**2.7%**
Pen pal list	0	0	0	0	0	**0%**

Membership	2	0	0	0	2	**0.3%**
Return call	11	12	15	24	62	**10.4%**
Await return call	12	1	2	2	17	**2.9%**
No action	13	2	10	43	68	**11.4%**
Total	**200**	**98**	**103**	**193**	**594**	**100%**
Mode	Listen	Info pack	Listen	No action	Listen	

Table 15 is based on live calls and answerphone messages, and indicates that the most frequent action taken by a NACOA volunteer is to Listen (24.4%), send out Information Packs (23.1%) and Find Resources (13.5%). The next largest percentage is No Action (11.4%). This is a very different picture to when all calls to the helpline during the allocated periods are included. When all 813 calls are analysed for their outcome, No Action rockets up to 47% due to the dropped, abusive and incomprehensible calls. Correspondingly, all other actions drop significantly in terms of percentages but not, of course, in real numbers.

Table 17 – What type of information packs were sent out

Info pack type	April 1998	July 1998	September 1998	January 1999	Total	Percentage
Child of an alcoholic	12	5	12	13	42	**30.7%**
Anonymous	19	26	9	17	71	**51.8%**
Professional	6	4	6	4	20	**14.6%**
Student	0	1	0	3	4	**2.9%**
Total	**37**	**36**	**27**	**37**	**137**	**100%**
Mode	Anon	Anon	Child of alcoholic	Anon	Anon	

The types of information packs can be broken down into four categories: children of alcoholics, anonymous, professional and student. These will change in the future as the number of calls increase and there is a need for more specialised packs. The largest category in Table 17 is Anonymous (51.8%). This is to be expected as many callers do not want to reveal why they are calling other than to receive an information pack. The next category is Children of alcoholics (30.7%). This is encouraging as it indicates that callers want to receive information for themselves and are on a quest for recovery. Professional packs sent out represent 14.6% of information packs. This indicates a need to raise NACOA's profile within the professional sector.

A statistical analysis was performed to elucidate whether the actions of NACOA were dependent upon the sex of the caller. The tables are in appendix 4. The result of the test was 20.24. This suggests that at the 5% level there is no significant difference in the actions taken with regard to the callers sex, and therefore, any observed differences are probably due to chance alone.

Conclusion

These results are very exciting and lead the way to more in-depth evaluation in the future. The information gained from this evaluation will enable the National Association for Children of Alcoholics to identify specific issues and to provide caller-led services. The three main areas for concern are the high percentages of unknown information, the small number of live calls and the low percentage of children of alcoholics, males and children calling the HelpLine.

The first issue will never be totally resolved as there are many callers who do not wish to impart any personal information. I feel, however, that it is important to log as much information about the caller in order to ensure that each call contributes to the refining of services. Much information may be gathered indirectly, for example, a caller does not have to state their exact age in order to be allocated an age category.

The fact that there was not a substantial increase in the amount of information gathered when the call cards came into constant use indicates a need for further training. It is important that all information is logged and that no empty boxes are left on the call card.

I also feel, however, that the high percentages of unknown information reflects the secretive nature of this group of people. Children of alcoholics are brought up not to talk about problems. Phoning the NACOA HelpLine is breaking the family rules, so the callers are reluctant to reveal any personal details.

The second issue refers to the fact that only 25.7% of calls during the sample time period were live calls. Nearly 25% of calls were logged as answerphone messages, with a further 40% logged as dropped calls. This indicates a

desperate need for more volunteers and extended hours of service. Increased funding, however, is the only way to solve this.

New equipment and call cards now allow the day and time of the call to be recorded. In the future, further evaluations will enable NACOA to plan services to meet existing needs with the limited resources available. This will also enable the type of call to be linked to a day and time. There may be an increase in abusive and incomprehensible calls, for example, on a Friday and Saturday night after the pubs have shut.

The low percentage of children of alcoholics ringing the Helpline indicates a desperate need to raise the profile of the National Association for Children of Alcoholics in the public consciousness. Less than 25% of callers presented themselves as children or adult children of alcoholics. Research has shown that there is a need for services for children of alcoholics, but, if the services available are not sufficiently funded those in need will not know of their existence. These issues must be raised in the public arena so that those who are approached by these children have an understanding of their plight and the knowledge of where they can go for help.

The fact that less than 25% of callers presented as children of alcoholics indicates the secretive nature of the callers. Nearly 43% of callers, however, chose to remain anonymous. Many of these may be children of alcoholics but did not wish to reveal any personal details and preferred to remain anonymous.

The low percentages of males (23.9%) and under eighteen's (14.5%) calling the HelpLine also indicate the need to advertise and target these groups. Again, this can only be achieved with greater funding.

I feel that it is important in future surveys that the whole year is analysed as the number of calls each month varies so much that it is impossible to choose truly representable months. I also feel that an annual evaluation will enable NACOA to record the effect of advertising campaigns and to observe the direction in which the charity is going. Not only that, but I feel that an annual evaluation would be useful for funding purposes. Firstly, to show funders that there is a need, and secondly, to illustrate the effect that the funding has had.

This study has been the first step in setting up an efficient and effective system to deal with evaluating the NACOA HelpLine. It has also created a baseline against which to compare future findings. I hope that I am involved in the future as I have found this to be an interesting and valuable experience.

I am very glad to be involved with NACOA as I have learnt, and continue to learn so much. I am also grateful for the support from everyone at NACOA, and especially many thanks to Hilary Henriques, without whom this work could not have been completed.