An Action on Addiction and Place2Be Partnership Project

Evaluation of the Moving Parents and Children Together Programme when delivered by Place2Be (M-PACT Plus)

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Executive summary

This report describes the implementation and value of a pilot project (M-PACT Plus) offering families access to an intervention aimed to reduce hidden harm (M-PACT) made available through schools with Place2Be counselling services. The pilot project was funded by Comic Relief and the Royal Foundation who also funded this independent evaluation. The evaluators have drawn on routine data collected by Action on Addiction and Place2Be as well as further qualitative data collected during the implementation of M-PACT Plus.

This report describes key learning with respect to outcomes for children, parents and carers, the school environment and sustainability, and makes recommendations for funders and partners for modifications, based on the learning.

Delivery and reach

1. The partnership between Place2Be and Action on Addiction led to the successful delivery of the M-PACT programme on 11 occasions during 2013-2015. 47 families accessed M-PACT during the pilot programme (attended at least one session) including 64 adults and 60 children aged 7-19 years. Thirty three children attended crèche facilities. The majority (67%) of individual participants completed the 10 week programme, which consists of an 8 week family based intervention, an individual family review and a reunion.
2. The number of schools from which referrals were made increased throughout the pilot project, with 38/77 schools making at least one referral and 18 schools making referrals to more than one iteration of the programme.
3. M-PACT Plus extended the geographical reach of M-PACT, which was not otherwise available to families. Prior to M-PACT, none of the children who participated was receiving a service to address their needs because of parental substance misuse. For approximately half (27) of the children who participated in M-PACT there is no recorded involvement of agencies other than universal services or Place2Be with their families. These families could be said to be 'below the radar' with respect to any form of targeted support.
4. Place2Be provided wrap around support for families involved with M-PACT: 52 children who had participated in M-PACT received one to one counselling before, during or after M-PACT. Some children also attended Place2Talk (34) and seven children attended Place2Talk only. Parents were also able to access counselling through Place2Be.
5. Ongoing support was also available to family members from other agencies following M-PACT. This mirrors what is observed when M-PACT is delivered in community or prison settings.

Outcomes for families

6. Some quantitative measures for children show modest improvements from Week 1 of the programme to reunion (based on Action on Addiction data). Although there is insufficient data for statistical comparison, these findings are in line with those from the national M-PACT data set. When considered alongside qualitative data, benefits for children included

improved family communication, family functioning, coping with challenges and understanding how addiction affects families.

7. There is additional qualitative evidence that some children are more confident, have strategies for keeping themselves safe and feel less isolated following involvement with M-PACT.
8. Quantitative outcomes for parents (Action on Addiction data) also showed similar trends to those found for M-PACT delivered in the community, with improvements in key areas such as family functioning, coping efficacy and communication. In interviews parents and carers also reported better communication, although some remained reluctant to talk openly about addiction with their children.
9. The findings for both children and adults suggest that for some these changes are sustained in the medium term (up to 3 months after the 8 week family based intervention). It has not been possible to follow up enough families for more than this period to draw conclusions about longer term outcomes.

Schools as a setting for M-PACT

10. The delivery of M-PACT was accompanied by training opportunities for school and Place2Be staff to develop their understanding of hidden harm and how M-PACT could help children affected by parental substance misuse. The training was highly regarded and respondents reported gains in knowledge and understanding of hidden harm and M-PACT. However, some school and Place2Be staff continued to report that they lacked confidence in their ability to identify and support families who might benefit from M-PACT.
    School and Place2Be staff emphasised that confidence and trust are key to engaging parents and carers in conversations about parental substance misuse and participating in M-PACT. Developing this trust can take time.
11. M-PACT is more likely to be integrated with a school's support for families where the school and Place2Be staff routinely share appropriate information about pupils and where schools already offer a range of services for pupils and parents. In these schools there are clear procedures for discussing concerns about the needs of children and about who is best placed to speak to parents about M-PACT.
12. Parents and carers value the role of schools and Place2Be in supporting them to access M-PACT.
13. The following factors have been identified which will support the sustainability of M-PACT:
    - Track record of M-PACT as a useful intervention for families affected by parental substance misuse
    - Continued integration of M-PACT into Place2Be practice, including supervision.
    - Growing awareness and capacity of School Project Managers
    - The role of M-PACT Plus coordinator in developing relationships with schools and other agencies, monitoring and evaluation
    - The development of a new website promoting better understanding of M-PACT
    - Local needs assessment and discussions with commissioners.

1. Contextual Background

Despite mounting evidence (summarised in Appendix 1) the harm caused to children by parental substance misuse remains largely hidden. 'Hidden harm' was defined in 2003 by the Advisory Committee on the Misuse of Drugs (ACMD) as 'parental problem drug use and its actual and potential effects on children'.[1] It is noteworthy that the ACMD makes no distinction between children who are known to services and those who are not, suggesting that any child whose needs arising from their parent's substance misuse are not being met is experiencing 'hidden harm'. In this report children whose specific needs in relation to parental substance misuse are not being met by existing interventions or services are considered to be 'below the radar'.

In 2006 Action on Addiction responded to the 2003 Hidden Harm report by developing and implementing a family based intervention known as M-PACT (Moving Parents and Children Together). Where available this intervention addresses the needs of families, including children, who have been identified in a variety of ways, for example through social services, because a parent is in prison or through drug treatment services. Evaluation of M-PACT has been largely positive although the need for longer term support for families and their children has been identified[2].

Action on Addiction is a registered charity, formed in April 2007 through the merger of three organisations: Action on Addiction, Clouds and the Chemical Dependency Centre. It has recently merged with COAP (Children of Addicted Parents) an online service for young people whose parents misuse substances. Action on Addiction also runs addiction treatment centres, a specialist family service, research programmes and an expert training centre.

Previously schools have not been a gateway for families to access M-PACT. Working with families around this issue can be challenging due to the stigma adults and children experience or perceive, parental denial or a lack of awareness of the impact their substance misuse is having. Simultaneously, school staff may be aware of parental substance misuse but may feel they lack the expertise needed to recognise and meet the full range of needs of children who are affected.

Many schools employ other agencies to help them meet the mental health and emotional needs of their pupils and students. Place2Be is a leading mental health charity for children offering in-school support and expertise to improve the emotional wellbeing of children and their families. Place2Be has an established role in those schools which purchase their service, providing one to one counselling and drop in services for children and support for parents.

[1] ACMD (2003) Hidden Harm
[2] Templeton (2012)

1.1 What were the aims of M-PACT Plus?

According to the Invitation to Tender for the evaluation, the **M-PACT Plus** programme aimed to

- bring together the skills and expertise of both Action on Addiction and Place2Be
- support children and their families affected by addiction and
- transform the outcomes for children.

The pilot project was built around the existing M-PACT programme with opportunities for longer term support for children and parents offered by Place2Be. The programme consists of 8 weekly sessions for groups of families, a review for each family to consider follow up needs and services and a reunion to which all the families are invited. There was an expectation that the M-PACT Plus model could provide support for children whose families were not otherwise known to services - referred to as 'below-the-radar families' and that working through a universal service would 'allow the door to support to be opened voluntarily by the child'.

M-PACT was piloted in four areas: The north west of England (Manchester and Salford), the North East (Sunderland and Durham) Shoreditch in London (later extended to include Southwark) and Harlow in Essex (later extended to include Enfield in Middlesex).

The M-PACT Plus model differed from M-PACT in the following ways:

- Schools with Place2Be were the gateway via which families could enter the programme, even if the referral came via another agency
- Referrals would come primarily via school staff, Place2Be staff or self-referral by children
- M-PACT would be delivered by Place2Be staff already experienced in one-to-one counselling with children and trained by Action on Addiction in hidden harm and to deliver M-PACT
- There would be potential for follow up support for children and parents through Place2Be where appropriate
- M-PACT was delivered on school premises.

2. Methodology

The aims of the evaluation were to:

- Monitor the implementation of M-PACT Plus
- Describe evidence for effects of M-PACT when accessed through schools with Place2Be
- Make recommendations for modifications based on the key learning

2.1 Theory of Change

One of the first steps in the evaluation was to develop a theory of change[3]. A theory of change offers the potential for formative assessment as an intervention develops and the possibility of negotiating outcomes to assess. In essence, adopting a theory of change methodology facilitates an iterative and interactive research process, based on dialogue and discussion with multiple stakeholders including funders, delivery teams and service users. It also encourages stakeholders to articulate any assumptions underpinning the intervention and enables the early identification of threats to successful implementation of an intervention. A theory of change was developed for the M-PACT Plus pilot project and modified as a result of the learning (Appendix 2).

The steps of change were developed with the funders and the delivery partners in February 2014 and tested when these were used as a structure for an interim report. The model also contributed to the development of subsequent questions about the 'wider benefits' of M-PACT such as the developing knowledge and understanding of hidden harm among school staff and others responsible for making referrals to the programme.

2.2 Evaluation Design

The evaluation was a pre, post and follow up design, with mixed quantitative and qualitative methods incorporating the theory of change approach outlined above.

In the absence of a control group confidence in evaluation findings can be strengthened by triangulation. We have used both methodological triangulation (where different measures are used to examine similar outcomes) and respondent triangulation (where different respondents have contributed data about the same outcome). For example, where questionnaire data and one to one interviews both indicate improved family communication and clients attribute this to the programme we can infer that the programme has at least contributed to this outcome.

[3] Laing, K and Todd, L (eds) (2015) Theory-based methodology: Using theories of change for development, research and evaluation. Research Centre for Learning and Teaching. Newcastle University. Available at: http://www.ncl.ac.uk/cflat/publications/cflatguides.htm

2.3 Methods

Appendix 3 sets out the methods used and the timelines for data collection. All quantitative data collected from or about clients were carried out using routine sources already used by Action on Addiction or Place2Be. Interview schedules and online surveys were developed specifically to address the aims and objectives of the pilot project and guided by the steps of change.

2.4 Methodological limitations

The design of this study did not allow for a control or even a 'wait' group, so it is not possible to attribute observed outcomes entirely to M-PACT Plus. The number of families engaging with the M-PACT programme was smaller than anticipated and there is considerable missing data, both within the questionnaires and at different time points. As a result it has not been possible to carry out tests of statistical significance.

We have no data to explain attrition rates. Families may not have been willing to complete the forms at all times. While completion at Week 1 is high participants may not have attended Week 8 for a variety of reasons not connected to their perception of value of the programme. Similarly non-attendance at reunion could be because things had got worse, because participants did not want to revisit bad times or because of other commitments. However, the increase in 'missing data' from Week 1 to reunion, from an already small sample, weakens the confidence we can place on the quantitative findings, particularly where the trends are small.

It is always challenging to collect data from those who are critical of an intervention. All relevant Place2Be and Action on Addiction staff, external stakeholders and family members were given the opportunity to talk to the independent evaluators but not all were able or willing to take that opportunity. Stakeholders, practitioners and family members inclined to be positive about an intervention are more likely to give their time for interviews or to complete surveys or questionnaires.

Only those families who had attended Week 8 could be invited for interview by the evaluation team. Those who had dropped out or were absent at Week 8 were not invited for interview. All families interviewed once agreed to be contacted for a further follow up interview. However, only one family was contactable before this report was submitted. We are aware that several of the same families were contacted in July by Place2Be for their Voices initiative and there is a possibility that some families felt they had nothing more to add. Thus, most interviews took place between 2-5 months after the final group session.

Families who were referred but not assessed or assessed but did not attend the programme have not been asked to participate in this study. Overall, families participating in this evaluation are not likely to be representative of all other families affected by substance misuse.

Facilitators and family members protested about the number of questionnaires participants were asked to complete and in particular that some (especially those routinely used by Action on Addiction) were difficult to understand, especially if the respondent had learning difficulties or English was not their first language. While evaluators and facilitators did their best to help the participants understand the questions used in these externally validated measures, this may also compromise the interpretation of some of the quantitative data presented here.

3. Key Learning:

For Families

3.1.1 Participants (as recorded by M-PACT co-ordinators)

Coordinators recorded leads or referrals to M-PACT for approximately 100 families[4]. Sixty families were assessed and 47 families accessed M-PACT during the pilot programme (attended at least one session) comprising 64 adults and 60 children aged 7-19 years who actively engaged with the programme and 33 who attended the crèche. (These figures are based on Referral Information Forms (RIF) completed by M-PACT coordinators). Action on Addiction provided information for 120 individuals and these data indicate that 67% of participants completed the programme (i.e. attended 6 or more sessions) (See Appendix 4).

The RIFs provide some information regarding the 40 families who were not assessed although these were not recorded systematically. In some instances families were recorded as 'leads' but were not eligible for M-PACT Plus because the children were too young or the substance user was not a parent or carer. In a few cases it appeared that another agency had advised against participation on the grounds it was inappropriate. Some parents did not respond to phone calls from coordinators. The level of inappropriate leads declined with time as external stakeholders, SPMs and school staff became more familiar with the criteria.

Similarly, we have some information about families who were assessed but did not engage. Some families were uncontactable after assessment, some had insurmountable health or housing problems, one was wearing a 'tag' which prevented leaving her home in the evenings, indicating that the families concerned had multiple problems to deal with. Coordinators have indicated where some of these families are being held in mind for future iterations of the programme.

3.1.2 Data from Action on Addiction

Action on Addiction provided questionnaire data from 45 families, comprising 58 adults (31 described as users and 27 as non-users) and 61 children aged 7-19 years (mean age, 10 years) for at least one time point. See Appendix 4 for demographic data relating to this subset of participants and the details of questionnaires completed.

The general trends based on these data are similar to those seen with the national M-PACT dataset which also includes community and prison programmes. In general, participants are positive about the programme and how it has helped them and their families. They report modest improvements in family functioning and coping, and other changes which are in line with the aims of the programme. With the national dataset some of these positive changes are statistically significant, meaning that they are unlikely to have occurred by chance. However, currently the size of the M-PACT Plus dataset means that statistical comparisons cannot be made with the community and prison programmes.

[4] Numbers available at different stages of the project vary slightly due to changes in the way this information was collected.

3.1.3 Data from Place2Be

Place2Be also contributed data about 49 children whose data could be matched to information collected by Action on Addiction.

3.1.3.1 Other agency involvement with families participating in the M-PACT Plus pilot[5]

According to the subset of data provided by Place2Be, 22 children participating in the M-PACT Plus pilot were members of families who were also accessing services provided by other agencies such as social services or CAMHS. Of these, 11 families were recorded as having involvement with drug and alcohol services. Most family members or children themselves were recorded as accessing more than one service in this subset (N=18). Where families were involved with drug and alcohol services, all were also recorded as accessing at least one other service provided by a specialist agency, such as domestic violence or social care. Two families were recorded as participating in systemic family therapy.

Importantly, it appears that 27 children participating in M-PACT Plus were living as part of a family where no other agency involvement was recorded, except Place2Be and universal services. On this basis these children could be said to 'below the radar'.

3.1.3.2 Place2Be involvement

RIF data suggest that 42 children (70%) were already attending Place2Be prior to the family attending M-PACT, of whom 36 had previously or were currently receiving one to one support through Place2Be and 5 who were recorded as attending Place2Talk. One child was receiving one to one support through a school counselling service not provided by Place2Be.

Local coordinators were asked for Place2Be identification numbers for all children and young people who had accessed the M-PACT programme. By the close of the pilot identified 52 children were positively identified as having participated in M-PACT and received one to one counselling before, during or after M-PACT. Some children also attended Place 2 talk (34) and seven children attended Place2Talk only.

Place2Be also offers parent counselling in the pilot areas. RIF data suggests that 13 (22%) parents had previously or were currently accessing one to one parent counselling.

[5] Based on families where P2Be and AoA data could be matched

3.2 Outcomes for children

Overview of outcomes for children

The theory of change indicated a number of expected long term outcomes for children including improved health and wellbeing and educational outcomes. Intermediate steps towards these outcomes included improved family communication, 'knowing addiction is not your fault', increase in a child's self-esteem, greater resilience, and improved attendance at school. Taken together, qualitative and quantitative data suggest some modest benefits for children participating in M-PACT, in line with steps in the theory of change. Overall, children indicate that communication in the family has improved, that the situation is somewhat better and they have a greater understanding of addiction and its impact on their families. In interviews some children report greater self-confidence and that they are able to identify strategies for keeping themselves safe in the future, including asking other adults for help. Children and other respondents attribute these changes to M-PACT. Some of these changes are associated with key protective factors and processes which have been identified as contributing to building resilience in this group of children.

The quantitative outcomes for children and parents/carers are set out in detail in Appendix 4 and 5.

Quantitative and qualitative findings relating to the steps of change are described together below.

3.2.1 Communication

At Week 8, most children (83%) agreed or definitely agreed family communication had improved, although this was not the case for a minority (17%) who disagreed (see Table 3.1). However, the overall family functioning score (SCORE15 - Table 3c, Appendix 4) and its subscale 'disrupted communication' indicates that children did not report such positive improvements at Week 8 or the reunion.

Table 3.1 Perceptions of family communication after the 8 week programme (Extracted from Tables 7a-c Appendix 4)

Talk more openly as a family	**Definitely or maybe not N (%)**	**Maybe yes N (%)**	**Definitely yes N (%)**
Children	6 (17%)	9 (26%)	20 (57%)
Using adult	1 (5%)	4 (18%)	17 (77%)
Non-using adult	2 (11%)	5 (28%)	11 (61%)

N.B. At the end of the 8 week programme children and adults were asked to respond to a questionnaire about how the programme helped them. This was completed once only, so there is no baseline for comparison.

In interviews, some children indicated that communication had improved in their families

> *Before we went to that group, the M-PACT, we never used to talk, we used to always shout at each other...'* Brothers (primary school age)
>
> *I wasn't so confident with me Mam, but I talked to her [at M-PACT] and I got used to talking to her* Boy (primary school age)

3.2.2 Understanding addiction

In response to the feedback questionnaire administered only at Week 8, around two thirds of children reported greater understanding of addiction and its effects on their family: 67% agreed that they understood more about drugs and alcohol; 66% knew about the effects on their family (after attending M-PACT). Importantly, 69% of children who responded agreed that they understood that the family's problems were not their fault.

In interviews most children agreed that they understood 'a bit' more about how drugs and alcohol had affected their family.

One child explained how that understanding had come about:

> *'Because everyone had an addiction you could judge it from their point of view, so it was easy to understand.'* Girl (secondary school age)

For two children it helped them to understand why their mother had gone into hospital for treatment and that they thought *'she was very brave'* to do that.

3.2.3 Family functioning

Children appear to report a very small deterioration in family functioning between Session 1 and Session 8 (see SCORE15 Table 3a, Appendix 4). However, other measures of family functioning related to the ways families were managing showed improvements, however. Children perceived that they were managing slightly better as a family over the eight week programme with the improvement continuing at reunion (see SCORE analogue - Table 4a, Appendix 4). Children also reported a modest reduction in 'severity of the problem' between Session 1 and Session 8, and then again at reunion on this measure.

3.2.4. Coping with challenges

Children were asked questions about how they coped with difficulties. Table 5, Appendix 4 shows that there was a steady increase in the mean coping efficacy score between Session 1 and Session 8, with a further small increase reported between Session 8 and the reunion.

3.2.4.1 Strengths and Difficulties

One of the measures used by Place2Be to assess childrens' needs is the Strength and Difficulties Questionnaire. This measure is taken when a child is first assessed for counselling with Place2Be and at the end of their counseling. This contains 25 statements in total which map onto the five domains emotional behaviour, conduct problems, hyperactivity and attention issues, peer relationships and pro social behaviour. Using the teacher version which can also be described as a 'trusted source', the professional allocates an appropriate score (using a 3 point Likert scale) to each of the statement items. The questionnaire can be used for children who are aged between 4 and 16 years. These data are routinely analysed to classify outcomes ranging from 'normal' to 'abnormal'. The evaluation team has analysed SDQ raw data for nine children who participated in M-PACT during 2014-15 which could be matched at Time 1 and 2 (See Appendix 5). There is no reason to think that this subset differs clinically or in any other way from the larger subset of children who participated in the M-PACT programme.

These data demonstrate that most of the children's behaviours do not reach a clinically problematic threshold across the outcome domains at any time point. Findings from this sample suggest that overall outcomes appear largely unchanged for the majority of the children over this period, indicating perhaps some parents' fears, that talking about addiction will upset or harm their children, may be unfounded (See Section 3.3.3.1).

3.2.5 Confidence

Children and young people had the opportunity to be interviewed with or without their parents or carers present. Most children opted to be interviewed with their parents. In these interviews, supported by visual methods where appropriate, we were able to explore some of the expected intermediate steps of change with children.

A small number of children indicated greater self-confidence and gave a range of examples. One young person at secondary school volunteered that she felt more confident at school:

> *'It really helps you to build your confidence. First when I went there I was really shy – even though I didn't know anything. The second week I was still really shy but when we were ending I was really confident. I felt like in English I can actually read out loud.'*
> Girl (secondary school age)

For some children increased confidence was also related to relationships with family members:

> *'I am stronger when I talk to Dad.'* Girl (primary school age)

Relationships with peers also benefited: One child explained that he finds it easier to make friends because he is

> *'not so stand-offish and less aggressive'.* Boy (primary school age)

This confidence also helped children to express their feelings:

> '*I've felt more confident and like [.....] now I can tell people how I feel.'* Girl (primary school age)

3.2.6 Children are safer

There was some evidence that children were more able to ask adults for help, a strategy likely to keep children safer in the future and which has potential to be generalised to other situations:

> *We just talk to anybody we think can help us'.* Boy (primary school age)

One girl (aged 10) explained to the interviewer that she now felt able to ask her Uncle (who did not attend M-PACT) for help if her mother used drugs again, now that MPACT+ had brought issues into the open.

This finding was supported in an interview with a school contact. The respondent described a child who had participated in M-PACT had made a disclosure unrelated to substance misuse which the school has acted upon. She attributed the child's ability to speak about this to attendance at M-PACT.

> *'If it's not hidden, we can help'.* Deputy Head teacher (pastoral responsibility).

3.2.7 Children feel less isolated because of parental substance misuse

During the data collection period facilitators spoke about the importance of children feeling less isolated. This had not previously been included in the steps of change, and this has since been amended (Appendix 3b).

> *[MPACT] breaks down the shame and isolation that adults and children carry.* Co-ordinator

Evidence for this also came from Place2Be counsellors who continued to work with the children after M-PACT

> *'He got a lot from it, and he still talks about it now. [....] he felt he wasn't isolated anymore, there were other kids with the same problem – it wasn't just him. He took that into the Place2Be room and he was able to work with that.'* SPM (speaking about a child whose family attended 3 sessions).

There were some indications from children that they felt less isolated:

> *People your [own] age – like probably other people's parents have got the same addictions as your parents so it means you can bond with them and they understand. It wasn't just happening in our family.* Girl (secondary school age)

3.2.8 Other outcomes for children

Other outcomes were reported by facilitators and recorded by Action on Addiction for a small number of children and young people. There is no objective baseline for these measures which are based on facilitator reports. However, this information indicates that a small number of children were no longer subject to child protection plans (N=8) and school attendance (N=2) general education (N=7) and school behaviour (N=6) were improved. Other changes for some children were reported by practitioners and school staff.

A volunteer counsellor described a child becoming less 'grabby':

> *'When I first started seeing her around the school she would run up to me and she was very grabby – feeling like she really had to get your attention, the only way she could get it was by physically grabbing at you. But as the course has gone on and the weeks have been going on and since it's finished, her approach to me is very different, because she trusts in the fact that I am going to pay attention to her without her having to grab hold of me, jump up in front of me, grabbing at me, shouting – maybe she knows, she has the self-worth to know she will be noticed without having to do that.'* Volunteer

A deputy head teacher spoke about a child who had previously been quiet and as a result of M-PACT was now

> *'....more outspoken about substance misuse issues and, if anything, a little too boisterous (which is a good thing!)'* Deputy Head teacher (Pastoral responsibility)

Most school staff, while being able to identify what the benefits of M-PACT for children could be, were generally conservative about actual outcomes and did not expect to see changes in less than 6 months.

3.3 Outcomes for parents and carers

Overview

Overall parents and carers felt listened to, valued both the non-judgemental approach taken by M-PACT facilitators, and the opportunity to share with and learn from the experiences of others. There is consistent evidence from quantitative and qualitative findings of modest positive change for parents and carers, whether users or non-users across, all the aspects of M-PACT including understanding addiction, coping and family functioning. While parents and carers reported improvements in family communication, some adult users continued to find it difficult to talk openly with their children about their problems with addiction, justifying this as protecting children or keeping them innocent. Most parents and carers attributed the changes they perceived to M-PACT.

The quantitative outcomes for parents/carers and children are set out in detail in Appendix 4 and 5.

3.3.1 Communication

The M-PACT objectives and theory of change indicate that improving family communication is key to improving all other outcomes for families.

At the end of the 8 week programme adults (both users and non-users) agreed that they talked more openly in the family. See Table 3. 1 above).

The changes in the SCORE 15 subscale of disrupted communication for using and non-using adults were small although all in the hoped for direction (i.e. indicating communication is improved) with the greatest changes being for adult users between Week 1 and reunion.) (See Tables 3 a-c, Appendix 4).

In interviews, the topic of communication could be explored in more depth. Adults spoke about communication on three levels:

- with other adults including other participants, practitioners and family members during the M-PACT sessions
- with their children both about drugs and alcohol and
- about day to day matters such as children's behaviour and 'getting on with each other'.

3.3.1.1 Communication with others during the programme

Adult participants valued being listened to in a non-judgemental environment:

> *I felt I could voice my concerns and opinions and people would listen without interrupting and being judgemental. There were people there to listen and they understood. It felt like someone cared for you, for what your feelings and thoughts were.....especially when you have come off drugs.* Father

Adults also valued the opportunity to discuss aspects of addiction with other participants:

> *It was good because you were getting advice from other people and sharing your experience and advice with others.* Mother

> *There are some things you shouldn't discuss in front of children, so it* [the adult group] *gives you the opportunity to voice your opinion on what someone said before.* Father

Some adults were able to say that being able to talk about addiction openly had helped them to recognise the effect this had had on their children.

> *It* [*M-PACT] makes you listen more to what problems you are causing other people.* Father

> *M-PACT*[6] *has made me realise what I was doing to these children* Mother

[6] Most participants referred to M-PACT when talking about M-PACT+

One mother reported lasting changes in her willingness to speak out about her problems, 6 months after attending the programme:

> *'I'm a lot more open now and I will speak. I'm not reserved'.* Mother

3.3.1.2 Communication with children and young people about addiction

Improved family communication was an objective of the M-PACT programme, particularly with respect to addiction. Practitioners believed that being able to talk about addiction with their children was potentially transforming for parents:

> *'For the adults to speak about these secrets to their children or to have the children there when they talk about it must be such a relief. The communication part [of the programme] is really helpful.'* Facilitator

Some parents and carers interviewed valued the opportunity to talk more openly about addiction with their children:

> *We managed to express our feelings and tell them everything that's gone on and not to be worried.* Mother

> *'The similarities were really obvious [between the adult's views and the children's views], just the language they [the children] used was simpler. It was a smaller word for the child. But it was the same meaning. It showed they understood.'* Mother

Others reported that talking about drugs and alcohol had continued after the programme:

> *Gradually after he'd been to the groups, he's been talking about it and how to cope with things, he's been marvellous'* Mother

and recognised the ongoing value of this openness:

> *In rehab and that, it's all about me, me, me and my addiction. But what the programme brought was <u>us</u>* (respondent's emphasis). *She* [the child] *has got more of a say. And so has [my wife].* Father

However, some parents and carers (especially those who had or continued to misuse substances) remained reluctant to talk about drug and alcohol misuse with their children directly during or after the sessions:

One parent justified her lack of openness as keeping her child 'innocent':

> *Some see so much and others are oblivious.....children should be innocent for as long as possible.* Mother

> I found it safest.....*It's not something you want to bring home. If you are going to talk about something distressing – I don't want that environment to be home. In my way of looking at it that would be negative so we could talk about things there* [at M-PACT sessions] *and* [the child] *was open with them, especially with [*named practitioner]. Mother

One child openly disagreed with her parent about the need to speak about the parent's drug use, suggesting this aspect of communication had not changed, several weeks after M-PACT:

> Mother: *She worries about me*
>
> Child: *No I don't*
>
> Mother: *I wanted her to have someone so she can just get things off her chest – she does not want to talk to me in case it upsets me.*
>
> Child: *This is insulting.*

While their own parents may not have been able or willing to be open about their problems with addiction, facilitators supported children to talk about addiction in the children's group and to hear the responses of other adults when they re-joined the parents' group:

> *'.....they are heard, they can be heard – So if they are not heard at home [.....]we will be meeting them again and they will remember [.....] people will remember that that happened.'* Facilitator

3.3.1.3 Day to day communication between parents/carers and their children

There was more agreement among adult interviewees about improvements in general family communication, including in sibling relationships. Parents found it helpful to have new ways of communicating and of encouraging positive behaviour:

> *'Communication has improved. It seems like such an easy task – it should be automatic and it's extremely difficult – we are all different personalities. It has helped me to tone down the shouting. It was a major breakthrough for me.'* Mother

One mother who reported that she spends more time talking with her children now than before M-PACT and that this had contributed to better relationships between her youngest children:

> *All the little things they asked for....they get it more, like they do get their one-to-one and they do have their squabbles now and again, but we are better at talking.....* Mother

Another said*.....we all get along, like before we all used to scream at each other and now we can talk to each other properly* Mother

> *...we never used to talk, I used to blame myself. I didn't want to talk to them, I just wanted them to get out of my way'* Mother

Overall parents and carers found it useful to talk with other adults about addiction. Not all were able to be open about substance misuse with their children, although where this happened both parents and children agreed it was beneficial. Parents and carers were more able to give examples of improved communication when it was related to family life and parenting.

3.3.2 Understanding addiction

In response to the feedback questionnaire, most adults agreed that they understood more about drugs and alcohol and their effects on the family after attending M-PACT. (Tables 7a-c Appendix 4). Sometimes this understanding exceeded the participants' expectations. One carer described being able to empathise with addicts in a way she had not been able to before.

> '*Because of what X had put us through I thought I would not be able to sit in a room with a load of people on drugs, because I would be so negative with them. [.....] It was nothing like that*.' Kinship carer

Another parent spoke about the genogram activity where participants explored patterns of addiction across the family:

> '*To see it all on paper and to see the patterns..... more than anything. It helped the understanding [of addiction]*.' Mother

and she hoped that this new understanding would help her children:

> '*You can't change it, you can't fix it [partner's dependence on alcohol] - that was the best thing for me. The children, if they take that away at their age then that will be great because it took me all my life to see that it's not my fault and I can't fix it.'* Mother

3.3.3 Coping with challenges

Parents and carers were asked to complete two measures of coping: One a 'Coping Efficacy Scale' (CES) and the 'Parent Coping Scale'. Both measures suggested parents were coping better as time went on.

Table 5, Appendix 3 shows that for adult users there was an increase in mean CES score between Session 1 and Session 8, with a slight decrease between Session 8 and the reunion – although there remained an overall increase between Session 1 and the reunion. The pattern was slightly different for non-using adults: there was an increase in mean CES score between Session 1 and Session 8, with no further change seen between Session 8 and the reunion.

Table 3.2 (extracted from Table 6, Appendix 3) shows that adult non-users reported higher Parent Coping scores than users at the start of the programme. The mean scores for both groups continued to rise as measured at reunion. Using adults showed the biggest changes between Week 1 and reunion.

Table 3.2 Parent Coping scores

	Session 1	**Session 8**	**Reunion**
Adult users (N=24, 14, 8)	3.18	3.17	3.67
Adult non-users (N=16, 9, 8)	3.43	3.5	3.56

3.3.4 Family functioning

SCORE15 also explores constructs related to family functioning. Although the changes recorded are small they are mostly in the hoped for direction: there is a general trend among using adults of a small perceived improvement in family functioning between Session 1 and reunion, despite a perceived deterioration at Week 8 (See Tables 3a-c Appendix 3).

Most families interviewed reported that their family is more 'bonded' and described better relationships among family members following M-PACT. One family reported there was no change as they were already a close and functioning family.

> *It's brought us closer together. Me and my Dad we have a relationship that will never fall apart.* Girl (secondary school age)

> *'It feels like we're a proper family now.'* Mother

In one family there was evidence of improved sibling relationships

> *'[.....] now we're getting on'* Brothers (primary school age)

And their mother agreed:

> *'The boys are looking after one another a lot better now.'* Mother

Some of these changes can be attributed to changes in parenting style, also identified in the steps to change:

> *Things are a lot different now.* [Boy, secondary school age] *still has his moments but they can be in the same room without fighting and literally tearing each other apart. I think it's been quite a good turn around. I say to them now, 'I am the parent you abide by what I say.' Things are a lot more improved.* Mother

> *'It's finding that fine line between 'angry' to 'just leave them', because I just didn't have that.'* Mother

> *'We have made a few changes. We speak to each other more. Don't get me wrong we still have arguments but I think it's more.....when an argument starts I ask 'where is it coming from?'.'* Mother

And to children having greater trust in their parents:

> *Now I can go to bed trusting me Mam, knowing that she won't have a drink while we're in bed*. Boy (primary school age)

For some, M-PACT has enabled them to see their role within the family differently:

> *It's like it's the man's role, protecting the family, but that brick wall has been knocked down. I can be open now and they understand. There's no* [simulates aggression]. *It's 'Ok. Let's chat about it.' That wouldn't have happened before M-PACT.'* Father

3.3.5 Other outcomes for adults

At reunion Action on Addiction asked facilitators to record data about other outcomes. A small number of adult users (not necessarily the same adults for each outcome) reported: accessing treatment (N=13), accessing other local services (N=18), referred for parenting support (N=12), improvements in general physical health (N=11) and gained employment (N=4). There is no baseline data for comparison with how things were before M-PACT so it is not possible to conclude if those accessing treatment were doing so as a result of M-PACT engagement.

3.4 Added value of M-PACT Plus

Overview

M-PACT Plus relied on an effective partnership between Place2Be and Action on Addiction, and on the ability of Place2Be counsellors to be able to adapt to their new role in delivering a family based intervention in a group setting. M-PACT Plus has extended the reach of M-PACT, not only geographically, but also to some children whose family members were not previously known to agencies other than universal services. More family members were recorded as accessing wrap around support provided by Place2Be after the M-PACT programme than before. Some families were also accessing ongoing support from local agencies, in a similar way to the conventional M-PACT model. Parent counsellors can play a key role in engaging families with and supporting families following M-PACT. Practitioners have valued the opportunity to work with the whole family and the wrap around support provided by Place2Be is valued by family members

3.4.1 Partnership between Place2Be and Action on Addiction

The successful implementation of M-PACT Plus relied on an effective partnership between Action on Addiction (who developed the M-PACT programme) and Place2Be who were tasked with delivering M-PACT Plus. The responsibility to develop and sustain this partnership rested with experienced staff appointed by each organisation. Evidence for the success of this partnership could be seen in

- A shared responsibility taken by senior staff for overcoming inevitable challenges to the implementation plans
- Adaptations to standard practice by Place2Be in including more specific questions about substance misuse in assessment forms
- Determination of senior staff to embed M-PACT in the pilot areas
- Provision of centralised administrative support for M-PACT coordinators
- Acceptance by Action on Addiction of activities which complemented the aims of the programme, suggested by M-PACT facilitators
- Development of 'practitioner days' to share and extend developing practice
- Development of specific tools for monitoring referrals (RIF)

The successful implementation of M-PACT Plus also relied on Place2Be staff being able to implement M-PACT according to the standard set out in the manual. There is clear evidence that Place2Be were able to select appropriate staff to be trained as M-PACT facilitators. These staff were subsequently able to extend their usual practice of working one to one with children, to being able to work with whole families and in a group setting. Previous reports have described the steep learning curve this was for many of the facilitators but also their satisfaction in being able to put their training into practice.

It would not have been possible to implement M-PACT Plus without the significant investment in partnership working and training this entailed.

3.4.2 Wrap around support from Place2Be

A ten week programme, in isolation, is unlikely to change long term outcomes for families where parental substance misuse is impacting on children and young people. When run in the community, M-PACT practitioners seek to guide family members to other sources of support. A key innovation in M-PACT Plus is the availability of services for children and parents in school. We have distinguished between M-PACT and M-PACT Plus by defining wrap around support as any Place2Be service which families could access before, during or after their engagement with the M-PACT programme. We have defined services offered by other agencies as 'ongoing support'.

In some cases it was not possible to offer or continue Place2Be services for children after M-PACT for a variety of reasons, for example if:

- The school no longer had a contract with Place2Be
- The child was no longer at the Place2Be school from which the referral was made
- A parent withdrew consent for the child to have one to one support

3.4.2.1 Place2Be services (wrap around support) for children

RIF data suggest 42 children (60%) were already attending Place2Be prior to the family attending M-PACT of whom 36 (54%) had previously or were currently receiving one to one support and 5 (7%) who were recorded as attending Place2Talk. One child was receiving ongoing support through a school counselling service not provided by Place2Be. This arose because the referring school was in a cluster with the same executive head teacher as a Place2Be school and did not at that time have a contract with Place2Be but had alternative counselling arrangements the child was accessing. One family (2 parents, 1 child) participated in M-PACT under this arrangement.

By the close of the pilot 52 children who had participated in M-PACT were recorded as receiving one to one counselling, of whom 34 were also attending Place2Talk. We have not been able to determine how many children accessed place2Be one to one counselling as a result of attending M-PACT.

3.4.2.2 Place2Be services (wrap around support) for parents

Each M-PACT Plus pilot area had at least one parent counsellor (who supported parents either through one to one counselling or 'parent partnership'). RIF data indicates that thirteen parents or carers (22%) were already accessing sessions run by Place2Be parent counsellors prior to their participation in M-PACT. We have not been able to determine how many parents continued, were referred or took up the opportunity for parent counselling after M-PACT.

Action on Addiction data (above) indicates 12 adult users were referred for parenting support although it is not clear whether this is from Place2Be or an alternative provider in the community.

The parent counsellors we interviewed were also M-PACT facilitators who took part in focus groups with other practitioners. They felt better able to support families where they had a whole family view.

> *'It was a fantastic opportunity for me to see the dynamics of the whole family'.*
>
> M-PACT practitioner and parent counsellor

In interviews some parents said that they first heard about M-PACT through the parent counsellor and those parents who were accessing this aspect of the service reported it was beneficial.

> *'I see [name of counsellor] - she really helps.'* Mother

It appears that Place2Be parent counsellors make a key contribution to M-PACT, both through identifying and in some cases raising the question of M-PACT with parents as well providing an important element of wrap around support for families.

3.4.2.3 Ongoing support involving other agencies

In some cases ongoing support was offered by other agencies. RIF data record six adults were accessing drug and alcohol treatment and eight accessing other local services following their participation in M-PACT. (These records may overlap with other data provided by Place2Be and Action on Addiction data above). It is important to note that M-PACT Plus did not appear to inhibit engagement by families with other services.

Thus both wrap around and ongoing support were available to families, not just as a follow up to M-PACT and not exclusively through Place2Be.

3.4.3 Did M-PACT Plus extend the reach of M-PACT?

The simple answer to this question is yes. This is the case because M-PACT was not available via other local agencies in the areas where the programme was piloted. Thus the families who participated in the pilot could only access M-PACT through the M-PACT Plus pilot.

Were these families 'below the radar' i.e. not known to other agencies?

As far as we have been able to determine, none of the children in this pilot project had previously had support specifically designed to meet their needs arising because of parental substance misuse.

In this sense the potential or actual harm experienced by the all children participating in this pilot project was hidden and their needs were not being met. Furthermore, most of the families told us in interviews they had not previously had the opportunity to attend any intervention as a family, or to work with other families affected by addiction. One family had attended a family intervention provided by a domestic violence agency and two families were recorded by Place2Be as having had systemic family therapy.

Before a child can begin one to one counselling, Place2Be requests consent from a parent or carer. (No assessment is done for children accessing the informal drop in service, Place2Talk). At this stage Place2Be records information from a range of sources about the family's involvement with other services (i.e. this could be about any member of the family, not necessarily the indicated child). Information provided by Place2Be suggests that prior to one to one counselling 27 children from families participating in M-PACT had no current involvement with agencies other than universal services such as GP or schools. This indicates that 55% of children in this pilot programme could be described as 'below the radar' as far as other agencies are concerned.

Eleven families who subsequently engaged with M-PACT were recorded as being involved with drug treatment services. This may be an underestimate reported because the information may not have been available to the person completing the assessment, for a variety of reasons.

It appears that M-PACT Plus extended both the geographical reach of M-PACT and enabled families of some children previously known only to universal services and Place2Be to access an intervention designed to address hidden harm.

3.4.4 Whose needs were being met by M-PACT Plus?

For the majority of families participating in M-PACT the referral was made primarily via a school or Place2Be staff member. In a school setting a parent's substance misuse is not usually or necessarily openly acknowledged. This is qualitatively different from usual M-PACT referrals where parental substance misuse is not a secret. (We are aware of only one parent who self-referred and total of four families who were referred by agencies other than schools). The opportunity to focus on a child's needs with respect to parental substance misuse, rather than a child's behaviour or achievement was welcomed by some school staff:

> *'I say [to parents] this is not about you or your substance misuse but about what can be done to support the student'.* School contact

For most of the families who participated the children's needs were crucial to their engagement:

> '*I'm trying to get things straight for the kids' sake. Their heads have been messed up.'* Kinship carer

> *'I really did it for [child] because I knew it would be helpful for her.'* Mother of one

Sometimes the parent or carer saw the need as a whole family issue:

> '[The family] *needed putting back together'.* Mother

> *'She [learning mentor] said it's to help families to bond who have been through a lot of issues and it was always what I had wanted....so I said, 'Give it a go. Why not?'.'* Mother

3.4.5 Were changes sustained after the 8 week programme?

Information about long term changes have been challenging to collect and difficult to quantify.

Most of the changes already described could be said to be medium term in that they were reported several weeks after the end of the 8 week programme. Almost half (45%) of participants completed questionnaires at the reunion (Session 10) approximately 3 months after the final M-PACT session: 26 children and 26 adults. We cannot infer anything about outcomes for families who did not attend the reunion. Some families we interviewed were actively looking forward to reunion or reported that they enjoyed meeting families again. While it is possible some families may not have attended the reunion because they had not sustained any changes, others may have 'moved on'. One parent told us that she had 'cut herself off' from anyone who was using drugs or alcohol as part of her recovery and that this included M-PACT families. Some may simply have had other commitments.

There were some indications that families attributed changes with regard to substance misuse to M-PACT*:*

> *Our whole lifestyle's changed, because obviously I was using drink and drugs before so now I'm not taking the drugs, it's normal life... it was a mess before'* Mother

> *If I didn't do that course I don't honestly know if I would have stayed clean, but to be put in that position, and given another chance with social services... It was a fantastic programme, I can't fault it. It done us the world of good anyway.* (Mother, same as above)

And establishing 'normal' family routines:

> *We get up on a morning, have our breakfast, do our hair, brush our teeth, get our clothes on and give ourselves a wash, have our meals, then on the night we'll have our supper, then we'll brush our teeth, or go in the shower on a night, get our 'jamas on and go to bed. We're in our routine now where everything's back to normal.* Mother

or changes in behaviour:

> *Things I set myself to do. Like less cleaning, well that hasn't happened* [laughs]. *But more cooking. We were living on take-aways. Once I'd done the housework I used be like I've cleaned the kitchen. Now I don't want the kitchen mucked up so – dinner – take-away, cos there is no mess.* [.....] *And now I use a slow cooker – prepare it all in the morning, put it in the slow cooker, clean up and it's so much easier. It's great.* Mother

3.4.6 Did outcomes improve because of the wrap around support?

We have not been able to compare statistically the outcomes for families participating in M-PACT Plus compared with the national Action on Addiction database, which is considerably larger. However, the overall findings suggest that M-PACT delivers similar changes to those achieved in community and prison settings over the medium term. Furthermore we have also not observed any detrimental effects of the wrap around support provided. Families attribute those changes to M-PACT and to the support of Place2Be.

It is worth reminding ourselves that the starting point for M-PACT families is different from those in the national data set, in that parental substance misuse may previously not have been openly acknowledged. School is a universal setting where parents (and some children) expect stigma and misunderstanding of addiction, and where professionals often feel they do not have the skills or abilities to intervene. We would expect agencies which usually deliver M-PACT, such as drug treatment services or prisons, to be more ready to initiate conversations about hidden harm than was the case at the beginning of this pilot. We are also aware that ongoing support is offered (and often taken up) by families attending M-PACT in communities and prison settings. However, having opportunities for on-site support in a school is likely to help families maintain contact with practitioners who, as a result of their M-PACT training and experience, now have a greater understanding of families' needs.

4. Key Learning: The School Environment

Overview

The partnership between Action on Addiction and Place2Be faced many challenges with respect to communication with schools about M-PACT Plus, including structural issues in the ways in which all organisations are able to communicate with schools to offer information, advice and training about social interventions.

Place2Be and school staff have become more familiar with M-PACT and their role in making referrals, However, some school staff and SPMs remain cautious about disrupting fragile relationships with families by raising questions about substance misuse.

Opening the conversation about M-PACT relies on a high level of trust between families and the practitioner who raises the question. Some schools have a relationship with Place2Be which makes it easier to decide the best person to talk to families about M-PACT. However, this relationship depends mostly on the senior management of the school. SPMs are not able to influence the policy or ethos of a school. Evidence suggests that once a family has engaged with M-PACT the school will make subsequent referrals, suggesting M-PACT Plus is becoming more embedded in pilot areas.

4.1 The schools

Of the cohort of 77 possible schools (including 5 secondary schools) [7] 38 contacted a coordinator about approximately 100 families.

4.2. Awareness and capacity building in schools

4.2.1 The challenge of communication with schools

There was a perceived need to build the capacity of the staff of each school across four areas of England to provide staff with the knowledge, understanding and skills to recognise and raise issues of parental substance misuse in a universal setting.

It was initially intended that the awareness of school staff about hidden harm and M-PACT could be raised through in-service training delivered by managers in Action on Addiction and Place2Be and arranged through local authorities and other local bodies. It was anticipated that key school staff would be released to attend this training. This model of delivery had the advantage of reaching a large number of staff in a timely and efficient way.

[7] Current numbers vary as some schools no longer have P2Be and some have recently joined

However, the introduction of M-PACT by Place2Be coincided with a trend to decentralise support for schools through academisation and Local Authority cuts. Structures of training and support offered by local authorities, public health and other bodies were being, or had already been dismantled and this has had a widespread effect on how organisations such as Place2Be and Action on Addiction communicate information, training and support to schools. There are also many competing demands on schools to address social or health issues.

The result of these factors for the M-PACT pilot has been that Place2Be and Action on Addiction had to find other ways to identify key contacts within schools and to encourage staff to take up the opportunity for awareness raising on a school by school basis. Managers, coordinators, cluster managers and SPMs were all been enlisted in this effort, which became crucial to the identification and referral of families for whom M-PACT is intended.

4.2.2 How awareness of hidden harm and M-PACT has been communicated to schools

In an effort to understand how awareness was raised, coordinators were asked, in early 2015, to detail their approaches to schools to offer short hidden harm training and M-PACT awareness sessions. The presentation was designed to fit flexibly into any opportunity schools could offer e.g. a staff meeting, all (or part) of a twilight or professional development training session or any other format suggested by schools. Meetings with senior staff or those responsible for inclusion or safeguarding were also offered. A case study from one area illustrates the process.

> February 2015: Of 28 schools, 5 were already aware of M-PACT and had made referrals. Three further schools were in contact with the coordinator about possible referrals and SPMs from another 3 schools had already met Action on Addiction staff or attended hidden harm training. In February SPMs from 17 schools were sent an e-mail offering a meeting and/or training for school staff about hidden harm. Three schools responded positively and one responded they were unable to take up the offer as they were undergoing changes to their senior management team. The remaining 13 SPMs were sent a follow up e-mail in March following which a further 3 schools responded positively.
>
> This activity resulted in 9 meetings with SPMs and school staff at 7 schools. Seventeen of the 28 schools have now made at least one referral, although not all of these have resulted in a family actively engaging with the programme.

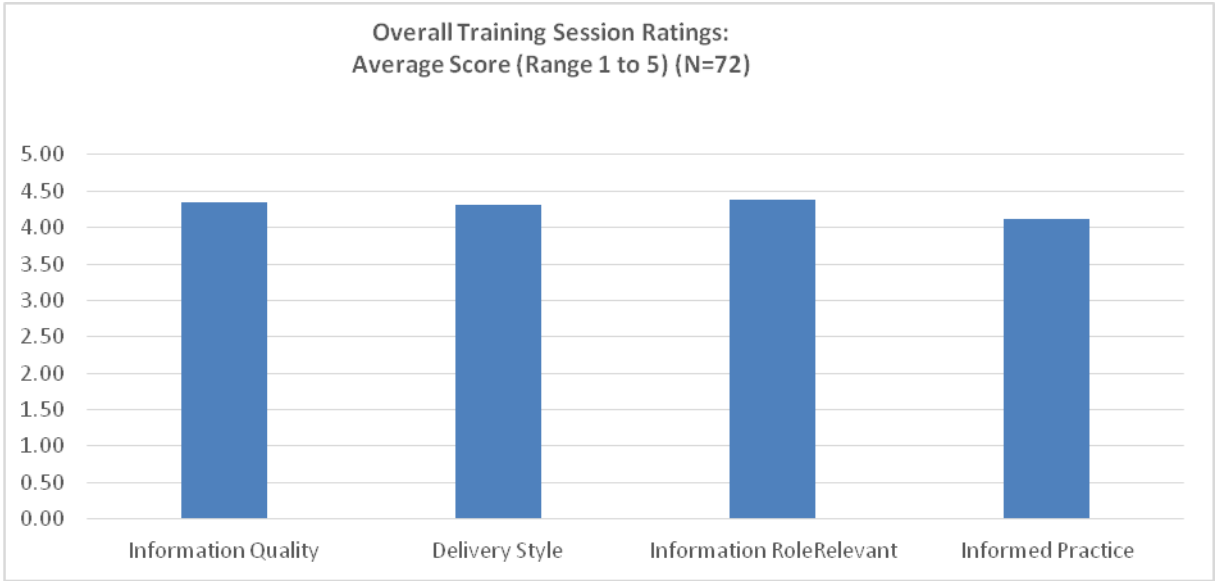
This pattern which emerged is one of gradual development of uptake based on frequent and repeated communication of a clear message, delivered in a way to suit the context of the school. It requires flexibility on the part of staff and has proved to be very time consuming.

4.3 Knowledge and understanding of hidden harm and M-PACT Plus among school staff

(See Section 5.2.1 and Appendix 5 for similar findings for Place2be staff)

Seventy two school staff completed the standardised training evaluation form[8]. The majority of respondents provided high scores across four areas, which included: quality, style, relevance of information and likelihood of informing practice (79%). Only three people provided low overall rating scores for the session (4%). The remaining minority of respondents provided medium scores (17%) to rate the session. See Figure 4.1 (Average scores for all respondents). The bar chart indicates school staff valued the training highly.

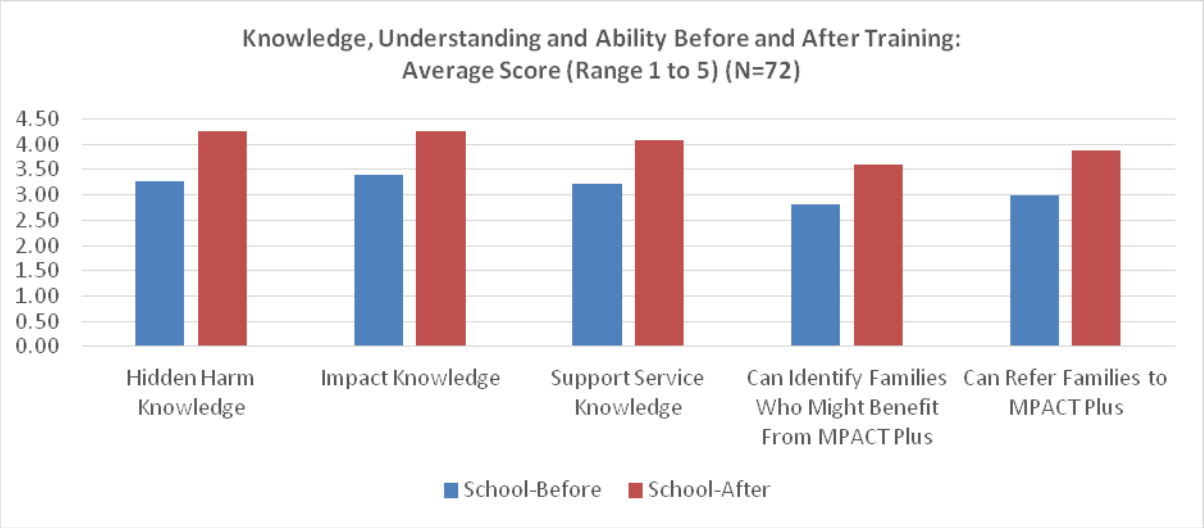
Figure 4.1: Overall Training Session Ratings by School Respondents (N=72).



The majority of respondents indicated positive change across five domains, following the training including: an understanding and knowledge base of hidden harm and the impact of substance misuse on families, knowledge about local services that support families, an ability to identify families who could benefit from MPACT Plus and an ability to support families to access the programme. Figure 4.2 shows the average scores that were provided by the respondents on a 'before' and 'after' session basis.

[8] A total of 201 respondents from Place2Be and schools participated in training, not all of whom completed the agreed standardised form

Figure 4.2: Knowledge, Understanding and Ability Ratings Before and After the Training Session by School Respondents
(N=72).



However, further analysis of the magnitude of change indicated that for some respondents low initial scores were resistant to change after the training.

Table 4.1: Magnitude of Change across Respondents Ratings on the School Based Training Session (N=72)

	Improvement in Score After Training	**No Change - Score Still High After Training**	No Change - Score Still Low After Training	Deterioration in Score After Training
Change in Hidden Harm Knowledge	**56.9%**	**38.9%**	0.0%	4.2%
Change in Impact of Substance Use on the Family Knowledge	**55.6%**	**40.3%**	0.0%	4.2%
Change in Local Support Service Knowledge	**52.8%**	**34.7%**	8.3%	4.2%
Change in Ability to Identify Families Who Might Benefit from M-PACT Plus	**54.2%**	**12.5%**	31.9%	1.4%
Change in Knowledge to Support Families to Access M-PACT Plus	**51.4%**	**20.8%**	25.0%	2.8%

The table above shows that a third of respondents remained uncertain about their ability to identify families who might benefit from M-PACT Plus and a quarter remained unsure how to support families to access M-PACT Plus.

It is possible that some school staff who did not consider that their role or work involved identifying families and so did not necessarily relate to the training material that demonstrated how families are referred to the programme intervention. Furthermore a small percentage of school staff did not identify a need to attend the training and these scores reflected a slight deterioration in knowledge and understanding as a result of the session.

These findings indicate the need for training to be more tailored to the needs of participants, where possible.

4.4 Trust and relationships

While knowledge and understanding of hidden harm and M-PACT are key to school staff being able to think of a family who might benefit from engaging with the programme, school contacts (and SPMs) have emphasised the importance of a trusting relationship between the parent and the person making the first approach about M-PACT. For some school contacts and SPMs this is a straightforward matter.

> *'I tend to be quite blunt about it.'* School contact

This is most often possible when families have been open about the effects of parental substance misuse on their families and are seeking ways to help their children. For others it takes time:

> '*When a child is flagged (and these are always flagged) I get to know the child, then start talking to the parent. This can be a process of 3 months. They are very suspicious of me and it takes time to build that relationship where I can drop M-PACT into the conversation.'* SPM

In some cases school staff and SPMs questioned whether speaking about M-PACT (and by inference substance misuse) will damage an already fragile relationship between the parent and the school. A Place2Be practitioner may lack confidence in how to approach a family and might seek more training, discuss with a colleague (e.g. in supervision) or consider who else might have a better relationship with a parent. There can be an expectation of denial and perceived stigma which discourages professionals of all kinds from starting the conversation. However, we have seen that in this pilot project different kinds of professionals including school and Place2Be staff have begun the process with almost 100 families, many of whom may never have spoken about issues to do with drug and alcohol use in a school setting before.

4.5 School characteristics

It is not sufficient to raise awareness of school staff about hidden harm and the availability of M-PACT. We have observed that the characteristics of a school can strongly influence whether or not professionals are able to use their knowledge and understanding of hidden harm and the relationships they have with families to talk about M-PACT.

Three types of school have been identified by this evaluation:

Type A: In Type A schools the mental health and wellbeing of children is taken care of by Place2Be who provide counselling and drop in services. The school and Place2Be operate more or less in parallel with the school making referring children to Place2Be whose staff provide the service.

> *'[There is a sense that] we brought you in to do it...we trust you to do it....go away and do it.'* SPM

This expectation also applies to M-PACT

> *'The school sees it as my job to make the referrals.'* SPM

The interaction between Place2Be staff and school staff is business like and matters of shared concern such as safeguarding are dealt with appropriately but communication about new initiatives such as M-PACT can take time. Even where school staff had the opportunity to attend hidden harm training, involvement with M-PACT can be seen as a risk:

> *'It [referring a family to M-PACT was] seen as a threat to the image of the school [....] not an opportunity to do something constructive'.* SPM

In Type A schools M-PACT is a bolt-on intervention.

Type B: In Type B schools, Place2Be services are integral to the school's support for children and young people.

> *The ethos of [this school] is to help students to develop as people, not just academically'.* School contact

There is regular, scheduled discussion between SPMs and school staff about children and young people who might be supported by Place2Be or who are receiving support from Place2Be. This means that where the possibility of a referral to M-PACT is considered there is a discussion about who should begin the conversation.

> *'Being part of a team means it is possible to choose the person with the best relationship with the family.'* SPM (same school as school contact above)

Type B schools often offer other well publicised services for families such as parenting classes and may host some external agencies such as CAMHS. Senior staff have usually been in place for some time. Communication about new initiatives like M-PACT are readily communicated, understood and acted upon. In Type B schools M-PACT is a built-in intervention.

Type C: In Type C schools, there is a range of barriers to communication about M-PACT and hidden harm. School and Place2Be staff may both assert that there are more pressing concerns than parental substance misuse, for example, poverty or homelessness.

Conversely the problem with parental drug and alcohol misuse may be seen as so ubiquitous as to appear normal in the community:

> *'Drugs and alcohol are so prevalent here and they will tell us about everything else but that.'* SPM

Senior leaders may also be unwilling to open up sensitive issues,

> *'There is a sense of collusion in the school [....] and there isn't a lot of challenging [of parents' behaviour] going on. It's a very difficult dynamic to work within sometimes.'* SPM

Type C schools may also have experienced challenges such as a poor Ofsted report or recent changes to senior staff.

There may also be resistance because M-PACT is a pilot project.

> *'[M-PACT is] here today and gone tomorrow. It needs to be there for the long term, for staff to know about it and how it helps families and students. '* School inclusion lead

> *'We would like to see the evidence.' School inclusion lead*

In some Type C schools a SENCO or Parent Support Advisor who is closer to the needs of families can work with an SPM to facilitate referrals where other staff cannot.

Type C schools are less likely than other schools to make referrals to M-PACT.

It is important to note that the picture this represents is not static and a Type C school can become a Type B school given the right circumstances. However, the relationship between M-PACT, Place2Be and the school is driven largely by the senior leaders in the school and is not in the control of SPMs who are part time and not in a position to change school ethos or policy.

4.6 Referrals by school staff

While all referrals are ultimately made via the SPM, as awareness of M-PACT has grown school staff have made more referrals/leads (increasing from 4 in the first iteration to 7.5 families [9] in the final iteration). At the same time referrals/leads from Place2Be staffs (SPMs, PCs or VCs) have declined from 22 to 17.5 families (not all these families progressed to assessment or engagement). The mean number of school staff referrals is 5 per programme and for Place2Be staff it is 17.

This pattern probably reflects a number of different processes we have observed:

- More schools know about M-PACT through the many efforts to raise awareness.
- More SPMs and Parent Counsellors have become familiar with M-PACT and have begun to see how families have responded to the question of attending M-PACT. They have become more confident in communicating this to school staff who are more likely to be involved in a referral.
- To some extent who makes the referral also depends on the type of school. Both Place2Be staff and school contacts agree that the best person to open the question of attending M-PACT is someone whom the families trust and possibly someone with whom a parent or carer has already shared information about the effect of a parent's substance misuse on their family. This discussion is more likely to happen in Type B schools.

4.7 Perceptions of school as referral point

Interviewees often spoke about the role of the school as a venue for referrals and M-PACT sessions. For some there was an existing relationship with a member of staff who initiated the conversation about M-PACT

> *'I was in school for a meeting about [name of child] behaviour and Miss [...] gave us a leaflet. Then I saw [SPM] and he saw Miss [.....] to speak about it'* Carer

For some parents it was natural for the school to be concerned about their child.

> *She* [the child] *was not doing good at school, she was upset and that, 'cos I was away in rehab. So the school got involved – and I am glad they did.* Father

Using school premises for the programme was also a plus point for families

> *'When you go to drug therapy, outside are all the dealers, so you feel really vulnerable. Where it was....it was just a school. No one knew why you was there. It was just a school.'* Father

Place2Be was also a trusted broker for parents within schools

> *'The school knew about my situation. [When M-PACT was mentioned by SPM] it just seemed like the next step'.* Mother

[9] RIF data

5. Sustainability

Overview

Communicating effectively with Place2Be staff about M-PACT is ongoing. SPMs were not always familiar with M-PACT at the outset and a few continue to lack confidence in their ability to identify families who might benefit from M-PACT which is not addressed by the current training model. Some remain wary of disrupting relationships with families by raising questions about substance misuse. There is considerable turnover of staff from year to year and it has been suggested that Place2Be include M-PACT in induction training for volunteer counsellors, SPMs and parent counsellors. The coordinator plays a key role in liaising with SPMs, school staff and families. A new website has been planned to make information about Place2Be more accessible to staff and families.

At the time of writing all four pilot areas are recruiting families to participate in a fifth iteration starting either in the autumn or spring term of 2015-16. Place2Be has applied for additional funding to extend the pilot for a further 18 months.

What is in place to sustain this and further developments?

- Track record of M-PACT as a useful intervention for families affected by parental substance misuse
- Continued integration of M-PACT into Place2Be practice, including supervision.
- Growing awareness and capacity of School Project Managers
- The role of M-PACT Plus coordinator in developing relationships with schools and other agencies, monitoring and evaluation
- The development of a new website promoting better understanding of M-PACT
- Local needs assessment and discussions with commissioners

5.1 Track record

M-PACT is developing a track record as a useful intervention for families in the four pilot areas. In interviews practitioners, school contacts and Place2Be staff are mainly positive about the actual and potential outcomes for children and their families. As we have seen, of the 77 schools which could make a referral to date 38 have done so and half of those have made a referral to more than one programme.

5.2 Integration of M-PACT into Place2Be practice

We have seen (Section 4.5) that an open discussion of who should open a conversation about M-PACT with a family depends to some extent on the way Place2be services sit within a school. There is also evidence that not all SPMs were as ready to embrace M-PACT as others. M-PACT was seen by some Place2Be staff as

> *'an Action on Addiction intervention, instead of joined up working. The foundations have not been put in place as a lot of SPMs see M-PACT (sic) as a separate entity. '* SPM

Others, however, have come to see M-PACT as an example of Place2Be's approach to supporting children

> *'It ties in well with the [Place2Be] ethos'*. SPM

And as a positive development for Place2Be

> *'Whole family work, that is the way to go'* M-PACT volunteer

This transition has been helped by developing the awareness and capacity of Place2be staff, bringing supervision for practitioners 'in-house' and promoting M-PACT within Place2Be at high profile events.

Experienced M-PACT facilitators have recommended that M-PACT should be part of induction training for Place2Be staff such as SPMs and volunteer counsellors, to further embed M-PACT as a part of the Place2Be offer in schools.

A range of staff are key to continuing integration of M-PACT within Place2Be, especially SPMs, Parent Counsellors and M-PACT coordinators.

5.2.1 Awareness and capacity of SPMs in M-PACT

5.2.1.1 Awareness

As direct communication with schools proved difficult, SPMs became key to M-PACT referrals and to communication with schools, on top of their routine contractual obligations. A survey of all SPMs in March 2105 found that all SPMs who responded (40) had heard of M-PACT. Most of them had found out through the M-PACT Plus coordinator (63%). A similar proportion (65%) had attended an M-PACT awareness or training session and three quarters of those found it very useful and helped them to understand their role (See Appendix 6). SPMs were also interviewed for the evaluation, some of whom were still developing their understanding of the pilot project and their role in enabling families to access M-PACT.

> *'I didn't know that was going to be my role [making referrals]. I thought that would be the coordinator.'* SPM

Some SPMs felt a sense of grievance about being asked to do more (e.g. attend assessment interviews) for no additional pay, while others felt underprepared to make referrals:

> *'It was, 'Here's a leaflet. Get on with it.'[making referrals].'* SPM

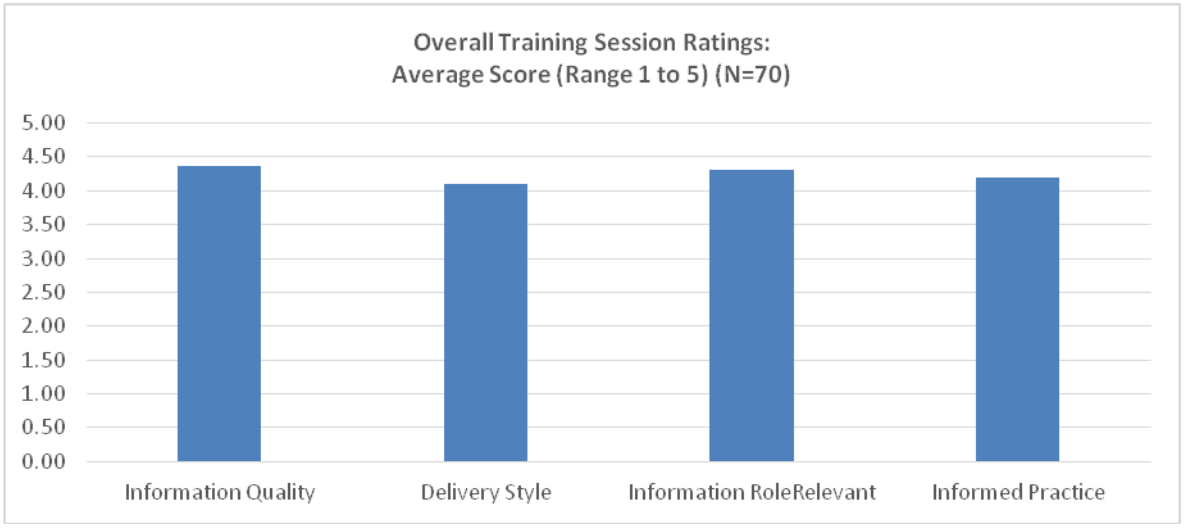
As the pilot progressed SPMs were offered increasing support to develop their knowledge and understanding of hidden harm and how M-PACT could help families. For example SPMs from Shoreditch and Southwark were invited to attend a full day's training at the Place2Be hub in Islington. In other areas this was been achieved through coordinators attending local SPM meetings, backed up with individual communication and regular discussion in supervision by cluster managers.

5.2.1.2 Response to training

Seventy respondents[8] who were connected to Place2Be (mainly SPMs and parent counsellors) completed the standardised training evaluation form (See Appendix 5). The majority of respondents provided high scores across four areas, which included: quality, style, relevance of information and likelihood of informing practice (75%). Figure 5.1 demonstrates that the majority of sessions for Place2Be were highly rated across all areas.

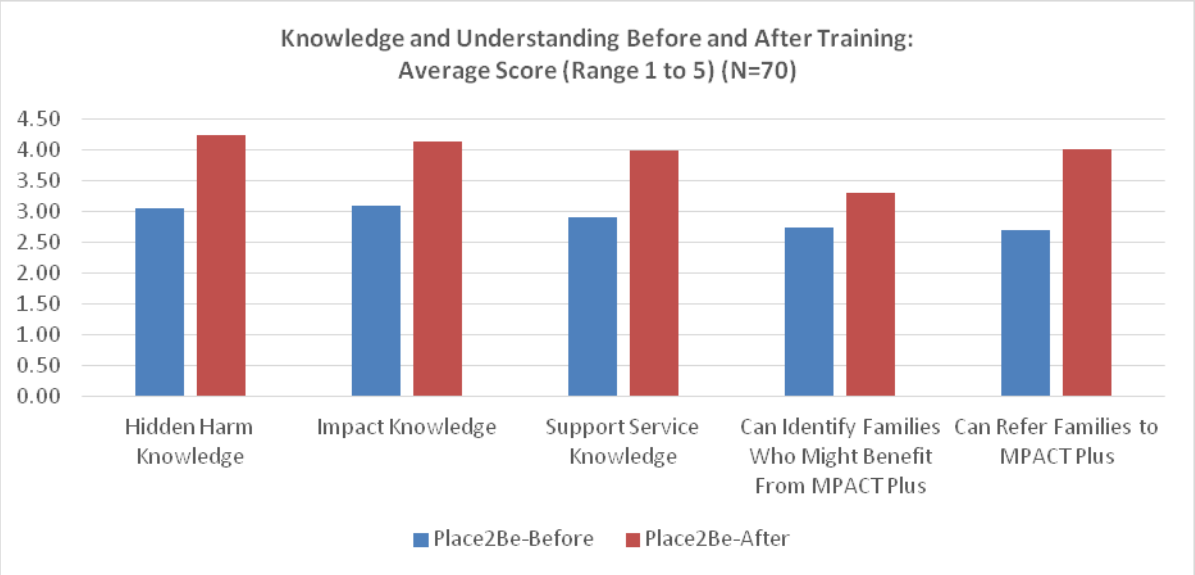
The majority of respondents also recorded high post training session scores across five domains, which included: an understanding and knowledge base of hidden harm and the impact of substance misuse on families, knowledge about local services that support families, an ability to identify families who could benefit from MPACT Plus and an ability to support families to access the programme. Figure 5.2 shows the scores that were provided by the respondents on a 'before' and 'after' session basis.

Figure 5.1: Overall Training Session Ratings by Place2Be Respondents (N=70).



[8] A total of 201 participants from schools and Place2Be attended training of whom 70 Place2 be staff completed the standardised evaluation form.

Figure 5.2: Knowledge, Understanding and Ability Ratings Before and After the Training Session by Place2Be Respondents (N=70).



As with the school staff, the average picture for the Place2Be respondents indicates the training was beneficial. The more detailed analysis of the magnitude of change helpfully informs as to where the greatest benefit existed.

Table 5.1: Magnitude of Change across Respondents Ratings on the Place2Be Training Sessions (N=70)

	Improvement in Score After Training	**No Change - Score Still High After Training**	No Change - Score Still Low After Training	Deterioration in Score After Training
Change in Hidden Harm Knowledge	**65.7%**	**31.4%**	0%	2.9%
Change in Impact of Substance Use on the Family Knowledge	**55.7%**	**42.9%**	0%	1.4%
Change in Local Support Service Knowledge	**57.1%**	**27.1%**	11.4%	4.3%
Change in Ability to Identify Families Who Might Benefit from MPACT Plus	**41.4%**	**12.9%**	40.0%	5.7%
Change in Knowledge to Support Families to Access MPACT Plus	**65.7%**	**15.7%**	14.3%	4.3%

Fig 5.3 shows that some respondents were uncertain about their ability to identify families who might benefit from MPACT Plus (40%) which persisted after the training.

Despite the investment in training, and a range of other activities designed to embed M-PACT in Place2Be's offer to schools, there remains a minority of Place2Be staff who feel unprepared to identify families who might benefit from M-PACT. This was explored in follow up interviews with SPMs.

> *[I] need more training on how to do this [identify parental substance misuse]. In our role we have to manage relationships and be trusted in our role. It takes all our effort to keep them [parents] consenting for their child to be at Place2Be. If I then raise M-PACT I'm potentially putting that child at greater harm as I will lose that consent and relationship. There needs to be more awareness of the role of the SPM within the school..... this hasn't been acknowledged.'* SPM

Recommendations for enhancing training are made in Appendix 5.

5.3 The role of the coordinator

The coordinator's role is multifaceted, including assessment of families, coordination and administration of the M-PACT programme, delivery and supporting other members of the team and, importantly, monitoring and gathering information for evaluation. The role of the coordinator is also crucial in promoting and sustaining M-PACT at a local level

> *'The coordinator needs to go into schools regularly and have their face known – coffee mornings, staff meetings. It's about establishing trust with someone [in the school]'.* SPM

One coordinator saw this process beginning most naturally following a school's first referral

> *'Once you get one referral your relationship [with the school staff] starts to build. Before that you are the unknown. When I meet with the SPM I try and meet with the SENCO or the Deputy but it's not always possible to match the diaries – it's a part time role.'* Coordinator

Coordinators also had a vital role in developing and maintaining relationships with other local agencies to which some family members were signposted for ongoing support.

5.4 Website development

The development of an addition to the Place2Be website which includes information about M-PACT and the testimony of families is expected to make it easier for Place2Be staff, school staff and families to access and share information to promote referrals and uptake.

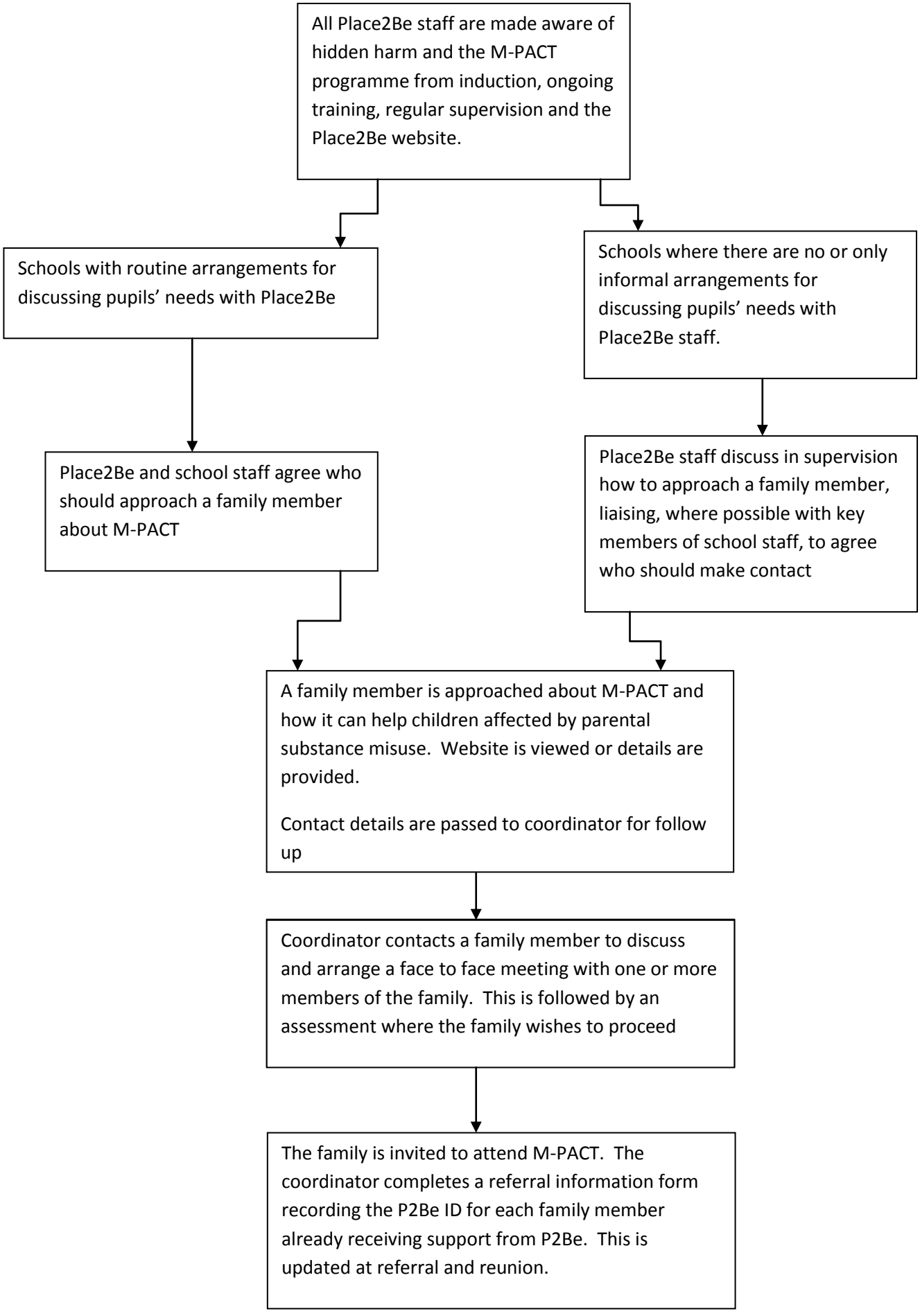
5.5 Discussions with commissioners of services in local areas

These are at an early stage. A needs assessment is being done area by area using Joint Strategic Needs Assessment and public health data.

5.6 Best practice model for referrals

The evaluators were asked to draw up a best practice model for referrals, based on these observations. The flow chart below has not been tested with practitioners and it is recommended that this model is used as a starting point for development.

M-PACT referrals: a suggested best practice guide



Conclusion

Place2Be and Action on Addiction formed an effective partnership to implement M-PACT in schools where Place2Be had an existing relationship. Findings suggest there were modest benefits for children, parents and carers in line with the aims and objectives of M-PACT and with the findings of the national Action on Addiction dataset. Families were able to access wrap around support from Place2Be and ongoing support from other agencies in their local community. Approximately half of the children who participated in M-PACT were from families who previously were known only to Place2Be and universal services.

Professionals in schools and from Place2Be have become more aware of hidden harm and how M-PACT can help families. Where M-PACT has been available it is becoming increasingly integrated into Place2Be practice and into the support schools offer to families.

Factors which will help to sustain M-PACT have been identified.

Recommendations

Section 3

- Place2Be should consider how to extend the M-PACT Plus pilot in the existing areas and how to introduce it in other areas, in agreement with Action on Addiction.
- The key components of M-PACT (e.g. the number of sessions, provision of food or transport, staff to family ratios, effective supervision of staff and sufficient time and resources for planning and implementing the programme) should be maintained in future iterations of the programme.
- Place2Be and Action on Addiction should consider how best to communicate information about the evidence for effectiveness of M-PACT Plus to key stakeholders in schools and other agencies with a role in reducing hidden harm, beyond the planned dissemination of this evaluation report.
- Place2Be should pilot and develop the draft model of best practice for referrals suggested in this report.

Section 4

Where M-PACT is available:

- Place2Be should include information about M-PACT in all communications with headteachers and senior managers.
- Place2Be and Action on Addiction should continue to offer training for school staff in hidden harm and M-PACT, through whatever means possible. The training should be targeted for those individuals most likely to have the trust of parents in raising sensitive issues.
- Place2Be and Action on Addiction should continue to inform external stakeholders are aware of M-PACT to encourage appropriate referrals to M-PACT and signpost families to ongoing support.

- Place2Be should ensure there are sufficient resources to meet the needs of families for wrap around support.

Section 5

Place2Be should include an awareness of hidden harm in induction training for all staff working with children and parents in schools.

In addition, where M-PACT is available:

- Place2Be staff (SPMs and parent counsellors) should be offered interactive training to enable them to continue to develop their confidence and skills.
- Cluster managers and all those responsible for supervision of Place2Be staff should be able to support SPMs and parent counsellors to speak to parents and carers about the effects of parental substance misuse and how M-PACT could help them and their children.
- The job description, terms and conditions of employment of the M-PACT coordinator should be reviewed, now that the scope and importance of this role is better understood.

Monitoring and evaluation:

- Coordinators should record how families engage with Place2Be and other services following M-PACT, providing a more immediate overview of wrap around or ongoing support families are accessing.
- Place2Be and Action on Addiction should continue to collect information about the outcomes of M-PACT Plus for children, parents and carers through routine data collection, and when possible commission a comparison with the national M-PACT dataset.
- Place2Be should continue to evaluate training for school and Place2Be staff and compare the outcomes with the baseline provided in this report.
- To support the implementation of these recommendations, Place2Be should consider training frontline staff in evaluation.
- Place2Be and Action on Addiction should continue to set aside sufficient resources for evaluation.