Addressing the needs of children of substance using parents: an evaluation of Families First's Intensive Intervention

Final Report

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Content

Executive Summary

Introduction

- Families First is a multi-component support service which provides advice, social work intervention and parenting support for adults and families on substance use related issues. Its intensive family support package has been developed from the Intensive Family Preservation (IFP) approach used by the 'Option 2' project in Cardiff and the Vale of Glamorgan and the Neighbourhood Enabling Team (NET), a Middlesbrough based Family Support Project funded by NRF which preceded the inception of Families First.

- In 2003, the ACMD published *Hidden Harm*, the findings of an investigation into parental problem drug use and its effects on children (ACMD, 2003). The enquiry estimated that there were between 250,000 and 350,000 children of problem drug users in England and Wales, which represents 2-3% of all under 16 year olds (ACMD, 2003). In response to Hidden Harm, the government outlined its commitment to conducting research into identifying what types of services and interventions work with children of problem drug and alcohol users and their families (DfES, 2005). This evaluation of Families First's intensive intervention is in accordance with this objective. The findings aim to add to the UK evidence base and inform the development of future interventions for children affected by parental substance use.

- The intensive family intervention aims to ensure child welfare and if parents are unable to make necessary lifestyle changes then alternative care arrangements are made. Upon referral to the project the majority of study participants were heroin and crack cocaine users or in some cases problematic alcohol users. Many had previous experience of social welfare involvement which in some cases had resulted in the permanent removal of children from their care. For many of the families involved, the intervention was their last chance to change their lifestyle in order to keep their child/ren in the family home.

Methods and sample

- The study was designed to identify the processes involved in service delivery, including intervention approach, the implementation and integrity of Families First, interagency working, as well as the outcomes of the intervention for participating families. Both quantitative and qualitative research methods were used, including semi structured interviews, questionnaires and Social Network Analysis to evaluate internal and interagency working relationships.

- Research was conducted with project staff (n=15), stakeholders (n=5) and a cohort of parents (n=11) from eight families over a twelve month period. In total, 29 semi structured interviews and questionnaires were conducted with parents.

Key findings

Care status and cost

- Care status findings indicated that participation in the intensive intervention prevented the majority of children in this cohort from care entry or prevented long term care placements outside of their family unit. All children were at high risk of entering care upon referral yet all were living with family members at twelve month follow up. Such findings indicate that Families First had a positive impact during the twelve month observation period.

- Economic analysis of the intervention revealed that the cost of support for each child whose family received the intensive support package between April 2007 and March 2008 was £6,555. The mean cost per family (including both children and adults) during this period was £12,642. A lack of comparison group data meant that cost effectiveness analyses were not possible, however national estimates for the average cost of children in care (£33,000) suggest that Families First is a cost effective approach to reducing the need for care.

- The support provided by kinship carers (predominantly grandparent carers) throughout the intervention process is believed to have contributed to the care outcomes observed in the majority of participating families. Kinship care arrangements were particularly important in preventing many children's short term entry into care by providing interim care placements whilst Families First worked with parents and the stability of the home environment was reviewed.

Kinship carers received little or no financial support and therefore provided significant cost savings to the local authority. Further investigations into the impact of caring for young children with little, if any, financial or emotional support was beyond the scope of this study.

Parental substance use

- For the majority of parents, participation in the intensive intervention was associated with cessation of illegal drug use, and/or stabilisation or reductions in methadone dosage for a twelve month period. However, this study did not seek to determine the effects of structured drug treatment, and so causality cannot be determined.

- Findings relating to alcohol misuse were not as clearly defined. This was mainly due to the small number of parents whose substance use related to alcohol rather than heroin or crack cocaine. Levels of alcohol consumed by two mothers decreased significantly for the first six months of the intervention; however, lower levels of consumption were not maintained for the twelve month period.

- Although not statistically significant, the findings did indicate a slight shift towards low levels of regular alcohol use (less than government recommended maximum weekly guidelines) amongst former illicit drug users over time.

Health

- Parental reports of child health and emotional well-being indicated that anxiety, specifically children's concern over what would happen to their parents, reduced significantly over time. Anxiety was attributed to the cause of soiling (Encorpresis) in one child and linked to the need for medication in another. Neither children were reportedly experiencing symptoms of anxiety at six nor twelve month follow-up. There were no other significant differences observed in the frequency of children's physical or emotional problems as the majority of children were healthy and in regular contact with their GP.

- Parents did not believe that their own state of health negatively impacted upon their daily lives or ability to provide care for their children. The few

reports of poor health were attributed to substance use, including deep vein thrombosis and kidney failure. All parents were in regular contact with their GP and none discussed their health as being an issue of concern.

Depression, parenting and socialisation

- Using a validated scale of depressive symptomatology (BDI) all parents were experiencing elevated levels of depression, which did not significantly change over time. Statistical analysis indicated that elevated levels of depression negatively impacted upon levels of family conflict and were also related to how parents felt they were able to cope with parenting.

- Many parents described how participation in Families First had led to an improvement in how they felt about themselves, which they linked to having the opportunity to talk to Families First staff about their problems.

Family conflict

- Family conflict, such as arguing and fighting with both immediate and extended family members, was found to be an important issue and one that also negatively impacted upon parenting. Study findings suggested that increased levels of family conflict were related to a reduction in how parents felt they are coping with the care of their child.

- Some parents described how Families First had brought families closer together through the involvement of wider family members (such as grandparents and aunts) during the intervention. This provided parents with additional support through the period of drug withdrawal and lifestyle change. The continued support of wider family members may also assist parents in the longer term when they were less engaged in support services.

Housing, education and employment

- A shortage of council housing stock in Middlesbrough was an ongoing concern for families and was viewed by many as a barrier to achieving change. Families who did move house during the evaluation period partly linked reductions in substance use and return of children to their care with

having the opportunity move away from former social networks and areas of residence.

- Although not a main priority of the intervention, the support provided did not greatly impact upon parents' education and employment opportunities. Despite some parents expressing a desire to access employment and starting training or vocational courses, none completed courses or accessed employment.

What reasons did parents attribute to improved outcomes?

- The majority of parents felt that participation in the Families First intensive intervention had resulted in a range of positive outcomes for their family.

- The combination of intensive support and temporary removal of children appeared to provide some parents with the motivation for change as they felt that they could achieve what was required if they were supported through the process.

- Additional factors such as timing, the use of Solution Focussed Behavioural Therapy (SFBT) tools[1], resolved housing problems, acknowledgment of personal responsibility and establishment of a truthful relationship with social workers were all themes identified in parents' descriptions of what they felt had enabled their achievements. These findings highlight the complexity involved in the design and implementation of interventions in this area.

Aspects of the intensive intervention valued by parents

- Therapeutic tools used to deliver the Solution Focused Behavioural Therapy model, such as goal setting and value cards were the most valued aspects of the intensive intervention. Goal setting in particular appeared to provide parents with a sense of control over the intervention process which then provided motivation for change.

[1] SFBT approach aims to build motivation and confidence allowing the family to start to think positively about the future. Techniques include a 'miracle question' and goal setting to assist families in envisaging change and planning their personal progress towards it (Hamer, 2005)

- Families also valued the opportunity to talk to staff and seek advice on family problems and parenting when required. Participants believed that this contributed to their successes

Social worker and parent relationship

- Communication between social workers and parents was often challenging, particularly during the initial stages of the intervention. Some parents described how negative passed experiences of social welfare involvement with their family meant that they often found it difficult to trust that Families First social workers would deliver what they were promising. Initially parents were concerned that children would be removed from their care and then support would be ended.

- Clear communication of the intervention's content and objectives at first point of contact with families as well as listening to parents were key factors that assisted the development of a trusting relationship between parents and social workers.

Length of support

- The appropriateness of a brief intervention for families with such complex needs is questionable as some families required more support than others. Families First acknowledged this and adapted their model accordingly as part of their ongoing approach to adapt the model to address the needs of families appropriately. The capacity of Families First to continue to provide support to the same families for long periods of time is an issue as families need to be able to access less intensive support through mainstream social welfare and community based voluntary/charitable support services post intervention.

Implementation and interagency working

- The flexibility of Families First's implementation as well as the skill and dedication of staff was instrumental in meeting the needs of families who accessed the service.

- The use of intervention models from both the NET Team project and Option 2 provided many of the procedures; intervention tools and protocols greatly assisted the implementation process. Access to these models also provided

staff with therapeutic tools, procedures and protocols which they then adapted to their model of work. This process however was not without its challenges, particularly as the families with whom they were working had complex and often chaotic lifestyles.

- Strong interagency partnerships were vital in delivering Families First's intensive intervention as well as a means of generating referrals. Replicating such partnerships in other areas may be challenging for other services intending to use this model as developing good working relationships between agencies takes time and commitment from all parties.

Conclusions

There is very limited evidence on the types of services and interventions that work to prevent children of substance users' entry into the care system and prevent the negative outcomes that literature has shown they are of risk, including problematic drug and alcohol use and an increased risk of physical harm. This evaluation builds upon the evidence presented by the Option 2 evaluation (Forrester et al, 2007) and presents an adaptation of the Option 2 model in the context of social worker case responsibility with a focus on the Solution Focussed Behavioural Therapy approaches to working with substance using families. These findings also present an intervention model which can be used to work with children at 'high risk' of care entry and adds to the existing literature that questions the appropriateness of short-term crisis intervention for substance using families with complex needs.

Evaluation findings suggest that the Families First model prevents the need for permanent placement of children into care and reduces the time spent in temporary care placements by helping parents to provide a safe home environment or by finding an alternative kinship care placement. These findings are limited by a small sample size and no comparison group and therefore implementation in other areas should be accompanied by an imbedded evaluation from the project's inception, based upon the current research model. However, the twelve month follow-up period of this evaluation would suggest that the intervention had a range of positive outcomes, including reduced parental substance use up to twelve months post intervention. The Families First model has potential to be used in both social work practice and wider community based family support services. The research based findings from this

study should assist the future development and conduct evaluations of interventions for families affected by substance use in the UK.

Recommendations

For future practice

- Intensive family support interventions should adopt a holistic family approach which includes children, parents and wider family members.

- Staff secondments and training may provide an effective means of embedding new approaches and skills to working with both substance using and non substance using families.

- The potential of incorporating Motivational Interviewing within the intervention model should be explored. Appropriate training and supervised practice based experience should be sought.

- Intensive family support interventions should work closely with child and adolescent mental health services as well as GPs to ensure that the mental health needs of individuals are addressed appropriately.

- In order to assist parents in achieving illicit drug abstinence or stabilised alcohol use, housing support should be made available to enable families to move away from former substance using social networks if it is deemed necessary.

For intensive family intervention research and policy

- A follow up study is required to investigate whether outcomes observed in this study are maintained in the longer term (> 12 months) or if there is a shift in parental substance use from heroin or crack cocaine to alcohol. Long term research is particularly important to assess the health, social behaviours, and educational attainment of children. Such research should incorporate an evaluation of the new mentoring element of the intervention package.

- A focus on data collection at local authority level is required to determine the full costs associated with local authority children and adult services to help inform the setting of suitable budget for services to help establish the cost effectiveness of drug prevention and social work interventions.

- A programme of research is required to evaluate UK support services for kinship carers who care for children of substance using parents. This research should also investigate the experiences of kinship carers in providing care in order to identify any gaps in service provision for both carers and children in their care.

- Further research is required to explore potential barriers to employment, education and training amongst substance users in order to inform the development of appropriate support to improve access to employment.

- Waiting lists may provide the most suitable comparison groups for intensive intervention evaluations. Where such lists are not available gatekeepers need to be identified in comparative interventions or social welfare locality teams to ensure sufficient sample sizes are achieved to accommodate for potentially increased attrition rates in the intervention group.

For wider substance use related research design

- A detailed outline of the intervention to be evaluated should be made clear in funding commissioners' calls for evaluation proposals. This should include a basic outline of the client group demographic, therapeutic model used by the intervention (if any) and intervention aims and objectives. Such detail will enable the development of an appropriate evaluation design.

- Evaluation research benefits from a multi method, longitudinal design in order to fully encapsulate the outcomes and experiences of participants. Researchers should obtain at least two forms of contact details. Voucher incentives provide a means of engaging participants and compensating all research participants for their time.

- Process based interviews with intervention staff should commence during the early stage of the evaluation to ensure the aims, objectives and individual

roles are clear from the onset and to assist in the development of service user and stakeholder interview questions.

- Researchers should adopt a flexible approach where interviews are conducted. Safety however is paramount and appropriate protocols should be in place.

- Quantitative outcome measurement of substance use interventions would benefit from the use of a readiness for change outcome measure in order to establish if this is related to actual changes in substance use.

- Community observer methods may not be suitable for research with some populations of substance users due to an inability to identify or provide multiple contact details of non substance using friends and family.

- Social Network Analysis is more suited to the study of large social networks.

1. Introduction

In 2003, the ACMD published *Hidden Harm*, the findings of an investigation into parental problem drug use and its effects on children (ACMD, 2003). The enquiry estimated that there were between 250,000 and 350,000 children of problem drug users in England and Wales, which represented 2-3% of all under 16 year olds (ACMD, 2003). Research has shown that children of problematic drug and alcohol users are at an increased risk of developing a range of negative social and psychological developmental outcomes, including problematic drug, alcohol use and an increased risk of physical harm (ACMD, 2003; Forrester, 2000; Kumpfer, 1987). In response to Hidden Harm, the government outlined its commitment to fund research identifying what types of services and interventions work with children of problem drug and alcohol users and their families (DfES, 2005)[2]. This evaluation of Families First's intensive intervention is in accordance with this objective. The findings aim to add to the UK evidence base and inform the development of future interventions for children affected by parental substance use.

Families First is an intensive family intervention which provides advice, social work intervention and support for adults and families on substance use related issues. The approach was adapted from the Intensive Family Preservation (IFP) approach used by the 'Option 2' project in Cardiff and the Vale of Glamorgan and the Neighbourhood Enabling Team (NET) Team, a Middlesbrough based Family Support Project funded by NRF which preceded the inception of Families First. The social work practice developed by Families First's Intensive Family Support Package was the first of its kind in the UK. Children in supported families are typically under the age of five years (including pregnant women and newborns) and are on the child protection register or at risk of being placed on it. Intensive support is provided to families, including drug and alcohol treatment support parenting skills and psychotherapeutic goal setting using a Solution Focused Behavioural Therapy (SFBT) approach (O'Connell, 2005). SFBT is a brief form of therapy that aims to help individuals create solutions to

[2] The government response to Hidden harm (DfES, 2005) outlines its committed to conducting research into what types of services and interventions work with these young people and their families. Parental problem drug use is therefore a key priority in the National Drug Strategy's Evidence base work programme.

problems rather than solve them (Gingerich & Einsengart, 2000). The package aims to enable families to make changes to their lifestyle which are necessary to ensure the safety and stability of the child within the home environment. The intensive support package works in the best interests of the child and if parents are unable to make necessary changes with support, then alterative care arrangements are made. Child welfare is the focus of intervention and for many of the families involved the intervention is their last chance to change their lifestyle in order to keep their child in the family home.

This evaluation of Families First involved parents who attend Families First services for problematic drug or alcohol use and followed their progress over a twelve month period. Both quantitative and qualitative research methods were used including interviews and questionnaires.

2. Methodology

2.1 Design

The evaluation of the Families First project in Middlesbrough was designed to investigate the support provided to children and parents who attend Families First as a result of problematic drug or alcohol use. The research was designed to identify the processes involved in service delivery, including intervention approach, the implementation and integrity of Families First and local context, including interagency working, as well as the outcomes of the intervention for participating families. This was achieved with the participation of parents, carers, intervention staff and key stakeholders. Due to the young age of the children that Families First support, only adults participated in the evaluation. Parental and/or carer reports of child development were used to monitor outcomes of children and young people.

Both quantitative and qualitative research tools were used in the evaluation including semi structured interviews and questionnaires. Social Network Analysis was conducted to analyse interaction between Families First staff members and other drug and alcohol support agencies in the area. For research with parents and carers questionnaires and interviews were administered at three points (baseline (t+0), six months (t+6) and twelve months (t+12) between February 2007 and February 2008 in order to investigate the progress of families over time. Interviews were conducted in the homes of parents and ranged from thirty to ninety minutes.

To assist parent and carer questionnaire design the Families First project manager completed a brief questionnaire in order to identify which of the key policy based outcome areas (e.g. Every Child Matters Outcome Framework, Hidden Harm) staff were working towards. After a comprehensive review of both adult and child outcome measures, matched against such policy outcomes (Woolfall, 2007), measures were then matched against the key areas identified as detailed in table 1.

Table 1. Outcome measures selected for use in this study

Measure	**Relating to adult or child evaluation outcomes?**	**ECM focus**	**Format and internal consistency**[3]
Beck Depression Inventory (BDI-11)	Adult	Severity of depression in adults & adolescents (13yrs+)	21 items (5- 10 minutes) Self report α = 0.88 child, 0.93 parent
Peds QL 4.0 Generic	Child	Health related quality of life including physical, emotional, social and school functioning	23 items (4 minutes) Self report and parental report α = 0.88 child, 0.93 parent
Adolescent Drug Involvement Scale (ADIS).	Adult	Levels of drug use, motivations, consequences and sense of control. (drug use table only)	13 item (5 minutes) Self-administered α= 0.85 (Moberg and Hahn, 1991)
EuroADAD	Adult	Family relationships, medical, school, social, psychological and substance use (family scale used only)	140 items (40 minutes) administered α= 0.73

A number of researcher derived questions were also developed where outcome measures were not deemed suitable (often due to length) or where additional questions were required to supplement measures. Examples include questions on child vaccinations and whether adults had been tested for HIV or hepatitis (B/C). In order to contextualise the findings obtained from quantitative methods, semi-structured interviews were also conducted. Interviews were used to gauge the views and experiences of the support received by participating families. This enabled the triangulation of data to identify any additional factors which may be attributable to observed changes in attitudes or behaviour, which are not a result of participation in the associated service. The interviews were semi-structured in order to encourage narrative production, so whilst each interview followed a different chronology the same broad issues were discussed with each participant. Preliminary data analysis was conducted between each of the interview phases to ensure that all areas of investigation were addressed and explored sufficiently with each participant.

[3] Information based on latest manual data or website of purchase, where this was not accessible study results are provided and referenced.

Stakeholder and project worker interview questions were previously piloted in an evaluation of PSS Impact conducted in 2006 which provided support for children of drug using parents in Wirral, Merseyside (Woolfall, 2006). In order to evaluate collaborative working, both internal, and externally to Families First, a Social Network Analysis questionnaire was developed. Social Network Analysis (SNA) is a relatively new area of social analysis (Scott, 1991). SNA utilises sociograms to visually represent relationships within a social group and adopts areas of graph theory to analyse interaction between members of social groups.

2.2 Sample

Interviews were conducted with all project staff who worked for Families First between February 2007 and September 2008 (n=15). Stakeholder interviews were conducted with members of the Families First Steering Group 2007/2008 (n= 5) which included: Joint Commissioning Manager, Safer Middlesbrough Partnership (x 2 change of post 2008), Deputy Director Intervention and Safety; Service Manager: fieldwork (Middlesbrough Children, Families & Learning) Early Intervention and Prevention Advisor (GONE).

At least one parent from each of the eight families completed all three waves of data collection with interviews conducted with a total of 11 parents on at least one occasion. Only one family was lost to attrition over the twelve month period as a result of concerns over researcher safety which prevented access. In one of the eight remaining families safety issues also prevented access to one single parent. Alternative access was gained to the kinship carers of the children in question who provided information on their progress. In another family, the father who had participated in baseline interviews (t= 0) was not available for follow up interviews; however interviews were conducted with the mother of the family who was also a substance user.

Families First were working with 18 children in a child protection capacity, six young people had previously been placed in permanent alternative care arrangements in some cases up to sixteen years prior to Families First's involvement. Parental reports of child development outcomes were obtained on 11 children over the age of four years, whilst the child protection status of all 18 children was monitored over the twelve month evaluation period. Demographic characteristics of the children and

parents involved in all three waves of data collection are shown below[4]. The age distribution of children (n=18) and parents (n=8) involved in the Intensive Support Package in a child protection capacity can be seen in tables 2 and 3.

Table 2. Age distribution of children that Families First are involved in a child protection capacity (n= 18)

Age of child	**N**	**%**
0 – 7 years	12	67
8 - 13years	6	33

Table 3. Characteristics of parents with problematic drug or alcohol use who completed all three waves of the Families First evaluation*

Parents (n= 8)	**m**	**SD**
Age	30.1	4.6
Number of children per parent	2.25 (t=0); 2.5 (t+12)	0.7 (t=0); 0.76 (t+12)
	n	**%**
Sex		
Female	6	75
Male	2	25
Ethnicity		
White	8	100
Single parent	4	50
Lived with spouse/partner	4	50

* Data taken from wave 1 (t=0) unless stated otherwise

As Table 2 shows, the majority of children with whom Families First were directly working were aged under eight years (67%) with six young people (33%) aged between 8 and 13 years. The mean age of children with whom Families First were working (n=18) was 5.3 years (SD= 3.9). Table 3 shows that the mean age of adult participants was 30.1 years (ranging from 22 to 37 years of age).

Parents had a mean of 2.25 children at baseline with two births added to the sample over the twelve month period (t+12 mean= 2.5). All adult participants were of white ethnic background. Seventy five percent (n= 6) of the sample were female and 25% (n= 2) were male; whilst half of the sample (50%, n= 4) were single parents. All single parents were female.

[4] Parental data for one family is not provided as the father who had participated in baseline interviews (t= 0) was not available for follow up interviews; however interviews were conducted with the mother of the family who was also a substance user therefore parental data from this family were used in qualitative findings only.

2.3 Procedure

In order to recruit parents and carers a letter and information sheets explaining the purpose of the study and requesting participation were distributed by project workers to all families (n=12) in contact with the service in December 2006. All interviews were conducted in the family home and took between one and three hours depending upon the individual's willingness to talk and number of child based questionnaires completed. Questionnaires were self administered or researcher administered at the request of participants. Written and verbal informed consent was obtained at each of the three data collection points. Parents were asked to provide two contact addresses to minimise attrition whilst social workers assisted in contacting hard to reach families during follow-up stages. All participants received a £10 high street voucher at each interview which proved to be instrumental to gaining access to some hard to reach parents. Stakeholder and project workers were invited to participate in semi-structured interviews in person or via email. Stakeholder interviews were conducted face to face or via the telephone. Project workers participated in face to face interviews (<2 hours) on a number of occasions in order to minimise disruption to their work.

2.4 Analysis

Qualitative interviews were tape recorded and transcribed verbatim. The NVIVO software package was used to assist the analysis of qualitative data. A thematic content analysis approach (Krippendorff, 1980) was used to analyse qualitative data. Data obtained from Social Network Analysis questionnaires were analysed using the SNA package Pajek. All other quantitative data analysis was conducted using the statistical software SPSS. A range of statistical tests were utilized including those suitable for the analysis of longitudinal data (e.g. Friedman's ANOVA, Wilcoxin sign ranks test).

3. Results

3.1 A documentation of the Families First intervention approach

The section below provides an outline of the Families First model of service delivery, including staff structure and examples of the support provided to families accessing the service.

Families First is a multi-component intensive support service which provides advice, social work intervention and support for adults and families on substance use related issues. Since its inception in 2006 the service has been part funded by the Neighbourhood Renewal Fund (Local Area Agreement), Middlesbrough Local Authority funding, Middlesbrough Council (Adult and children social care) with seconded or specifically funded workers from West Middlesbrough Neighbourhood Trust, Tees Valley Esk and Wear and Middlesbrough Primary Care Trusts.

Families First services include:

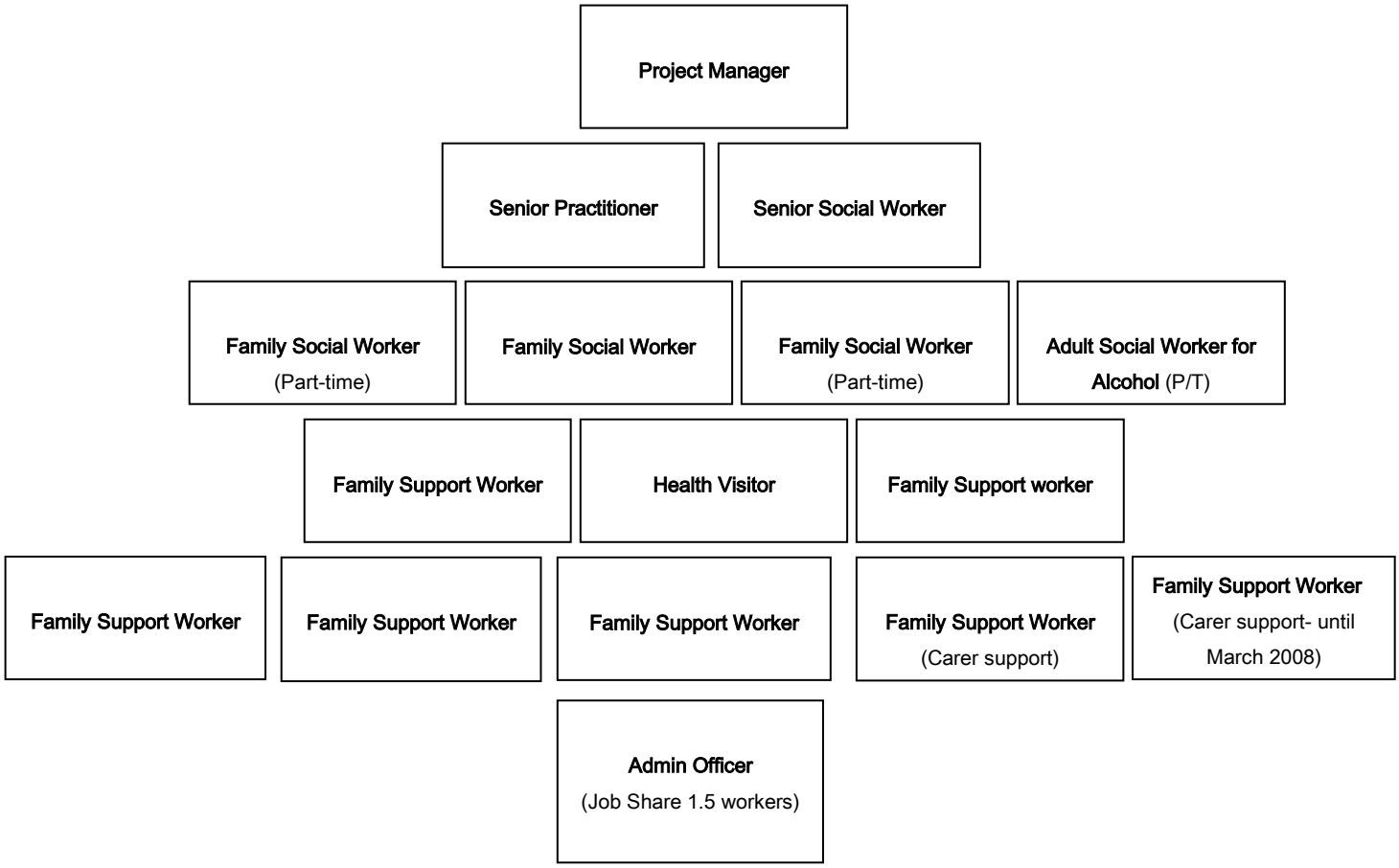
- an intensive support package for families (which includes many of the elements listed below);
- carers support;
- (referral to) residential rehabilitation (across the UK);
- assessment and planning;
- housing and benefits advice;
- parenting skills;
- one to one support;
- pre birth assessment (including Middlesbrough Primary Pregnancy Protocol);
- health promotion;
- signposting;
- family mediation.

The overarching aims of Families First are:

- To keep children with their families where it is safe and possible to do so;
- To help families during times of crisis;
- To support parents/carers to recognise their drug and/or their drug and or/alcohol issues and help them change.

In August 2008 the project consisted of 17 members of staff. The structure and roles of staff within Families First are shown in Figure 1.

Figure 1: Families First Staffing Structure



The Intensive Family Support Package

The Intensive Family Support Package has been developed using research findings and good practise identified in the work of the NET Team (a Middlesbrough based Family Support Project funded by NRF which preceded the inception of Families First), and the Options 2 Project in Swansea. Option 2 is an Intensive Family Preservation (IFP) service which focuses on families in which parents have substance misuse problems (Forrester et al., 2008). The Option 2 model includes the use of motivational interviewing and family therapy systematic approaches such as Solution Focused Therapy (Forrester, 2007). Workers focus on two families at any one time (approximately 12 families per worker per year) so they are available 24hrs a day seven days a week. Work is usually conducted in the home or local community with the intervention lasting between 4-6 weeks, which they regard as “the natural

duration of a crisis" (Hamer, 2005). Follow up visits are made at one, three, six and twelve months with 'booster sessions' for families in times of crisis for a maximum of two days. Option 2 workers are not social workers, they do not have case responsibility for the children they work with and take referrals from childcare social workers when there is a child deemed to be at risk.

Families First adapted this model for their Intensive Family Support Package in the context of case responsibility using or adapting the protocols developed by Option 2 in their therapeutic approach to working with families. Many of the aspects of the Option 2 model adopted by Families First relate to the Solution Focussed Behavioural Therapy (SFBT) approach rather than the more evidence based Motivational Interviewing (MI). Families First has six qualified social workers (four of whom are part time) who are able to remove a child from a family if they are deemed to be at risk, and have all related legal responsibilities. This is a fundamental difference to the approach to working evident in the Option 2 model and Families First has developed procedures and protocol to ensure the service model is transparent to families and other collaborative agencies.

Referral criteria:

- Parents with problematic drug and/or alcohol use who are in crisis;
- Risk of children being removed/subject to child protection investigation/ named placed on the Child Protection Register;
- Risk of family breakdown due to parental substance misuse.

Families First specifies that if a family does not recognise the urgent need to make changes to their parenting practices and lifestyle then the intervention team will not be able to work with them at that point in time. Alternative interventions are provided in collaboration with adult support workers and partner agencies.

Key elements of the Intensive Support Package:

- Response to referrals are made within 48 hours;
- Decision regarding acceptance of case made within 72 hours through a consultation meeting between all team member and the referrer (If case not accepted advice provided);
- Risk assessments;
- Safety plan- covers risks;
  strengths, plan and required action;

- Working agreement with families about
  what needs to change;
- Values exercise (see below),
- Goal setting (See below);
- Family journals and reflective letters
- Assessments of progress throughout with
  key reviews at the six week and four month stages;
- At 4 months a maintenance plan is put in place if the child is no longer at risk and is to stay in the family home. The case is then transferred back to social welfare.

The Intensive Support Package is not a 24 hour service as in Option 2, but an out of hours service is available to families, including weekends. During interviews staff reported that if 24 hour support was required then this would indicate that the child may not be safe in the family home. The four month maintenance plan provides an extension to the six week intensive intervention period which moves Families First beyond a brief intervention as the workers have a flexible approach to reinforcing behavioural change over a four month period.

The package aims to enable families to make changes to their lifestyle which are necessary to ensure the safety and stability of the child within the home environment. For example, some of the cases described in this evaluation began with supervised visits which were gradually increased over the 4 month period if the parents have made the necessary changes to their lifestyle and parenting practices and were achieving set goals. If the parent(s) were unable to change their lifestyle and the child cannot be safety placed back in the home then an alternative placement is sought. The Intensive Support Package works in the best interests of the child and if parents are unable to make necessary changes with support, then alterative care arrangements have to be made. The support provided aims to reduce many of the risk factors which children of drug using parents are susceptible, including depression, social isolation and an increased risk of children using drugs in later life (Day et al., 2006; Clark et al., 2005; Brook et al., 2007). Whilst also enforcing protective factors against negative outcomes such as parental drug stabilisation, school attendance, consistency in family routines (Peleg-Oren and Tiecham, 2006).

The Families First team provides a flexible approach to support and adapts and changes their approach to address individual needs. This has been evident from workers' own reflections on their learning since inception, as well as from interviews conducted with parents and carers. For example, a brief period of intervention was not viewed by staff as sufficient for some families with more complex needs. In some cases where additional support was required, the maintenance plan was extended with a relapse prevention package made available to parents whose case has been transferred back to locality teams. Adult support, which includes one to one support, advocacy and advice are also made available for both kinship carers and parents to assist families post intervention. Re-referral is viewed as an option available to families if deemed necessary such as in cases of a new pregnancy.

As shown in Figure 1 the overall team is multidisciplinary and therefore able to apply individual skills to each family. Workers are allocated to different family members who then work as a team to provide a holistic package of support to each family.

Examples of therapeutic tools used with children and adults

Values Exercise

Value cards are used with both adults and children to help them identify the most important things in their life. This aims to help them to identify the changes that need to be made. Each of the cards has a statement and the parent or child are asked to put them in piles of 'very important', 'important', 'sometimes important' and 'sometimes not important' (younger children pick out their top 6). The most important cards are then discussed and documented with any inconsistencies between values and lifestyles raised in an attempt to motivate behavioural change. Examples of the 'very important' adult and child cards chosen by families receiving the Intensive Family Support Package are shown below.

Adult values example

1. Coming off the drugs
2. Being emotionally strong
3. Getting our family back together
4. A good quality of life for me and my family.
5. Honesty
6. Having a happy and long marriage or relationship
7. Control

Child values example
1. Being loved
2. Learning new things
3. Being healthy
4. Spending time with my family
5. Being nice to other people
6. Having school clothes ready for school

Goal Setting

Solution Focussed Brief Therapy (SFBT) uses a number of questions which help individuals establish clear, observable goals which are used to facilitate and monitor change. This incorporates what is known as the 'Miracle Question'. There are various ways of framing the question depending on the individual. The following example is taken from one family's goal setting exercise:

"*If there was a 'Miracle' you both said that if you woke up in the morning you both would be normal people. You felt everything would be 'perfect', meaning that (child's name) would be at home in your care. You both would have a lovely home and be normal parents. Drugs would not exist in your lives. You would give (child) a good childhood that would be different from your own which had been difficult later in life. You would take (child) out on family outings and have fun. (Father's name) will have a job. Difficult or stressful things would happen but you would be able to cope with them as adults and not need drugs to cope".*

The miracle question has been used by Families First workers to help parents identify the objectives of intervention participation, and actions to achieve this. In addition, specific goals are set with clients using a scoring system based on the Option 2 model. At the beginning of the intervention individuals must define their individual problem, an example would be:

> "*Amy has been reliant upon alcohol for 6 years. Her addiction and lifestyle has affected the family and lead to problems with caring for her son".*

Using the scale -2, -1, 0, +1, +2, workers and clients assign outcomes to each of the points on the scale. For example -2 (the most unfavourable outcome thought likely) might be:

"Amy continues to drink to excess on a daily basis. Amy is drunk in front of her child and the police are called to the property as the child is at risk. He does not attend school and the school take action regarding this. Amy's son does not undertake any activities outside the family home. Amy does not engage with local support services. Amy's son is removed from her care"

+2 (Best anticipated success) might be:

"Amy continues to reduce her drinking and her alcohol use does not affect her daily routine or have an impact upon her son. Her son is attending school and has other interests and activities outside of school".

Workers and clients can then rate their position at the start of the intervention and work towards improving their position on the scale. Families are informed that level '0' would be the expected level of success at the end of the intensive intervention with the aim of highlighting the need to continue to improve outcomes after the intensive support is over. Outcome '0' for Amy's family would be:

"*Amy is not drinking to excess and is engaging with local support agencies. Her son is attending school every day, sometimes on time. Amy is spending some time with her son and undertaking activities with him*".

3.2 The impact of the Families First intervention upon parent and child outcomes: quantitative study findings

The following findings have been taken from structured questionnaires administered to a cohort of parents at baseline, six month and twelve month follow up interviews. As discussed in the methodology section (section 2) both research derived questions and validated outcome measures were used to monitor parent and child outcomes over the six months. The areas of investigation included child protection, substance use, health and wellbeing, family life, employment education and housing, access to services and child related measures of school, health, emotional and social functioning. Child protection data was double checked against data obtained from project workers to ensure accuracy as some parents were uncertain about the legal status of their children.

Child Protection in the evaluation cohort

As shown in table 4, five children entered care during the twelve month evaluation, three of whom had entered care in the week prior to Families First's involvement. None of these children were in care at the twelve month follow up.

Table 4. Summary of Impact of Families First on care entry (n=18)

	n
Number of children who entered care*	5
Days in care (mean)	67.8
Number living at home Feb 2007 (t=0)	5
Number who entered interim care arrangements (kinship care) over the twelve months**	10
Number living at home Feb 2008 (t+12)	16
Number in kinship care arrangements Feb 2008 (t+12)	2
Number in care in February 2008 (t+12)	0

*including prior to Families First involvement (n=3, 6 days prior)
**One placed before referral and stayed in kinship care arrangement

Kinship care arrangements proved vital in preventing children's entry into care of the local authority by providing interim care placements whilst Families First worked with parents and the stability of the family home was reviewed. In two cases, grandparents provided permanent home placements for children when it was decided that parents were unable to change their lifestyles sufficiently to provide a stable and safe home environment.

Children who did enter care were separated from their families for a relatively short period of time (mean = 67.8 days). This compares with mean of 353 days for children whose families participated in the evaluation of 'Option 2' project in Cardiff (Forrester, 2007). Such comparisons however should be treated with caution due to small sample size of this evaluation (n=18) compared with that of the Option 2 evaluation (n= 278). The number of children on the child protection register decreased from four at baseline, to two at six month follow up, to there being no children deemed 'at risk' at the final stage of administration (t+12).

Table 5: Care status: Waves 1 (t=0) and 2 (t+6 months)

	Wave 1(n=17)*	Wave 2 (n=18)	Wave 3 (n=18)
Form of care order	n	n	n
No form of care order in place (living with parent/s)	5	8	15
No form of care order in place (kinship care)	1	1	0
Interim care order (living with parent/s)	5	0	0
Section 20 (temporary foster care)	3	0	0
foster care proceedings	2	0	0
Private fostering regulations/ residence order (kinship care)	1	1	1
Supervision order	0	8	2
Total	**17**	**18**	**18**

* One child not born in the month of baseline interview

The care status of children in this sample over the one year period is shown in table 5 (see Glossary on page 88 for definitions of formal care orders). A range of care orders had been put in place by social workers to protect children at baseline, these included temporary foster care (Section 20) and interim care orders, in which children remained in the family home whilst further investigations were made.

At twelve month follow up the number of children with no form of order in place had risen from five to 15. None of the children in this sample were permanently placed in care of the local authority. One child remained with his mother's former partner's parent (not blood relative) who had sought and successfully secured a residence order so he could live with his brother for whom they had been providing care for a number of years. Supervision orders were in place for two children who were living at home with their parents, such cases will be monitored by Middlesbrough social services for one year unless extensions are made by the court.

The change in the form of care orders in place from baseline to twelve month follow up highlight the progress made by parents in seven of the nine families over the year by providing safe home environments for their children to stay with them in the family home. The support provided by kinship carers in the two remaining families has enabled these children to stay out of the care system and remain in the care of extended or immediate family members.

Parental Substance use

Table 6 below shows the nature of parental substance use of the eight participants who self reported substance use at baseline (t=0), wave 2 (t+6 months) and wave 3 (t+12 months).

Table 6: Prevalence of self reported substance use t=0, t+6 & t+12 (n = 8 parents)

	Wave 1 (t=0)		Wave 2 (t+6)		Wave 3 (t+12)		Sig?**
	*n (%)**	*Mean Rank*	*n (%)**	*Mean Rank*	*n (%)**	*Mean Rank*	
Any illicit drug use	4 (50)	-	2 (25)	-	3 (37.5)	-	-
Any illicit drug use (daily)	1 (12.5)	-	1 (12.5)	-	1 (12.5)	-	-
Heroin	2 (25)	2.00	1 (12.5)	2.00	1 (12.5)	2.00	No
Cannabis	2 (25)	1.94	1 (12.5)	1.94	3 (37.5)	2.13	No
Crack Cocaine	1 (12.5)	1.88	0 (0)	2.00	1 (12.5)	2.13	No
Cocaine	0 (0)	1.94	0 (0)	1.88	0 (0)	2.19	No
Ecstasy	1 (12.5)	2.00	0 (0)	2.00	0 (0)	2.00	No
Amphetamines (speed)	1 (12.5)	2.13	1 (12.5)	1.94	0 (0)	1.94	No
Prescribed methadone	5 (62.5)	2.06	5 (62.5)	2.06	4 (50)	1.88	No
Alcohol	6 (75)	1.75	7 (87.5)	2.06	8 (100)	2.19	No
Tobacco	6 (75)	1.81	7 (87.5)	2.19	7 (87.5)	2.00	No

* at least several times a month

** Freidman's ANOVA statistical test

Frequency of reported substance use (mean ranks) were calculated for each drug named in table 6 over the twelve month evaluation period. There were no significant differences[5] observed between scores for frequency of any substance used over or between the three questionnaire administrations. Overall, reported illicit drug use amongst this sample remained at low and consistent level over the 12 month period, which is a positive outcome for both children and families. The small sample size and possible under reporting of substance use may also have impacted upon such findings despite researcher assurances of confidentiality. As drug testing could not be utilised, self reports had to be taken at face value. However, Families First staff

[5] Friedman's ANOVA and Wilcoxin sign ranks test

confirmed that drug users were hair tested (instigated by solicitors) prior to children being placed back in the family home and all tested negative for illicit substances.

One parent reportedly stopped using heroin in the first six months of Families First involvement and was still reporting abstinence at the 12 month follow-up. Only one parent continued to use heroin and crack cocaine; this parent was no longer in the care of her child. All families who had reported heroin or crack cocaine use at baseline, or former use prior to research and had since had their children placed back in their care, did not report any Class A drug use at six month or twelve follow up. Although not statistically significant, a reduction in the reported mean dose of prescribed methadone was also observed over the twelve months (see figure 2 below) from a mean of 94ml[6] (SD =29.0) in wave 1 (t=0) to 83ml (SD = 28.6) in Wave 2 (t+6) to 79 ml (SD = 33.6) in wave 3 (t+12).

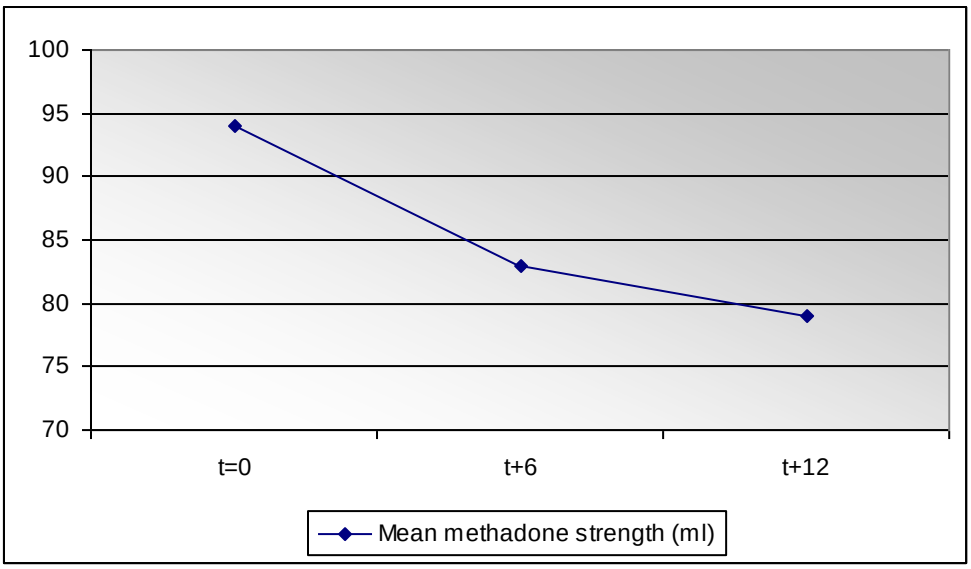


Figure 2: Mean methadone strength (ml) t=0, t+6 & t+12 month interview (n=5)

The number of parents consuming alcohol at least several times a month increased over the three waves of data collection from 75% (n= 6) at baseline to 100% (n= 8) at twelve month follow up. This increase was mainly attributable to parents consuming low levels of alcohol occasionally, rather than an increase in parents drinking over government weekly recommended maximum units (14 units for women and 21 units for men). As shown in figure 3 below, for this sample (n= 8 parents) the total units of

[6] Methadone comes in a variety of concentrations. Methadone Mixture is most frequently mixed at 1mg/ml (i.e. 1mg methadone hydrochloride in 1ml of liquid). This was the frequency of mixture reported in this sample.

alcohol consumed in the week prior to interview decreased over the 12 month period (t=0, mean = 85.31 to t+12, mean = 43.00 units). This reduction in alcohol consumption was significantly different between baseline (t=0) (mean rank = 3.00) and six months follow up (t+6) (mean rank = 0.00) ($z = -2.032$, $p < 0.05$), however this observed reduction was not significant between six and twelve month follow up, baseline and 12 months or across three data collection points.

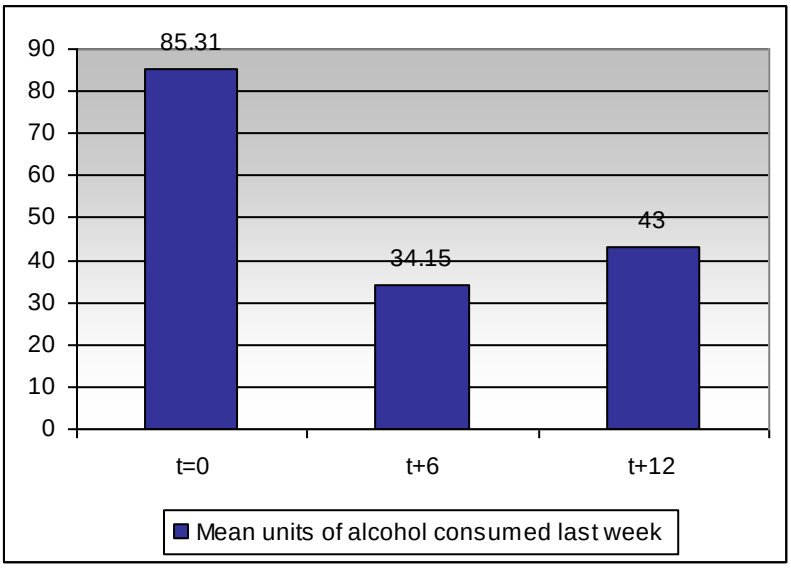


Figure 3: Mean units of alcohol consumed in the week prior to t=0, t+6 and t+12 month interview (n=8)

These changes in alcohol consumption are mainly attributable to a few female participants who reduced their alcohol consumption substantially during the first six months of participation in the intervention. As shown in table 7, at baseline there were three females (mean weekly units = 202) and two males (mean weekly units= 34) consuming over the government recommended maximum weekly alcohol limits. Overall the data is skewed by two females who stated they had consumed approximately 158 and 415 units in the week prior to baseline interview. At six month follow up, however, one parent had reduced weekly consumption from 158 to 131 units and continued to drink alcohol on a daily basis. The second parent stated that they had substantially reduced consumption from 415 units to 70 units and no longer drank alcohol on a daily basis reducing consumption to several days per week. Both of these parents had entered a residential rehabilitation program since baseline interview. The second parent was taking the prescribed medication Campral© (acamprosate calcium), which are delayed release tablets for the treatment of alcohol dependence. At the twelve month follow up, however, both parents' weekly consumption had increased to 158 and 120 units respectively. Overall, such results

indicate that although weekly alcohol consumption did decrease for the sample during the first six months of involvement with Families First, this was not maintained over a twelve month period.

Table 7: Self reported alcohol consumption

	t=0			t+6			t+12		
	n	*mean*	*SD*	*n*	*mean*	*SD*	*n*	*mean*	*SD*
Females consuming >14 units of alcohol per week	3 (37.5)	202.2	194.8	2 (25)	100.6	43.3	3 (37.5)	99.3	71.2
Males consuming > 21 units of alcohol per week	2 (25)	34.0	2.8	2 (25)	30.0	8.48	1 (12.5)	24.0	-

Table 7: Self reported alcohol consumption over government recommended maximum weekly guidelines.

Parental health and wellbeing

A range of outcomes relating to parents' health and wellbeing were evaluated. These included depressive symptomatology and self reported physical health including blood borne viruses and drug related illness. Basic measures of health maintenance were also included such as whether parents ate breakfast on the day of interview or were registered with a dentist. Severity of depression in all parents and carers was measured using the Beck Depression Inventory- second edition (BDI-11). Clinical score guidelines (see table 8 below) are provided to compare depressive symptomatology with a sample of patients with clinically diagnosed depression (Beck, 1996) as clinicians are recommended to adopt a much lower range to detect depression.

Table 8: Beck Depression Scale 11 criteria (Beck et al., 1996)

Total Scores	**Range**
0-13	Minimal
14-19	Mild
20-28	Moderate
29-63	Severe

As table 9 (see Appendix A) shows the mean depression scores for the Families First sample fell within the moderate range for a clinically depressed sample across all three waves of data collection. This suggests that all parents were experiencing elevated levels of depressive symptomatology, and this did not reduce significantly

over time[7]. Three parents (38%) had depression scores which fell within the severe range at baseline and six month follow-up interview. One of these parents was diagnosed with depression after the six month interview and with treatment her score reduced from 35 (severe depression) to 21 (moderate depression) at twelve month follow up. Another parent reported receiving antidepressant medication, however their BDI score increased within the severe range over a six month period (BDI score = 29, t+6; BDI score = 42, t+12). This finding may have been a result of increased levels of alcohol consumption (weekly units= 70 [t+6], weekly units =120 [t+12]) interfering with the effects of such medication. Depression scales are also confounded by measuring somatic symptoms which are a result of both depression and substance use.

A significant difference ($z= -.983$, $p<0.05$) was observed between BDI symptom 'past failure' mean ranks scores between baseline (t=0) (mean rank = 2.44) and final administration (t+12) (mean rank = 1.50). This suggests that the degree to which parents felt that they had failed as a person reduced significantly over the twelve month period. No other significant differences were observed for mean item scores for any other of the 21 BDI symptoms. The relationship between daily illicit drug use, weekly alcohol consumption, strength of methadone and BDI score were also examined[8] however no significant association was found at any point of data collection.

Participants were asked to rate their own physical health over the twelve month period. There were no significant changes in self reported health over the evaluation period[9] with the majority of parents (50-62%) stating that their health was at least good over the three waves of data collection.

[7] Friedman's ANOVA test
[8] Spearman's rho correlation
[9] Friedman ANOVA and Wilcoxin sign ranks test $p>0.05$

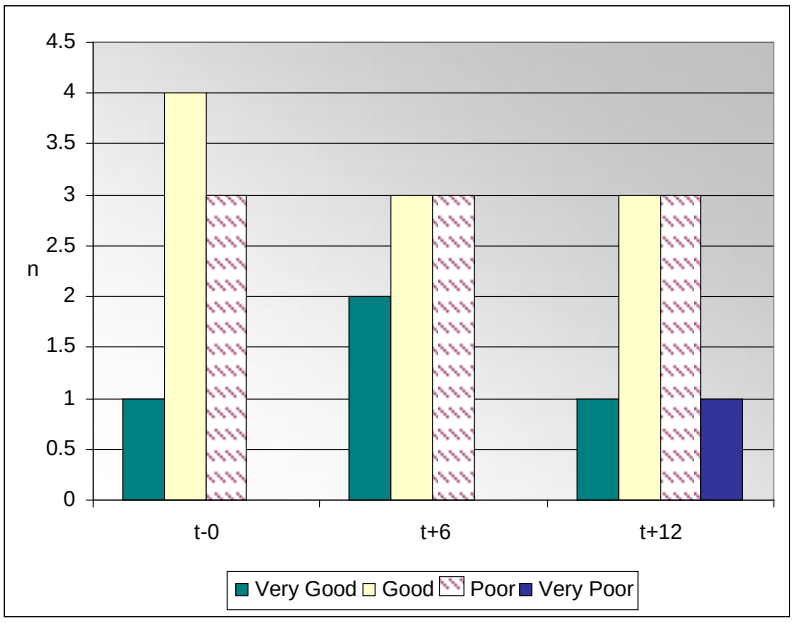


Figure 4: Self reported physical health of parents t=0, t+6 & t+12 (n=8)

Three parents consistently rated their health as being 'poor'. Many of the reported health concerns were related to substance use including Deep Vein Thrombosis (DVT) and leg ulcers as a result of injecting heroin into leg veins (n = 2 parents) or "signs of kidney failure" as a result of alcoholism (n = 1 parent). Two parents self reported "depression" as being the reason for their reported poor health. All parents had been tested for hepatitis A, B, C and HIV between one and five years prior to interview; all but one parent tested negative. This one parent was diagnosed with hepatitis C during the evaluation period although the cause was not known. In terms of nutrition, all participants were asked if they had eaten breakfast that day, over the three data collection points, five of the eight parents did not eat breakfast daily. Takeaway meals were not a common part of the diets of families as the mean number of takeaways consumed per week ranged between 1.25 (t=0) and 0.37 (t+12).

Parenting and family life

Parents were asked to rate a range of questions relating to parenting and family life such as 'How much conflict is there in your family?' on Likert scale of none/not at all, a little, a fair amount and a lot.

Table 10: Parenting and family life t=0, t+6 & t+12 (n = 8 parents)				
	t=0 Mean Rank	*t+6 Mean Rank*	*t+12 Mean Rank*	Significant difference over time?[10]
How much conflict is there in your family?	2.69	1.69	1.63	Yes (p<0.01)
How do you think you are coping with being a parent at the moment?	2.06	2.00	1.94	No
How important is it to get help or counselling for family problems?	2.31	2.06	1.63	No
Do you feel safe in your home?	1.69	2.00	2.31	No

Family conflict was defined as arguing and/or fighting with relatives during the month prior to interview. As shown in table 10 and figure 5, the amount of family conflict reported by parents significantly reduced over the twelve month evaluation ($\chi^2 = 9.57$, $p < 0.01$). Self reported family conflict reduced significantly from a mean rank of 2.69 (a fair amount to a lot) at baseline to 1.63 (a little to a fair amount) at twelve month follow up. As figure 5 shows however, although statistical significant changes were not observed in the other measures of parenting and family life that were administered, there were some notable trends.

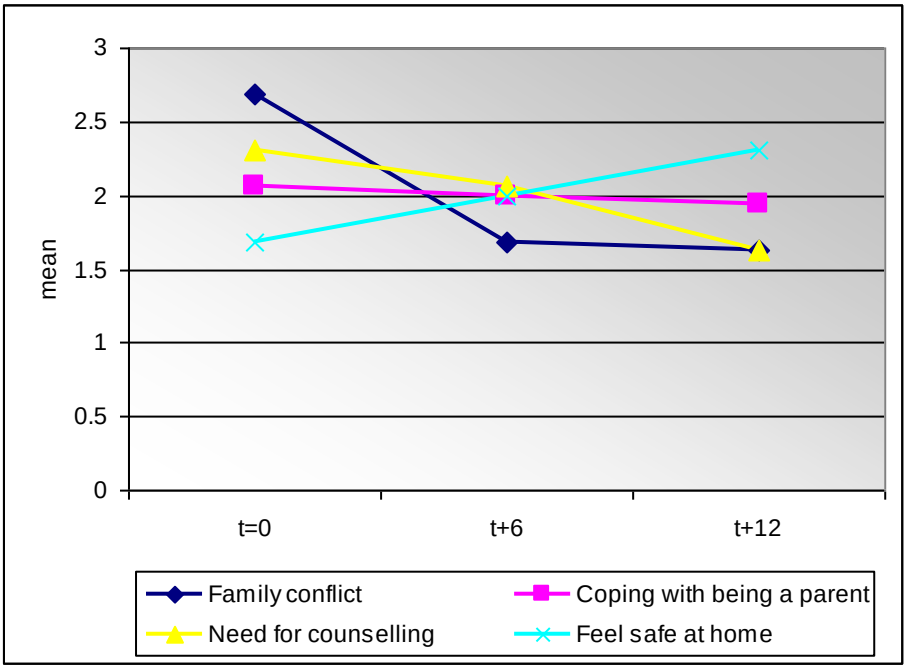


Figure 5 mean scores for parenting and family life measures t=0, t+6 and t+12 month interview (n=8)

[10] Friedman ANOVA

How parents felt they were coping with being a parent worsened slightly from a mean rank of 2.06 (t=0) to 2.00 (t+6) and 1.94 (t+12); all parents felt they were coping a fair amount and none stated that they were not coping at all. How safe parents felt in their own homes increased slightly over the three waves of data collection (mean rank of 1.69 (t=0) to 2.00 (t+6) and 2.31 (t+12), although not significantly[11]. A slight reduction in the need to get help or counselling was also observed across the three waves of data collection (mean rank of 2.31 [t=0] to 2.06 [t+6] and 1.63 [t+12]),

None of the measures relating to parenting and family life (including how parents felt they were coping as a parent or the need for help or counselling) were statistically associated[12] with children being taken into care during the twelve month period. However, a range of variables including: levels of depression; family conflict; feeling safe at home and the importance placed upon receiving counselling for family problems were all shown to be related to this sample's perceptions upon how they were coping with being a parent at different stages of the evaluation.

A significant negative relationship[13] between depression scores and how participants felt they were coping with being a parent was identified in the final administration ($r [6] = -.716$, $p<0.05$). This suggested that the higher the depressive symptomatology reported the less the individual felt they were coping as a parent in the final questionnaire administration stage. A significant negative relationship was also observed between the amount of family conflict reported and how parents felt they were coping being a parent at 6 ($r [6] = -.741$, $p<0.05$) and 12 month follow up ($r [6] = -.730$, $p<0.05$), suggesting that an increase in levels of family conflict were related to a reduction in how parents felt they are coping with the care of their child. In addition, at six month follow up, self reports indicated that an increase in how safe parents felt at home was related to an increase in how they felt they were coping as a parent ($r [6] = 0.802$, $p= <0.05$).

At baseline interview there was a significant positive association[14] ($r [6] = 0.717$, $p= <0.05$) between how parents felt they were coping and the level of importance which they placed upon receiving help or counselling for family problems, suggesting that the more importance a parent placed upon getting help or counselling for family problems the more they felt they were coping as a parent at that time. The need for

[11] Friedman ANOVA and Wilcoxin sign ranks p>0.05
[12] Spearman's rho correlation
[13] Spearman's rho correlation
[14] Spearman's rho correlation

counselling for family problems decreased slightly over time (mean rank =2.31 [t=0]; mean rank= 2.06 [t+6]; mean rank 1.63 [t+12]), although this change was not statistically significant[15].

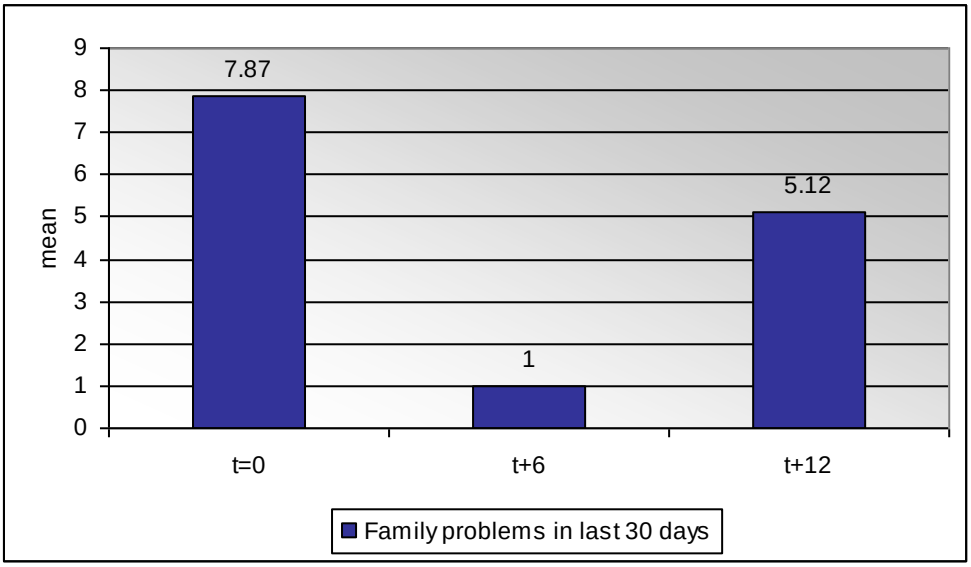


Figure 6: Number of day's parents reported experiencing family problems in the 30 days prior to interview

Parents were asked to recall the number of family problems they had experienced in the 30 days prior to interview. As figure 6 shows, the mean number of days reported did reduce from 7.87 days at baseline to 1 day at six month follow up and then increased to a mean of 5.12 days at twelve month follow up, however there were no significant differences[16] observed between scores for the number of family problems reported during the twelve month evaluation period.

Relationships between substance use and depression scores were explored for each of the three evaluation points. Depression scores (BDI-II) at twelve month follow up were positively correlated (r [6] = 0.730, p= <0.05) with the number of days parents reported family problems in the 30 days prior to questionnaire administration. Although only significant at one data collection point this correlation suggests that the more depressed a parent is the more often they will experience episodes of family conflict. No other significant relationships were identified between substance use, depression, removal of children by the local authority and days of family conflict experienced by participants.

[15] Friedman ANOVA and Wilcoxin sign ranks test p>0.05
[16] Friedman ANOVA and Wilcoxin sign ranks p>0.05

Employment education and housing

None of the participants accessed any full or part time paid employment during the research period and all were in receipt of a range of state benefits. At wave three (t+12) one parent did state that she had started working on a part time voluntary basis. There were no significant differences in how parents felt that they managed their money over time. As shown in figure 7, the majority of participants were positive about how well they managed their income with only one parent stating that she managed her money very poorly (t=0 & t+6) or poorly (t+12).

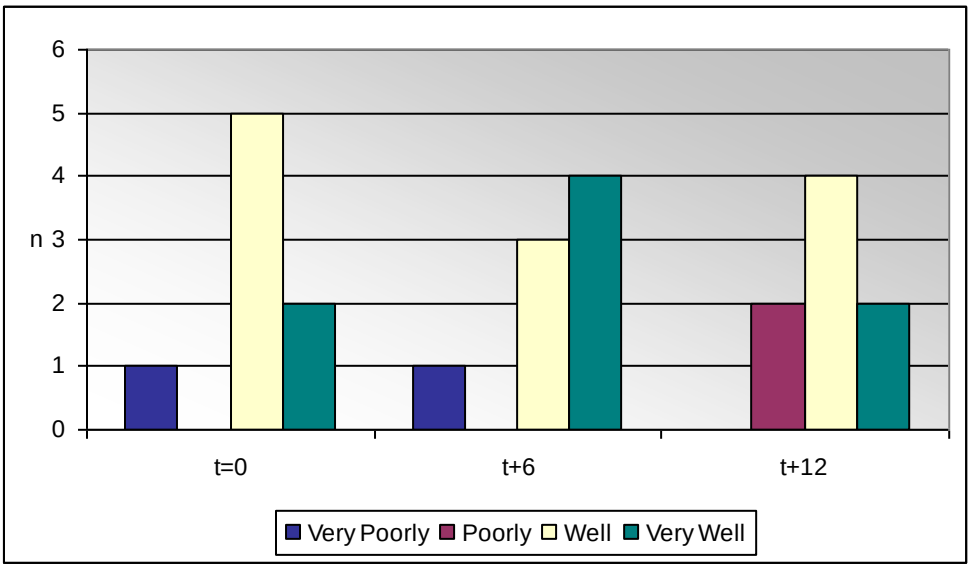


Figure 7: How parents felt they managed their income at t=0, t+6 and t+12 month interview (n=8).

The majority of participants had low levels of education with approximately a third of the sample (n= 3 participants, 37.5%) having no formal qualifications. Other qualifications held included at least five GCSE's (n= 4 participants, 50%) or NVQ level 1 (n= 1 participant). Levels of educational achievement remained the same throughout twelve month study period. At baseline, three participants were attending training or vocational courses (mainly computer based training such as Computer Literacy And Information Technology (CLAIT) however none of these parents completed the full teaching term.

Housing was identified as a major issue for many participants with some participants having been on housing waiting lists for over five years. The number of participants waiting for housing increased from 50% (n=4) to 75% (n=6) over the three waves of

data collection. Further discussion of housing issues are presented in section 3.3, qualitative interview findings.

Access to other Middlesbrough based support services

Parents were asked to list the support services which they accessed in addition to Families First. There was a significant difference in the number of parents accessing support services over time ($\chi^2 = 4.667$, $p < 0.05$). All eight parents were in contact with a range services at baseline interview (mean number of services = 1.62, mode = 1, range = 2), this had reduced to seven parents at six months (mean number of services = 1.50, mode = 1, range =3) and five parents at twelve month follow up (mean number of services = 1.25, mode = 0, range = 3). As shown in table 11, drug and alcohol treatment/support and Sure Start were the most commonly and consistently accessed support services for parents over the twelve months. By the final wave of study no parents reported having contact with social services, or prostitution support, which some had been previously accessing. In terms of social services, two children from this sample were on supervision orders at twelve month follow-up, therefore it would have been expected that parents would have reported some form of contact with social workers.

Table 11: Most commonly accessed support services by parents in addition to Families First by type of service t=0, t+6 & t+12.

	Service by type		
Most commonly accessed	t=0	t+6	t+12
1	Drug and alcohol support	Drug and alcohol support	Drug and alcohol support
2	Social Services	Social Services	Child and Family support service (Sure Start)
3	Probation	Child and Family support service (Sure Start)	DIP
4	Critical Care Outreach Services	Prostitution support	Housing
5	Child and Family support service (Sure Start)	Health visitor	-
6	Prostitution support	Housing	-

There was no significant difference in the number of children accessing support services over the study period. At baseline and six month follow up parents reported

that seven (63%) children whom Families First were working with in a child protection capacity were in contact with a range of art, music and sports based support services. At twelve month follow up this had reduced to four children (36.3%) in contact with such services. Overall, such findings may indicate a reduction in the need for multiple support services which supports the previous finding of the reduction over time in parents reporting a need for help or counselling for family problems (see figure 5).

Children's health, emotional and social functioning

Parental reports of child health and wellbeing for children aged over four years (n=11) at baseline and twelve month follow up (see table 12) showed that the majority of children were registered with a dentist (n=9 children [t=0], 10 children [t+12]) and had visited the dentist during the twelve month period (n= 8 children [t=0], n=10 children [t+12]). None of the children had been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), but as this sample had a mean age of 5.3 years this is not surprising.

Table 12: Child health issues and access to health services (n =11 children >= 4 years)

Children….	*t=0*	*t+12*
	N (%)	*N (%)*
Diagnosed with ADHD	0 (0)	0 (0)
Registered with a dentist	9 (82)	10 (91)
Visited the dentist in the last 6 months	8 (73)	10 (91)
Has persistent health problems	3 (27)	3 (27)
Visited the doctors in the last 6 months	6 (55)	4 (36.4)
Receiving medication for anxiety or depression	1 (9)	0 (0)

Parents reported that three children had persistent health problems including glue ear (Otitis Media), soiling (Encopresis) and "knee problems" (n= 2 siblings). The child who was soiling at baseline was not continuing to do so at six and twelve month follow up. One child was receiving medication for anxiety at baseline which was no longer being prescribed at subsequent follow ups.

As shown in table 13 (see Appendix A), parents answered a series of questions relating to their child's physical, emotional and social function. Frequency of problems were calculated for each wave of administration on a scale of 0 (never) to 3 (always). The only significant difference identified ($\chi^2 = 7.600$, $p < 0.05$) related to reports of children worrying about what would happen to their parents, which

decreased over time (mean rank = 2.35, n= 6 [t=0]; mean rank = 2.05, n = 4 [t+6] & mean rank = 1.60, n = 1 [t+12]). There were no other significant differences in the frequency of children's physical, emotional and social problems reported by parents over the three waves of data collection and none of the parents reported children having any persistent problems (recorded as 'often' or 'always' in the month prior to administration). Scores for emotional functioning, measures of reported anger (mean rank = 2.25, n= 5), and children feeling sad (mean rank = 2.30, n= 4) were slightly elevated at baseline administration (t=0) when compared to social functioning measures (i.e. 'getting along with other kids' mean rank = 1.85, n=0) however there were no statistical differences observed in such measures over time.

School functioning

Table 14: Parental reports of child school functioning mean ranks* t=0, t+6 & t+12 (n=11)

School functioning (problems with…)	t=0 mean rank (n**)	t+6 mean rank (n)	t+12 mean rank (n)	Sig?
Paying attention in class	1.91 (0)	1.91 (0)	2.18 (0)	no
Forgetting things	2.05 (1)	1.91 (0)	2.05 (1)	no
Keeping up with schoolwork	2.00 (1)	1.86 (0)	2.14 (1)	no
Missing school because of not feeling well	2.09 (4)	1.82 (2)	2.09 (4)	no
Missing school to go to the doctor or hospital	2.32 (5)	1.91 (2)	1.77 (1)	no
Truanting from some lessons	2.00 (0)	2.00 (0)	2.00 (0)	no
Missing school because of not wanting to go	2.05 (2)	1.91 (2)	2.05 (2)	no
Missing school because I (parent) let him or her	2.05 (3)	1.91 (2)	2.05 (3)	no

** Friedman's ANOVA*

*** at least sometimes*

As shown in table 14, there were no significant differences observed in the school functioning of children of drug and alcohol using parents in this sample over the evaluation period. As the majority of these children were under ten years of age and low reported levels of measures such as truanting (n= 0 [t=0, t+6 & t+12]) were anticipated. The main school functioning problems identified relate to a small number

of children who consistently miss school because of not feeling well (n= 4 [t=0 & t+12]), not wanting to go to school (n= 2 [t=0, t+6 & t+12]) or parents letting them stay off school (n= 3 [t=0], n= 2 [t+6 &t+12]) which remained at a consistently low level across the twelve month study period. Children missing school to go to the doctor or hospital was the only notable change over time (n= 5 [t=0], n= 2 [t+6] & n = 1 [t+12]) which coincides with the reduction in persistent health problems reported by parents.

3.3 Views and experiences of parents: qualitative study findings

In order to contextualise the findings obtained from quantitative methods, semi-structured interviews were conducted at baseline, six and twelve month follow up with parents (n= 9) from the eight participating families. An additional two parents completed baseline interviews only and have been included in the analysis. Findings therefore relate to data gathered from 29 semi structured interviews. Interviews enabled the triangulation of data to identify any additional factors which may be attributable to observed changes in attitudes or behaviour, which were not addressed by quantitative measures. As parental accounts and experiences of Families First's intensive intervention approach were gathered during the intensive support, as well as retrospectively, these findings provide insight into the often complex relationship between substance using parents and social workers during the intensive support, as well as retrospective accounts which historically form much of the evidence base surrounding social work approaches to working with parents in child welfare cases in the UK (Forrester et al., 2008, Department of Health, 1995).

A range of themes were identified from interviews that fell into seven areas. These include: initial and retrospective responses to Families First intervention approach*;* descriptive outcomes for parents and children*;* what parents felt instigated their behavioural and attitudinal change*;* housing and social networks*;* elements of the service valued by families*;* parents views on the negative aspects Families First's intensive intervention and suggested improvements and accessing future support.

Initial and retrospective responses to Families First's Intensive Intervention

When parents were asked to describe their experience of Families First's intervention all chose to discuss the relationship they had with staff and the intensity of the support which had been provided. The majority of parents' attitudes towards Families

First staff changed substantially over the three waves of data collection. At baseline interview parents provided mainly negative descriptions of their initial reaction to workers and the intervention approach, but these were no longer as evident at the twelve month follow up stage.

'Perceived interference' was the main theme identified in parents' descriptions of Families First staff at baseline as parents (n= 5) described the staff as having interfered in their personal lives, as one parent stated: "*they are interfering and busy bodies*". This notion of interference was exacerbated for some by the number of staff (including staff from other Middlesbrough based support agency workers) who arrived on their doorstep during the first week of the intervention. For one parent the number of different workers arriving to help her had caused confusion: "*there was different ones coming everyday so I was getting all confused. I seen about nine of them".*

Parents appeared not to trust Families First social workers at the beginning of the intervention and were fearful that their children would be removed from their care. One parent stated that she felt that social workers wanted her to fail so Families First could remove her child; this belief was also recalled by other parents (n=2) retrospectively (t+12 months).

> *"I think that they thought that I didn't deserve to get him back".*
>
> *"In the beginning I though they were busy bodies and they were just out to get (Child) and I wasn't going to get him back*".

Such fears of Families First removing children were attributed to the negative views held by all parents towards social workers. For many, their past experiences of social welfare support had led them to believe that social workers would not provide sufficient support to help them (n=9). The following quotes illustrate some of the reasons given for the negative views of social welfare support services:

> *"Where was Social Services then in 1993 when I was getting kicked all over, blood all over my daughters pram, nose broken, ribs, having to go into refuges to get away from the father; where was Social Services then? It's all too late, I went for help and I didn't get help".*
>
> *(Mother) "With social workers you can pick a phone up…*

(Father) "And three days later they'll get in touch with you".

"I mean I haven't even had any help about my daughter and her getting adopted, well they've mentioned her but, what about going to do something? But, they haven't helped me"

This fear of children being removed from parents was in one case linked to previous experience of being in care herself:

"To be truthful with you, I have always had a thing about social services because I have been involved in care all my life and to be quite frank with you I shit myself, because the first thing I thought was that they were going to come and take my kids".

Many of the negative attitudes held by families were no longer evident in the descriptions of the Families First intensive intervention at the twelve month interview stage. Many of the families who had held negative views (n=4) stated that their initial reaction to Families First's intervention had not been correct and that with hindsight Families First has been working in their best interests in order to keep their family together.

"But when I think back they were only doing their job, they are not supposed to sit there and say everything I want them to say… now I know they are here to help me and the goals they have set are to help me as much as it is to help the kids".

In contrast, two families were positive about the support that they had received in the few days prior to baseline interview as it had not been the negative experience that they had anticipated. Parents in both families had a clear understanding of what the intervention involved and what would happen in the forthcoming weeks, this clarity appeared to alleviate any apprehensions they had about the support package:

"*So when they came and explained everything I was pleasantly surprised, I had thought the worst straight away, they have given me loads if help and support".*

Finally for one father there was a clear distinction between the support provided by social workers in Families First and Middlesbrough social welfare locality teams as he felt that Families First had been working to keep their family together:

> *"It felt like Social Services were trying to take the kids away and Families First were trying to bring them back home to us".*

These findings suggest that intensive family support models with social worker case responsibility such as Families First have an additional barrier to climb in engaging families due to their apprehension of a support package which involves social workers. This is primarily due to the negative views held by parents towards social workers based upon their past experiences of social welfare involvement. For a small number of families a clear explanation by Families First staff on what the support package was to entail at first point of contact appeared to act as a means of addressing any negatively preconceived assumptions.

Descriptive outcomes for parents

Various lifestyle, personal, emotional or attitudinal outcomes of Families First's involvement were described by parents. Such outcomes included: reduced or stabilised drug or alcohol use; leading a 'normal' lifestyle; improved self concept and confidence; keeping the family together and improved family relationships.

Substance use

The most common outcome of participation in the Families First intervention described was reduced or stabilised substance use. All parents stated that involvement with Families First had helped them to reduce their alcohol or cease their illicit substance use at some point during the evaluation.

> *"Before they (Families First) were in touch I would just be waking up, drinking all day, going to bed and it was just the same every day. Now they are coming I have started a course and sorted the drinking out".*
>
> *"I have stopped using because of it (Families First)".*
>
> *"Helping me get off, get my self sorted and think straight going day by day and plodding along".*

One couple described how the support provided by Families First had helped them to deal with daily life without the use of crack and heroin:

> *"They are helping us like with coping with being off the drugs".*

Despite all parents having received support from Middlesbrough based drug and alcohol services in addition to Families First, only one parent stated that she felt the other drug and alcohol support received had contributed to her and her partner's illicit drug abstinence. Five parents stated that Middlesbrough based drug and alcohol support agencies had not helped them in any way, two of whom described how they found such agencies intimidating due to the group therapy approach often adopted to treatment.

> *"I don't know about other people but I wouldn't feel comfortable going to those places. You feel like they are looking down on you".*
>
> *"Me and (partner) aren't the most communicative people, we like to stay in, in our shells sort of but, like together sort of thing. So we didn't like it".*

These findings suggest that parents believed that the intensive, one to one support provided by Families First had helped them achieve the substance use related outcomes observed.

Being 'normal'

Throughout interviews six parents made repeated references to being 'normal', which for them was reference to a lifestyle that did not include substance use. As the following quotes illustrate, being 'normal' was what parents were striving towards as an overarching outcome of the process which they had undergone:

> *"We have to do normal things and normal living".*
>
> *"Just try and be normal, that's what I want".*

For one family their main goal was to have their first holiday abroad which they viewed as a major step in their progress towards a 'normal' family life. This goal was achieved along with the removal of previously held ASBOs and acceptance onto the housing waiting list which they had not expected due to being previously removed as a result of drug dealing from council property. All of these positive outcomes were attributed by parents to the Families First intervention package.

Self confidence

Five parents described how they felt the support had provided them with a positive personal outcome such as an increase in confidence, self esteem or a sense of achievement, as the following quotes illustrate:

> *"They were making me feel better about myself".*
>
> *"I can be myself again I don't need to be abrupt to people or hideaway".*
>
> *"I feel a lot more positive now than what I did before".*

One couple described how their involvement in a family support promotional video had provided them with a sense of achievement. Both explained how their selection for involvement was a positive outcome for them both as it meant that their progress was acknowledged by workers.

> "*A couple from Newcastle, a couple from Liverpool, a couple from Middlesbrough and she said like 'we picked you' so, do you know what I mean, it was nice to know that they were thinking that we have come out as good as that at the other end. So yeah, it was really good for us".*

Keeping the family together

The prevention of children's entry into the care system due to the involvement of Families first was discussed by parents (n= 4).

> *"If we still had social services we definitely wouldn't have the kids with us now".*

As the above quote illustrates, one couple stated that if they had not entered the support package and had continued to receive support from their local social welfare department they felt that they would not have made sufficient progress to ensure their children remained in their care. At the final interview stage two other parents described how they were close to not having any social welfare involvement with their family due to their children no longer being viewed as being at any risk. These parents felt that was an unexpected and positive outcome of Families First's intervention process.

Improved family relations

Parents (n=3) attributed their involvement with Families First with the development of a closer bond with family members. This included one parent who stated that Families First staff had helped her bond with her child and two parents who explained

how the involvement of family members in the intervention had improved relationships with their own parents. The following interview excerpt illustrates how for one father the involvement of his mother in the intervention had led to a reestablishment of trust, which his former substance use had damaged due to him stealing from her to pay for his addiction.

> *"Obviously my mam doesn't listen to me what I'm saying but she hears it from someone else… they are telling her the same things that I am telling here it gives a bit more (pause) believable, because obviously I have lied a lot in the past. Now she is really good, she knows, she really trusts us now. I mean she will go out of the room and leave her purse where she wouldn't have before".*

The professional support provided to these families appears to have helped establish family relationships which parents felt had been negatively affected by their substance use.

Descriptive outcomes for children

Despite data not being collected from children themselves, parents were asked if they felt that the support provided by Families First had impacted upon their children in any way. In response, some parents (n=4) described a range of behavioural and emotional outcomes for children between the ages of four and ten years, which they described as being a result of in participation in the Families First's support package. Three parents reported reduced anger in their children as a positive outcome of family support work*:*

> *"[Family support worker] helped out our [child] because he had anger management, so. It did help him".*

Whilst other parents (n= 4) stated that their children were listening to instructions more often (n=2) or adhering to the routines that were established by family support workers up to one year post intervention (n=2).

> *"My kids still make their beds in the morning and stuff like that and they got them into that routine".*

Observed happiness and confidence in children were both regarded as outcomes of the intervention by two parents. The remaining child outcomes discussed related to how children were more likely to approach parents if they had a problem (n= 1) and how parents (n=2) felt their drug abstinence would have a positive impact upon their children's lives in the longer term.

"It will help him because of getting of the drugs. They are going to benefit from it that way".

What parents felt instigated their behavioural and attitudinal change

As the quantitative data has shown, all but two children remained with parents up to one year after their involvement with Families First's intensive support and reported substance use remained at a low and consistent level. In light of the negative attitudes held by the majority of parents towards the support package at baseline, and the fact that five children (n= 4 families) were placed in temporary care prior to or during the intensive support, views on what parents felt had helped them to initiate lifestyle and attitudinal changes were sought. A number of themes were apparent in parent's descriptions of change, the majority of which were directly attributable to the intensive intervention. Reasons for change included: removal of children from their care, acknowledgment of personal responsibility, the establishment of a truthful relationship with workers and readiness for change (timing).

Removal of children

Five parents stated that the removal of their children coupled with the individual goals (SFBT) set with Families First provided a sharp realisation that immediate change was necessary.

"It's given me a kick up the arse basically. It's letting me know that I can't just push them away sort of thing, because that they are there".

"Taking the kids away, that made me realise that kids were more important than drinking, what I was doing. That's the only thing that has helped me".

Parents felt that intense support provided at the time that children were removed was the key to the positive outcome they had achieved, particularly as several of these parents had previously experienced children being permanently removed by social services a number of years prior to Families First's involvement. As the following quotes illustrate, parents were more willing to embrace support when they realised that they would get their children back if they achieved the goals that had been set.

"I had to do like everything they (Families First) wanted me to do to get them back; so I done it".

(Mother) "we came of drugs because of (child name)".
(Father) "we knew that we wouldn't get him back if we had stayed how we were then, do you know what I mean? At the end of the day"…

(Mother) …"They gave us the incentive".
(Father) "they gave us the incentive yeah".

Four of these parents managed to make the required changes stipulated to have their children placed back at home, one parent did not achieve such changes and a kinship carer placement was identified. As the following quote illustrates this parent was aware of what she needed to do to ensure her child remained care but did not stop using drugs despite two attempts at rehab which were funded by Families First.

(Researcher) *"And did the threat of losing* (child) *make you think that you need to stop using the drugs and work with them* (Families First)*?".*
(Mother) *"Yeah, but like, I have still gone back on them* (heroin and crack cocaine)*".*

Acknowledgement of individual responsibility

Individual responsibility was also a theme evident in parents explanations of what they felt had led to their change in lifestyle, including reduced alcohol consumption or abstinence from heroin and crack cocaine over a twelve month period. The following quote illustrates the moment when Families First workers helped one parent acknowledge her individual responsibility for the impact her substance use was having on her children.

"The first time I went in they started asking us like to fill in bits of paper, like as a group and one of the first questions on one of them was about your kids and how your kids felt. Straight away I couldn't answer it, I just flipped, I shot the table upside down and cried my eyes out for hours and hours. Obviously because I had never really thought about things like that and they were there constantly, making sure that I was alright".

The emotional support provided to this parent at this point of realisation appeared to have been important in helping her deal with how her substance use may have impacted upon her children. Three additional parents stated that an acknowledgment of their personal responsibility for ensuring their children were not permanently placed in care had provided them with the motivation for change, as the following quotes illustrate:

"Instead of getting upset and turning to the bottle, get upset and take the kids for a walk, or, I don't know, it's a different whole approach. Instead of it being me and my bottle it's me and my kids"

"It's down to myself"

"Now we realise that we have got to focus on the problem ourselves".

This final quote illustrates that when this particular parent had acknowledged her individual responsibility for making the changes required the intervention process became much less difficult.

> *"I think that was just me, I was in me downs and once I had acknowledged, you know, I don't know, it was easier".*

Readiness for change

Timing was an issue raised by the majority (n=6) of parents who felt that Families First had offered support at a time when parents were ready to stop using heroin or reduce their alcohol consumption for the sake of their children. As the following quotes illustrate:

> *(Mother) "we were both ready to stop".*
> *(Father) "yeah, him (child) added to the mix as well".*
> *(Mother) "Like with (other children who were previously taken into care), I wasn't ready then, but now I am. Because I feel guilty and I say, I say to my mam 'how come I never done this with (other children)? and she said 'because you weren't ready then'.*
> *(Father) "He (child) just come at a specific time when we really needed the help and because of him (child) the help we needed we got at the right time, you know what I mean?"*

This next quote highlights how one couple had previously attempted to stop using drugs and failed. They felt that readiness for change and the intensive support package had enabled them to succeed.

> *"Like I am 37 now and she (partner) is 32 and it was time to change, it was too much it had been going on so long. We had a go at it (giving up drugs) about six year, seven year ago, and we nearly done it then so I knew that it wouldn't be long before we would change, do you know what I mean? It's never been in our heads that we would be on drugs for life, we always knew that we would get off it. It was just a matter of when and we just needed the extra support from FF I suppose to give us that extra push".*

Establishing an open parent/social worker relationship

One parent stated that when she began to tell the truth in relation to her substance use her relationship with Families First staff improved which enabled her to embrace the support provided rather than dread the arrival of workers at her home.

> Mother) *"You have just got to be truthful; you have got to want to change for it to work".*
> Researcher) *"And when you were more truthful did you find that they* (Families First) *were more responsive towards you?"*

Mother) *"Mmm Hu* (yeah)*. It wasn't a drag anymore, you were excited to see them, rather than 'oh god' they are coming back again".*

Housing and social networks

Housing and disassociation with former social networks were issues of concern for the majority of families (n=7) at some point during the research process. The housing problem identified by parents appeared to be due to a waiting list/bidding system used for former council housing in Middlesbrough which is managed by a 'not for profit' landlord company (Erimus Housing). Parents stated that demolition of large areas of housing as part of the regeneration of Middlesbrough town centre had led to a shortage of social housing stock. Potential tenants are required to pick a property and then wait on a list for that property that requires weekly 'bids' to be placed in person at the housing association. Waiting lists for more undesirable properties are much shorter than for larger houses in more desirable areas of Middlesbrough.

The desire to move house was also identified in the quantitative data collected with over half of the sample waiting between six months and eight years on housing association lists to move from the areas of Middlesbrough in which they resided (n= 5 families) or to move to larger accommodation due to an increase in family size (n= 2 families). Only one of the parents interviewed was happy with her housing situation. This parent's house was privately owned in a more affluent suburb on the outskirts of Middlesbrough compared to the central areas in which many of the participating families were residing.

Five parents (n= 3 families) stated that Families First's assistance with the housing bidding system in order to find alternative housing in a new area away from former social networks had been key to what they had achieved. These parents felt that their reduced substance use and return of children into their care were inextricably linked to having moved away from substance use related networks in their former areas of residence. As the following quote illustrates:

> *"We moved areas from the town centre. If we were in the town centre when we were fighting for (child's) custody we wouldn't have got him because it would have been so hard for us, not just because of our own personalities or our own beliefs or 'owt, just because other people in the area wouldn't have allowed us as they would have been at the door all of the time".*

Former drug using friends, or in one case alcohol dependent family members were regarded by parents as potential barriers to achieving the lifestyle changes required

to ensure children remained in their care. Even though parents acknowledged that they were able to re-establish such networks or instigate new substance use related networks if they wished, regardless of where they lived, they felt that the increased physical distance from their substance using networks had given them the space to create their new lives and establish new, non substance-use related friendships. One parent illustrated this in his description of his new friends and how their relationship differed to that he had with his old drug using friends:

> *"It's just not friends who are on your door all the time; it's just once or twice a week or something. You know you will have a chat with them, then I will have a chat with my mate and all that. They work you see, like the ones next door, they work, well five days a week and maybe on a weekend I will have a couple of cans with him. But they're not knocking on your door and all that when you come in. It's a different type of friend, its more like realistic friends, like it's supposed to be I suppose. Its not like 'are you coming to get high somewhere' you know what I mean? Which is good".*

One parent, however, believed that the area in which substance users lived was irrelevant as she thought that drug users were everywhere in Middlesbrough. Her approach was to keep to her own business and not associate with her former drug using acquaintances.

> *"You just keep yourself to yourself and that's that, drug people are anywhere around the city if you just keep yourself to yourself it doesn't matter. I see most people that I know on drugs and I just don't bother with them, you just keep yourself to yourself".*

Elements of the service valued by families

As shown in table 15, parents identified six main components of the Families First intensive intervention that were valued highly, these included: use of therapeutic tools; listening to parents and providing advice; support with family relationships; intensity of support and availability of staff; parenting support and support accessed through referrals to other support agencies.

Table 15: The components of the service valued by families (in quotes)

1. Use of therapeutic tools (e.g. SFBT and value cards) (n= 11 parents)

"We always read them (value cards). Not that we have had a crisis but we always look at them just to keep them fresh in our minds".

"I picked three goals to work for because it was seventeen weeks or something and three goals to work for. That was like get my family back together, reduce methadone 5ml every two weeks and get off it and the other one was to get my house sorted. So she (Families First

worker) would work with me to do that. If it wasn't for her I don't think I would be where I am now".

"Doing like assessments with me and my life story from being a baby and all about my passed and everything. I think I needed to get that out".

2. Listening to parents and providing advice (n= 8 parents)

"We talk and go through things".

"Once we got the Families First involved and they talked to us about stuff and all that you know. I just realised and thought to myself, what am I doing? I am going to end up losing my kids for good and the kids mean everything to me, you know what I mean? So, I just sorted myself out then".

"I just think that you need to talk to someone, just to realise where I stood again".

Father) "I couldn't just put my finger on whatever started me off on drugs, you know what I mean? Like people say what triggered them? You know what I mean, I don't know why I done it. I just got on them. They (Families First) help you like, I don't know…
Mother) They help you put it in the right way for you
Father) Yeah, like you hadn't thought about it in that way, you know what I mean, but when they have said it you think 'oh yeah'. They have been brilliant help".

3. Intensity of support and availability of staff (n= 8 parents)

"With all the core group meetings and things like that. To get the baby home as quick as possible. I think that is enough actually, like everyday there is something happening. They are going away and doing it".

"We had an appointment everyday. That's what was keeping us a bit more stable wasn't it?"

4. Support with family relationships (n= 4 parents)

"I was worried at first but it has brought us closer, a lot closer".

"Its helped bigger than I thought it would have, even though everybody knew the situation that was going on I don't think they (family members) realised how much a little bit more help would have helped".

5. Parenting support (n= 4 parents)

"Helping me with the kids".

"We were having real problems with (child) weren't we? Her behaviour it was terrible. She was beating up her younger brother. She chipped his tooth, she was scratching him, she's made him bleed, scars over his face and they come in to help didn't they? You know, taught us…yeah taught us how to make her stop really".

6. Referrals to additional support agencies (n= 4parents)

"They have arranged for me to see a counsellor, which is helping quite a bit".

"They have helped me with education and stuff, going to college and that".

1. Use of therapeutic tools

For parents, the most valued aspects of Families First's support package related to family therapy systematic approaches to working with parents. Goal setting, used in

Solution Focussed Behavioural Therapy (SFBT) approach adopted from the Option 2 project in Cardiff (Forrester, 2007), was the singularly most valued aspect of the support provided. Parents recalled how the setting of goals provided them with a motivation to achieve the changes required to enable their children to live with them. For some parents the goal setting enabled them to achieve things that they would never have thought possible, as one parent who suffers from agoraphobia recalled:

> *"Well I set goals, we set goals, and I was doing allsorts. It might not seem much to you but it was a big deal for me. I was starting to get up and I was going out and I took the kids to the museum".*

Many of the parents described how they themselves had set the goals with help from the Families First staff which appeared to have provided them with a sense of control and ownership over the process.

The use of value cards (see section 3.1) provided a focus for two couples interviewed, one of whom stated that they used the value cards long after they had completed the intensive support package as it provided them with a reminder of their progress and how it needed to be maintained.

2. Listening to parents and providing advice

Parents placed high value on the opportunity to talk to Families First staff about their problems and the advice provided in order to identify possible ways of addressing their problems. In many cases the opportunity to talk to someone about their substance use and children provided the first step in acknowledging their individual responsibility which provided the motivation for change.

3. Intensity of support and availability of workers

The intensity of support provided to parents during the first weeks of the intervention was valued by parents as they stated that the daily tasks set by workers provided structure to their lives, which they believed assisted them in achieving the goals they had set with workers, including reduced drug and alcohol use. The availability of staff during times of potential crisis was also viewed as important. As the following quotes illustrate:

> *"Like I got a bit depressed and I could have gone back over, but luckily enough we never, we told them how we were feeling and everything and they come and seen us".*

> *"Just a phone call away, that's all it is".*

One parent compared the work of Families First to that of the support he had received from previous social workers. Although he acknowledged that some social workers had worked in the best interests of his family he identified that there was a difference in the structure of Families First support and availability of workers compared to that offered by his previous social workers. In particular he placed value upon the availability of workers at the beginning of the support process when he was coming off heroin:

> *"If you get a good social worker they'll work with you as well but its the way that its structured isn't it with Families First?…they are there all the time, especially in the early days when you are getting off drugs and you really need help".*

4. Support with family relationships

Parents stated that Families First had provided support that had improved family relationships between themselves and extended family members. As part of the initial stages of the Families First intervention the team identify extended family members in an attempt to make them aware of the situation and if possible identify suitable family members who may be able to provide a kinship care placement if children were to be removed from the care of their parents. At baseline interview some parents were very clear that they did not welcome this approach as Families First had contacted family members or children's fathers who they had chosen to disassociate themselves with for a variety of reasons.

> *"I didn't see my dad for years, I asked them not to go to my dads but they went to my dads, they got my dad back in my life. I didn't want him involved or nothing".*

At twelve month follow-up however these parents had changed their views towards Families First's involvement of family members as they had provided unexpected support which had improved family relationships.

5. Parenting support

Value was also placed by parents on the support provided to children by family support workers. As the quotes in table 15 illustrate family support workers helped parents to deal with children's behavioural problems by providing advice and practical tools to be used to deal with angry or disruptive child behaviour. Family workers also helped parents to establish routines with children such as regular bed

times or for older children, making their own beds when they got up in the mornings. Rewards systems were then used by parents to help instil the routines they had developed with the support of workers.

> *"The rewarding stuff with (child), that's good isn't it? She knows doesn't she? If she is really naughty she won't get a reward".*

Two parents explained how they appreciated the family worker support which had also provided them with some space away from children during the intensive period of support.

> "*They'd take the kids. You know [Family support worker] would come and take me shopping…they really are brilliant*".

6. Support accessed through referrals to other support agencies

Families First's referral of families to additional support services was regarded as an important aspect of the intervention by parents. Referral to training or employment related agencies was discussed by three parents who had identified the wish to enter the employment market within their goal setting procedure (SFBT). One parent described how Families First had arranged for her to see a counsellor which she felt was helping her to deal with issues in her past. Finally, one parent valued attending a separate substance use support agency rather than accessing all forms of support from Families First as this provided a means of separation so that Families First was not in control of every aspect of his support:

> *"I think maybe it is a good thing that you come away from them to talk to someone else (about substance use); you don't feel like they have got you under everything, it's a different situation".*

Parents views on the negative aspects Families First's Intensive Intervention and suggested improvements

Working with parents in relation to child welfare is challenging and the parent/worker relationship appears to have been the most challenging aspect for parents and Families First workers who participated in this study. Each case has had its own complexities and the temporary removal of children from parents (n= 3 families) by Families First social workers during the evaluation period tested such relationships to the maximum. Three parents stated that as the Families First package had worked for them, there was nothing they felt could be suggested for improvement, as the following quote illustrates:

"If it's worked so well for you, why would you need it to change? Somebody else might have a different opinion. There is nothing that we would change because it has worked for us, no, we wouldn't change anything".

However, during the twelve month evaluation a number of recurring themes relating to negative aspects of the Families First were discussed by parents. Due to the observed changes in parent's attitudes towards the Families First intensive intervention, parents were asked to suggest how they felt the intervention could be improved at the final interview (t+12 months) when they had time to reflect upon their experiences. Table 16 presents quotes from the main themes identified in the negative experiences described by parents and the corresponding suggestions for improvement made during the final interview.

Table 16: Components of Families First's intensive intervention which parents suggested for improvement (in quotes)

Problems	***Suggested improvements***
1. listening to parents	
"We needed someone to talk to". "It was more like what I should be doing to sort the house out"	"If they were more (pause) tried to understand a bit more". "Like me tell them what I needed to help, not them telling me how I needed help". "I think they should just listen a bit more to what you say". "They could like, get their facts on things more. They should look into things more before they make a decision".
2. A trusting relationship between worker and parent	
"And it breaks my heart, because at the end of the day, they've led me proper down the garden path". "I just don't think that they should promise you things and then drop you at the drop of a hat".	"You need to be able to trust them". "If you are going to have someone in your life who is going to delve into your life, your kids, you're self, your past, your future. You need to be able to trust them".
3. Dealing with parental substance use	
"They try to tell you things about drugs as well and they haven't got a clue do you know what I mean?" "They have been conditioned to look at things in certain ways. Like do you know what I mean, if they see a scruffy house and people were on the drugs, they will automatically start seeing things that they believe are drug orientated when they have got nowt to do with drugs".	"They need more help with that definitely, the drugs side of it". "If one of them was a trained drugs councillor, trained drugs worker. If they have ten people working in their offices, surely two of them could be trained drugs councillors". "Its just drugs have different effects and that's what they need to know, you know what I mean, families feeling different effects, they need to give different help to different families

"Just because I have got a drink problem doesn't make me a bad person".	who are suffering different effects".
4. Length of support	
"They are just all 'you don't need our help no more' and then next minute you have relapsed because they are not there no more to keep you on your toes". "I wish they were working with us all the way through".	"I think what they do is good, maybe check up on the people a bit more…once a month" Mother) I think that there should be something in between that's just… Father) an after care service Mother) not social workers, just support workers, just to ease you off a little bit Father) just so that they can fill the gap that social workers have left, you know what I mean".

1. Listening to parents

As stated previously, families placed high value on having the opportunity to talk to Families First staff about their problems. Although the majority of parents did feel that workers did listen to them, three parents discussed how they felt that some Families First staff dictated to them rather than listened to them. One couple described how, in the early phase of the intervention, they needed to talk to workers but felt that this opportunity was not provided. As the quotes in table 16 illustrate, many parents, including those who were positive about the support package, stated that the intensive family support package could be improved if staff were able to allocate extra time to listen to parents in order to identify and address their needs sufficiently.

2. A trusting relationship between worker and parent

A trusting relationship between worker and parents was viewed as an important aspect of support. For one mother, the high value she placed on the establishment of trust with the workers was due to the level of involvement workers had in her family's life and her associated emotional investment; as the following quote illustrates:

> *"If you are going to have someone in your life who is going to delve into your life, your kids, your self, your past, your future. You need to be able to trust them".*

During interviews however, some parents felt that a trusting relationship was not always apparent between themselves and workers. As outlined previously, the establishment of trust between workers and families was inevitably problematic due to removal of children, and the negative views often held by parents in relation to social workers in general. Some parents acknowledged that it may be difficult for

social workers to trust them, particularly when substance use is an issue, as this quote highlights:

"*It's just hard to believe because a lot of people say they haven't (used drugs) when they have*".

Three parents stated that they needed to trust workers to deliver what they were promised as they felt let down when promises were not delivered (see table 16). These parents suggested that it would be better for workers not to make any promises to families rather than not fulfilling them as it resulted in a loss of trust between worker and parent. This loss of trust also appeared to impact upon a parent's willingness to engage with the intervention as such parents appeared to be increasingly negative towards Families First after such an episode.

3. Dealing with parental substance use

Several comments were made about the lack of Families First workers substance use related knowledge. Parents stated that although they accessed specialised substance use support from additional Middlesbrough based agencies, they felt that Families First staff should have a good substance use related knowledge base in order to prevent incorrect judgements being made about them, particularly in light of the fact that Families First do have case responsibility and can remove children from the care of parents.

One couple described how Families First staff had incorrectly suspected a father was using heroin due to symptoms that were caused by prescribed methadone. This resulted in both parents contacting their drug support agency key worker for help with the situation as they feared their child would not be returned home as anticipated:

> *"Our key workers at the Fulcrum she told them (Families First) about like Methadone, because he (father) was feeling a bit drowsy one time and they were thinking that he was using. He wasn't, it was just the methadone and they were laughing at us as if to say 'what, methadone makes you drowsy?' It does…especially when you are on a decent amount".*

Both parents explained how Families First had welcomed advice from the drug support agency and sought additional training as a result of this experience; however they both felt that an intervention working specifically with substance using parents would benefit from having a specialised drugs worker as part of the team in order to

prevent a reoccurrence of this situation with families in the future. Substance use training for all members of Families First was also suggested by other families who felt that workers made incorrect judgements about their behaviour as a result of insufficient substance use related knowledge. As the quotes in table 16 illustrate, two parents stated that they felt some Families First workers had been judgemental towards them and their lifestyles as a result of their negatively preconceived attitudes towards substance users. Another parent felt that workers would never be able to fully understand what families go through when they reduce their substance use as they had not experienced withdrawal themselves.

> *"There is nothing worse than sitting there talking to someone and they are like 'oh yeah I know' and your like 'you don't know though' and they are like 'well it cant really happen like that can it?' and you are like 'it can happen like that, you do rattle like that', do you know what I mean? How do you know?"*

This parent suggested that Families First should employ an ex-service user to provide support to both families and staff.

4. Length of support

In total, four parents reported finding the transition from the intensive support package to the less intensive maintenance plan difficult, as parents were used to seeing Families First workers on a daily basis for advice and support. As the following quote illustrates:

> *"They were doing work every day when the kids weren't here but as soon as the kids came back they started dropping off of us. You would have thought it would have done more wouldn't you?"*

The majority (n= 6) of parents suggested that additional, but less intensive support could be put in place between the six week and four month assessment stages of the support package. Many described the end of the six week programme as seeming abrupt due to the intensive of support they had previously experienced, as the following quotes illustrate:

> *"I don't think it needed to be longer but I do feel that there needs to be more support after that six weeks rather than just dropping you".*

> *"It would have been better if there was an after care service"*

One couple acknowledged that longer support may create a notion of dependency and that they had to learn how to cope without support in order to sustain their

achievements in the longer term. In the following excerpt both parents described how they viewed the reduction in house visits by support workers as a sign of their achievements:

> *Father) "you can't have them all the time can you? Because you have got to learn how to cope by yourself now…now we realise that we have got to focus on the problem ourselves".*
> *Mother) "Which is a good thing as the less and less people are about the more we know that we are doing well".*

Accessing future support

Finally, the majority of parents (n= 7) stated that they would access support services in the future if they felt that it was necessary. Despite the removal of her child, one parent stated that she would access Families First for further support in order to secure a place in rehab if it was made available. Two parents stated that they would be more likely to ask for help for their children, rather than for themselves. In terms of barriers to access to support services for this sample, two parents categorically stated at twelve month follow up that they would not approach Families First or any other agency for support in case their children were removed.

> *"No, in case they took the kids off me again".*

This included not accessing support from practitioners within drug and alcohol agencies whom parents felt would be obliged to report their substance use to social services who would then remove children from their care.

3.4 Implementation and inter agency working

Implementation

The extent to which an intervention is implemented as intended has been associated with improved outcomes for service users (Dusenbury et al., 2003); however flexibility in development has also been shown to be important. Key elements to a successful programme implementation include adaptive planning and service development that are responsive to changing client needs; practitioner training and locally developed procedures and protocols (Berman and McLaughlin, 1976).

A series of interviews were conducted with Families First staff (n=15) and key stakeholders (n= 7) in order to evaluate the integrity of implementation of Families First. Stakeholder interviews were conducted with members of the Families First

steering group and were structured around four keys areas including: Families First's implementation; aims and objectives; referral processes and targeting, and inter agency working. Social network analysis was used to further explore local partnership working. Data was gathered using a questionnaire and distributed to Families First staff at the onset of the process evaluation phase. Staff members were then asked to list all the people they worked with on a regular basis (defined as more than twice a month), and then assign a rating to each of the relationships they had listed based upon the frequency of formal discussion in regard to key issues including: information on adult clients; information on children in need and information on children in a legal child protection capacity. This provided a means of weighting relationships, allowing the evaluation team to identify key relationships in the administration of Families First.

As outlined in section 3.1, the intensive intervention was developed using research findings and good practise identified in the work of the NET Team, a Middlesbrough based family support project funded for three years by Neighbourhood Renewal Fund (NRF) which preceded the inception of Families First. In addition, Families First was also developed using the Option 2 project model which is an Intensive Family Preservation (IFP) service that focuses on families in which parents have substance misuse problems (Forrester et al., 2008). Although both models were adapted to suit a local and case responsibility context, it was clear from the interviews conducted with staff members that the experiences of the NET team, coupled with Option 2 training, assisted in strengthening their understanding of their approach to working with families. Access to these knowledge bases also provided staff with therapeutic tools, procedures and protocols which they then adapted to their model of work. This process however was not without its challenges, particularly as the families with whom they were working had complex and often chaotic lifestyles. At the beginning the team decided to take each case in turn and tailor support to meet individual need, the process of which was based upon staff experience, the Option 2 approach and daily team discussions.

The main implementation challenge discussed by staff during interviews related to how individuals had to rethink their approach to working as Families First uses a holistic family approach rather than the more traditional segregation of child and adult services. Individuals who had previously worked with adults found themselves having to develop new skills to work with children and vice versa. Many staff described this as being a steep learning curve as one adult worker described: *"I have had to grow a*

different skin". Team work, strong leadership from the project manager and practical experience gained from working with families referred to the intervention appeared to have assisted with this transition, although many staff acknowledged that learning from practical experience would be ongoing. Workers described how team meetings would identify an issue for a family, a decision was then made as to who had the most appropriate skills to deal with the issue, which then enabled others to observe and learn. The need to draw on the wide skill and knowledge base of staff members meant that a number of social workers, family support workers and adult workers would be involved in one families support package rather than one worker having case responsibility which is the more common social welfare and Option 2 approach. The majority of staff stated that this approach provides them with the additional perspectives and skill required to meet the needs of complex cases. Analysis of internal communication between members of the Families First team using SNA showed that there were strong communication links between all staff regardless of whether the information they were exchanging was in relation to children in a legal child protection capacity, children in need or adult clients. As would be expected, staff such as adult support workers and family support workers were less prolific in sharing legal child protection information due to this being social workers' role rather than communication failures. The findings demonstrate that Families First do work as a team in making decisions and delivery support to families rather than segregating adult and child support.

Interagency working

Inter agency working has been important in the development of Families First. As shown in figure 10 social network analysis revealed a wide range of communication links between Families First and external organisations, reflecting a strong partnership approach to service delivery.

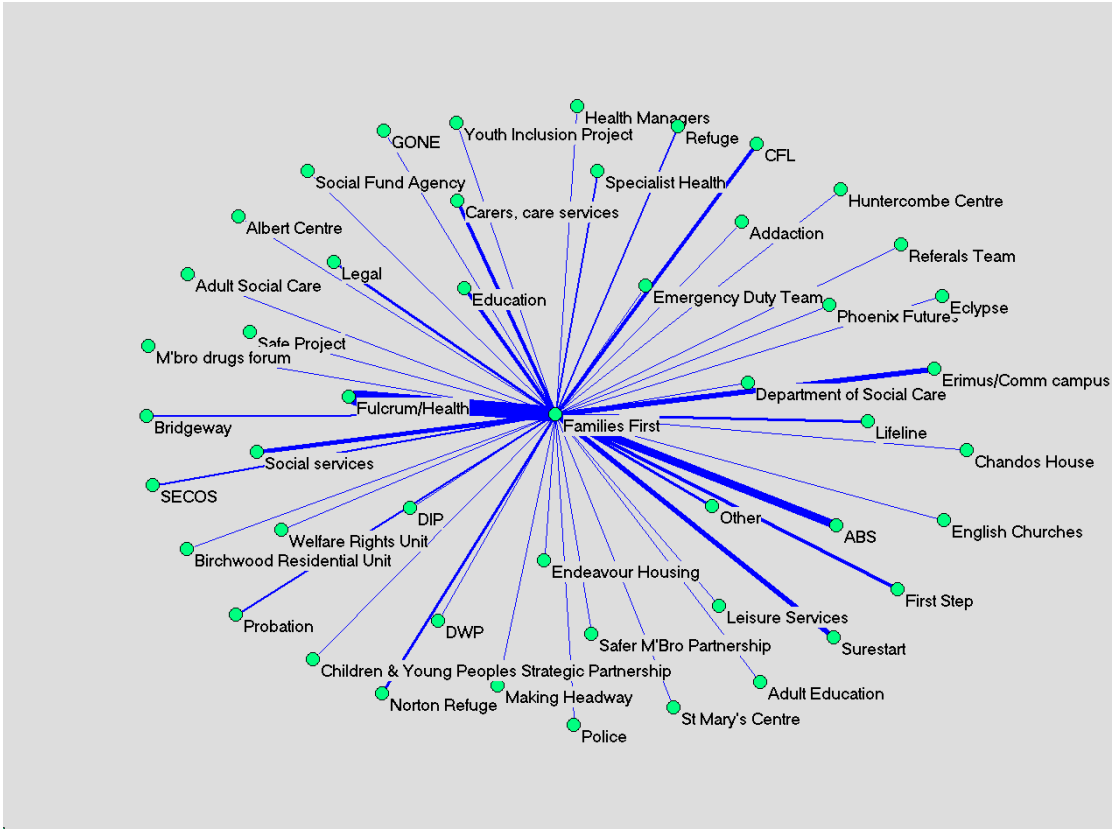


Figure 10: Sociogram showing formal discussion links between Families First staff and external organisations on matters relating to Families First.

The sociogram shows key agencies with whom Families First staff members communicate with on a more regular basis (thicker lines indicate more frequent communication). Health services, most prominently drug and alcohol support agencies such as the Fulcrum Medical Practice and Addictive Behaviours Service (now called Middlesbrough Alcohol Treatment Service), were reported by staff members as key contacts with whom formal discussion was made on a regular basis. A wide range of services are shown that have all been involved at some level in supporting the families in contact with Families First. Appropriate referrals from many of these agencies have been essential to ensure that intensive support was provided in order to help prevent children's entry into care. Ongoing efforts have been made by Families First staff to raise awareness of the intervention model in order to generate referrals. This has involved many visits, presentations and networking at both local and national level. Many of the staff and key stakeholders interviewed stated that appropriate referral generation was an ongoing issue for Families First, particularly in terms of embedding new approaches to working with substance using families within mainstream social work practice. One method which appeared to have

assisted with this process was the secondment of staff from Middlesbrough Council locality teams into Families First. Seconded social workers stated that their placement within the project helped to establish links between the team and mainstream social welfare to encourage referrals and ensure that future referrals would be made on their return to locality teams.

Overall, many of the elements associated with successful intervention implementation (Dusenbury et al., 2003; Berman and McLaughlin, 1976) such as adaptive planning, service development and training were evident in the set up period of the Families First intensive intervention. The challenge of integrating traditionally segregated child and adult services appears to have been overcome with team work, strong leadership from the project manager and practical experience gained from working with families receiving the intervention. The Families First team adapted their support model and were responsive to varying client needs which included the involvement of a team of workers to address needs appropriately rather than the one designated worker having case responsibility. Flexibility in the length of support was viewed by staff as having been important in achieving long term positive outcomes for some families to prevent relapse or the entry of children into care. Interview findings suggested that partnership working had been key to referral generation and access to a range of specialist services for families in Middlesbrough. The use of seconded job placements may provide an effective means of embedding new approaches to working with substance using families within mainstream social work practice and ensuring appropriate referrals are made to the intervention.

What does it cost to deliver Families First?

An economic analysis of Families First was conducted using a modified version of the Drug Abuse Treatment Costs Analysis Program (DATCAP) which had been piloted, along with a substance use evaluation toolkit, in an evaluation study conducted by the team at Liverpool John Moores University (Lushey et al., 2008). Between 1st April 2007 and the 31st March 2008 Families First cost a total of £353,998.91 to deliver (this included costs for seconded workers in order to reflect the actual cost of the intervention if it were replicated). Between these dates 57 children from 31 families accessed the intensive intervention. The average cost of support for each of the 57 children whose family received the intensive support package between April 2007 and March 2008 was £6,555. Average cost per family during this period (n=31) was £12,642.

Due to the lack of suitable comparison group it was not possible to conduct a cost effectiveness analysis as intended. Care order summary data were provided by Middlesbrough social welfare in order to draw comparison between costs and care status however, detailed information on parental substance use, presenting crisis and family structure were not available therefore it could not be established if the groups were comparable.

The last available Children in Need Census (DCSF, 2006) indicated that the average annual cost per child was £33,360 for looked after children, £7,280 for children supported in their families and £15,080 for all children. The cost of care for children also varies depending upon the level of support required for an individual, for example, for children who display emotional or behavioural problems the cost can vary between £50,000-54,000 and for children with more complex needs such as offending behaviour and behavioural problems can be over £95,000 per annum due to the need for additional support. However, these figures are an underestimate as they do not include wider overheads, local authority costs or increases in the overall cost of care placement since 2005 (Department of Health, 2006; Le Grand, 2007). Nationally derived figures that include children where parental substance use is not an issue are clearly not directly comparable to the Families First costing, however the Families First estimated annual cost of £6,555 per child, whom research suggests are at risk of presenting more complex emotional and behavioural needs, is substantially lower then these national estimates.

4. Discussion of the Families First evaluation findings

The evaluation of Families First's intensive intervention in Middlesbrough was designed to investigate the support provided to children and parents who attend Families First as a result of problematic drug or alcohol use. Families First is a multi-component support service which provides advice, social work intervention and parenting support for adults and families on substance use related issues. The intensive family intervention aims to ensure child welfare and if parents are unable to make necessary lifestyle changes then alterative care arrangements are made. Upon referral to the project the majority of study participants were heroin and crack cocaine users or in some cases problematic alcohol users. Many had previous experience of social welfare involvement which in some cases had resulted in the permanent removal of children from their care. For many families, the intervention is their last chance to change their lifestyle in order to keep their child in the family home.

The study was designed to identify the processes involved in service delivery, including intervention approach, the implementation and integrity of Families First, interagency working, as well as the outcomes of the intervention for participating families. Both quantitative and qualitative research methods were used, including semi structured interviews, questionnaires and Social Network Analysis to evaluate internal and interagency working relationships. This was achieved with the participation of parents, carers, intervention staff and key stakeholders. Key findings from the evaluation are discussed below.

Care status and cost

Care status findings indicated that participation in the intensive intervention prevented the majority of children in this cohort from care entry or prevented long term care placements outside of their family unit. All children were at high risk of entering care upon referral yet all were living with family members at twelve month follow up which does indicate that Families First had a positive impact. Findings show that children who were placed in care were returned home in a relatively short period (an average of two months) when social workers felt that parental substance use and the home environment had changed sufficiently to assure their welfare. For many families the support provided by the intensive intervention enabled families to make the changes necessary to provide appropriate levels of care for their children and keep children in the family home. What is not known is whether the positive outcomes observed will be sustained and whether children's welfare can be assured in the longer term.

Study findings indicate a significant cost saving for the local authority in terms of preventing the need for care during the twelve month evaluation period. Although preventing or delaying care entry may not always be in the best interests of a child if home environments are not meeting their needs, the quantitative and qualitative study findings suggest that these parents had in many cases made substantial changes to their lifestyles that were maintained up to twelve months post intervention.

The small sample size and lack of comparison group means that these results should be treated with caution. Cost analysis was only possible at a very basic level and the possibility of conducting any meaningful analysis between Families First and the local authority was hindered by an inability to access detailed financial and client data from the local authority. Existing literature suggests that this not a problem specific to Middlesbrough authority as further work is required nationally to determine full costs associated with local authority children's social services (Le Grand, 2007).

Kinship care

The support provided by kinship carers (predominantly grandparent carers) throughout this process is believed to have contributed to the care outcomes observed in the majority of participating families. Kinship care arrangements were particularly important in preventing many children's short term entry into care by providing interim care placements to safeguard the needs of children whilst Families First worked with parents and the stability of the home environment was reviewed. In some cases (n=2) grandparents provided permanent home placements for children when parents were unable to change their lifestyles sufficiently to provide a stable home environment. Both placements prevented children's permanent placement into the care system and were of no cost to the local authority as kinship carers did not receive any money for the care they provided. It is clear that kinship care was an important contributing factor towards preventing care entry of children in this study, however further investigations into the impact of caring for young children with little, if any, financial or emotional support were beyond the scope of this study and warrant further research to ensure the needs of children and their carers are appropriately addressed. The UK evidence base on what works in supporting kinship carers and their children is sparse and requires further research to inform drug prevention and social work practice and policy. The adult support package provided by Families First may well provide a model of support which compliments the intensive intervention and furthers the holistic approach to supporting families.

Parental drug use

For the majority of parents, participation in the intensive intervention was associated with cessation of illegal drug use, and/or stabilisation or reductions in methadone dosage for a twelve month period. However, this study did not seek to determine the effects of structured drug treatment, and so causality cannot be determined. In the one case where parental use of crack and heroin use was maintained, Families First worked with the child's grandparent to secure an alternative home environment. Parents described how the intensive support had provided structure and support on a one to one basis which had helped them reduce or abstain from drugs or alcohol and adjust to life without substance use. The majority attributed their reduced or stabilised substance use to the Families First intensive intervention rather than the drug and alcohol related support they had also received from other Middlesbrough based support services. The one-to-one approach of Families First was viewed as being preferable to group based therapy approaches used by drug and alcohol services, which some parents found intimidating.

Under reporting of substance use may well have impacted upon such findings, despite researcher assurances of confidentiality, as parents may well have been fearful of disclosing substance use in case their children were permanently removed from their care. However, interview findings and hair strand forensic tests conducted with some parents (instigated by solicitors) prior to children being placed back in the family home tested negative for illicit substances which suggest that under reporting did not significantly impact upon these findings. During interviews many parents made repeated references to being 'normal', which for them was reference to a lifestyle that did not involve illicit drug use or problematic alcohol use. Being 'normal' was what parents were striving towards, and in some cases felt they had achieved. All such parents believed that Families First had provided them with an opportunity to lead a normal life.

Parental alcohol use

Findings in relation to alcohol misuse are not as clearly defined which is mainly due to the small number of parents whose substance use related to alcohol rather than heroin or crack cocaine. What is clear is that the levels of alcohol consumed by two mothers decreased significantly for the first six months of the intervention; however, lower levels of consumption were not maintained for the twelve months, despite attendance at rehab, and for one parent, the use of the medication Campral©

(acamprosate calcium). In addition to this, the number of parents from this sample consuming alcohol at least several times a month increased over the three waves of data collection. This increase was mainly attributable to parents occasionally consuming low levels of alcohol, rather than an increase in parents drinking over the weekly government recommended maximum units. The findings do however indicate a slight shift towards alcohol use amongst former illicit drug users. Although unproblematic at the point of data collection it is unknown if this increase in alcohol consumption is related to a change in lifestyle, which in UK society often involves drinking alcohol in a social capacity, or a potential shift in substance use addiction from illicit drugs to alcohol. Additional research would be required to monitor levels of substance use amongst parents sampled in the longer term, when children are removed from the child protection register and support services are less frequently engaged with families.

Family health and wellbeing

Although addressing the health needs of parents was not a main priority of the Families First intervention, poor mental and/or physical health can negatively impact upon a person's quality of life and their ability to provide appropriate care for their children. Findings showed that poor health was not an issue that parents felt negatively impacted upon their daily lives or ability to provide care for their children. The few reports of poor health were attributed to substance use, including deep vein thrombosis and kidney failure. All parents were in regular contact with their GP and none discussed their health as being an issue.

Key findings in relation to parental reports of children's health and emotional well being indicated that anxiety, related to children's concern over what would happen to their parents, reduced significantly over time. According to parents, anxiety was the cause of soiling (encorpresis) in one child and linked to the need for medication for anxiety in another. Both children had been temporarily placed in care prior to data collection as a result of child welfare concerns. Neither children were reportedly experiencing symptoms of anxiety at six nor twelve month follow-up. Although these findings were limited by sample size and parental reports, they do highlight the negative impact parental substance use has upon the emotional wellbeing of children, particularly during periods of child welfare assessment. The improvements evident in these findings show how parents felt that the support package helped to reduce concerns held by children about what would happen to their parents over a twelve month period.

Depression, parenting and socialisation

Findings from the measurement of depression within this sample suggested that all parents sampled were experiencing elevated depressive symptomatology (according to the Beck Depression Inventory (BDI-11) which did not significantly change over time. The majority of parents were not receiving any form of treatment for depression. Medical treatment of one parent appeared to reduce depression levels from severe to moderate, however due to the adverse affects associated with combining alcohol with antidepressants this mother's consumption had to be reduced significantly before her GP would prescribe anti depressants. Higher levels of depression were shown to have negatively impacted upon individuals felt they were coping with parenting at the final stage of the evaluation; this stage was when parents were less engaged in support services and receiving less support with parenting.

A sub scale of the BDI indicated that the degree to which parents felt they had failed as a person was significantly reduced and sustained over the twelve month period suggesting that although overall levels of depression were not reduced, the support provided did have a positive impact upon an individual's sense of past failure.

Interviews with parents supported this finding as many described how they felt that participation in the intensive intervention had led to an improvement in how they felt about themselves, which was linked to having the opportunity to talk to someone about their problems rather than through medical intervention. In the quantitative findings, the importance parents placed on counselling was also found to be associated with how parents felt they were coping with parenting, which further emphasizes the importance parents place upon having a professional to talk to about their problems.

The challenges of treating depression amongst substance users suggests the need for specialist assessment and advice in order to help improve the health and wellbeing of substance using parents. A focus on the cause and treatment of depression by services such as Families First may well assist in helping parents to sustain positive lifestyle and child welfare outcomes in the longer term, particularly when they are less frequently engaged with child welfare support. Identifying appropriate medical treatment for depression amongst substance using parents is complex and these findings suggest that having someone to talk to about problems

can improve individuals self perception although this may not be sufficient as a stand alone method to help significantly reduce overall depressive symptoms. Closer partnership working between Families First, substance use support agencies, GPs and mental health specialists may assist in providing appropriate support and treatment to address individual need.

Child social and school functioning

The measurement of child social and school functioning was limited by the age of children in this sample (mean = 5.34 years; SD = 3.93). This not only meant that parental or carer reports had to be obtained rather than from children themselves, but also that many useful indicators of children's social and school functioning were not appropriate to approximately half of the children sampled. For the eleven children who were of school age, data on children's school and social functioning did not indicate any issues of concern or notable changes behaviour such as school attendance, keeping up with homework or getting along with other children over the twelve month period. The number of children who missed school to attend the doctors or hospital did reduce slightly and was attributed to the observed improvements in health related problems reported for a small number of children.

Family conflict

Family conflict, such as arguing and fighting with both immediate and extended family members, was found to be an important issue for parents and one that was found to be related to how parents felt they are coping with the care of their child. Family conflict reduced over a twelve month period; this in turn was found to have improved the extent to which parents felt they were coping with their role as parents. Higher levels of depression were also found to be associated with increased frequency of family conflict, which again suggests the need for interventions to address the levels of depression observed in substance users in order to have an impact upon all aspects of family life.

After expressing initial apprehension about the involvement of wider family members in the intensive support, at the final stage of the evaluation some of the parents interviewed placed high value in the opportunity Families First had provided them with to improve relationships with family members such as their own parents and siblings. Some parents described how Families First had brought families closer together which provided them and their children with additional support through the

period of drug withdrawal and lifestyle change. The continued support of wider family members may have also assisted parents in the longer term when they were less engaged in support services. These findings support the recent policy and practice drivers that emphasise the need to provide a holistic family approach for parents and children affected by substance use rather than being client centred (DfES, 2005a, p.iii; Home Office, 2008a; Department of Health, 2008; National Treatment Agency for Substance Misuse, 2008).

Housing and social networks

Housing was an ongoing concern for families who lived in council property, with some having waited over five years on a housing waiting list. A shortage of council housing stock, coupled with a bidding system for housing that required weekly 'bids' being placed in person at the housing association (Erimus Housing) were perceived as being the main issues preventing families from being able to move. For many, housing was viewed as a barrier to achieving change as parents felt that moving area of residence would ensure disassociation from former substance using social networks by creating a physical space between themselves and the people with whom they had shared their substance using lifestyles. Other families were waiting to move due to larger accommodation due to an increase in family size. Over the evaluation period, Families First and housing officers assisted three families in moving house. All such parents partly attributed their reduced substance use and return of children to their care as being linked to moving away from their former social networks and areas of residence.

Education and employment

As is the case in wider problematic substance use populations, levels of education were low and all parents were unemployed and receiving state benefits. Despite some parents expressing a desire to access employment and starting training or vocational courses, none completed courses or accessed employment by the end of the research. No specific reasons were provided by parents as to why courses were not completed although at the final interview one parent had begun to work voluntarily in her local community.

What reasons did parents attribute to improved outcomes?

Qualitative study findings suggest that the majority of parents felt that participation in the Families First intensive intervention had resulted in a range of positive outcomes

for their family. In addition to solving housing problems, the most common reason parents attributed to their achievements was the removal of children from their care coupled with the goals set by Families First as part of the Solution Focused Behavioural Therapy approach. The combination of intensive support and removal of children appeared to provide parents with the motivation for change as they felt that they could achieve what was required if they were supported through the process. Several parents described how they had past experience of children having been taken into care but had not been provided with appropriate support or opportunity to make the changes necessary to provide appropriate care for their children. The intensive intervention appeared to help parent's acknowledge that they were responsible for their actions and that they could not rely on anyone else to make the changes required to keep their children out of the care system. Timing of the intervention was also described as an important factor as those parents who did achieve the goals set by Families First stated that they were ready at the point of referral to stop using drugs or reduce their alcohol consumption and embrace the support provided. It is felt that the themes identified in parents' reflections on their progress are interlinked, as temporary removal of children appeared to evoke a sense individual responsibility at a time when parents were being made aware of what changes they had to make within a specified time period.

These findings highlight the complexity involved in the design and implementation of interventions in this area. Whether parents are ready to change is possibly the most difficult issue for intervention staff to establish, yet one which staff interviewed felt they had become more adept with increasing experience. Temporary care placement was deemed as necessary by Families First social workers to ensure the safety of a child and was not used as a tool to help instigate parental behavioural change. This need for temporary care in itself indicates the extent of problems these families were experiencing when they were referred to the intervention and that Families First work with children are at 'high risk' of care entry.

Aspects of the intensive intervention valued by parents

Therapeutic tools used to deliver the Solution Focused Behavioural Therapy model such as goal setting and value cards were the most valued aspects of the intensive intervention. Goal setting in particular appeared to provide parents with a sense of control over the intervention process which then provided motivation for change. By setting goals alongside parents at the beginning of the intervention rather than

dictating what changes had to be made, Families First staff were able to begin to develop positive relationships with parents as well as provide them with a sense that keeping their children out of care was achievable if they were able to achieve their goals. Families also valued the opportunity to talk to staff and seek advice on family problems and parenting whenever they needed it. Participants believed that this contributed to their successes. During the early intervention stages when parents were reducing their drug and alcohol use the availability of workers and daily structure provided by the intervention through appointments with other support agencies and home visits from Families First workers was viewed as an effective means of helping parents through this critical period.

Social worker and parent relationship

Individual accounts of the intervention and how it was delivered often involved discussion of relationships with Families First social workers. Findings demonstrated that the majority of parent's attitudes towards staff changed dramatically over the twelve month evaluation period. Communication between social workers and parents was often challenging, particularly during the initial stages of the intervention. Many of the parents held negative views of social workers which were based upon perceptions of being let down by social welfare in the past. These negative perceptions meant that parents often found it difficult to trust what Families First was promising them, as they did not believe that Families First would not remove their children and then end regular contact. Clear communication of the intervention content and objectives at the first point of contact with families, as well as listening to parents and allowing time to prove to families that the intervention would deliver were key factors that assisted the development of a trusting relationship between parents and social workers. This was not achieved with all parents, but for the majority, negative attitudes towards the intervention were not evident in the final interviews. These findings demonstrate the skill and professional competence of Families First staff.

Dealing with parental substance use

Families First staff are trained in substance use issues and work in collaboration with local drug and alcohol support services in order for parents to access specialised treatment and advice. Some of the parents expressed concern that incorrect judgements had been made about them by Families First staff due to a lack of substance use related knowledge. In one instance Families First staff were quick to

seek advice from specialist agencies when such issues where brought to light however, the decisions staff make about parents substance use on a daily basis often necessitates a high level of substance use knowledge. Suggestions made by parents to enhance the substance use knowledge base within the team include the recruitment of a specialist drugs worker and involvement of an ex service users to provide advice and support to both families and staff. Since final interviews were conducted Families First has been working to incorporate a mentoring element to the intervention which will involve ex-service users providing support to families accessing the intervention. Evaluation of this new element will help to ascertain its effectiveness in supporting both staff and families through the intervention in order to inform the development of future family support services that may wish to use this intervention model.

Length of support

The appropriate length of intensive family support services has been an issue of ongoing debate within the existing crisis intervention literature. The appropriateness of a brief intervention for families with such complex needs is questionable as some families required more support than others. Almost half of the parents sampled described how they had found the transition from intensive support to maintenance plan difficult. Some parents acknowledged that intensive support does need to be time specific so that parents do not become dependent upon daily support from social workers, however many suggested that there should be more of a transitional period before their case was transferred back to locality teams. The adaptation of the Families First intervention observed over the twelve month evaluation period to include additional adult support during and post intervention, relapse prevention package and re-referral moves this model beyond a brief intervention and acknowledges the need for families affected by substance use to maintain contact with support services to help sustain achievements. The capacity of Families First to continue to provide support to the same families for long periods of time is an issue as families need to be able to access less intensive support through mainstream social welfare and community based voluntary/charitable support services post intervention. As stated previously, having someone to talk to was extremely important to the parents involved in this study and helped them deal with their problems. If support is not easily accessible for families, or they are apprehensive about seeking additional or alternative support, then parents may relapse.

The continued support being accessed by families in this study from drug and alcohol support agencies and Sure Start is encouraging and will hopefully provide continued access to substance use and parenting support to help parents maintain stable lifestyles which are free of problematic substance use. What is of concern however is the reported lack of contact between families and social workers in locality teams despite two children in the sample being on supervision orders at the time of data collection. This finding could be due to a lack of reporting by parents, rather than no contact with social workers, however the reservations held by a few parents about contacting any services in the future in case there was a risk their child could be removed from their care highlights the need for sustained and frequent contact between social workers and substance using families after the intervention period.

One possible solution suggested by many key stakeholders and the Families First project manager would be to expand the Families First model for use with families across Middlesbrough. This would include its use by social workers and support workers in mainstream and voluntary/charitable organisations with all families regardless of whether substance use was an issue. The use of secondments between social welfare locality teams and Families First as well as training provided by Families First staff would assist this process and help embed the new approach to working across services as well as assist in referral generation and the post intervention transitional period. The fact that this proposal was suggested by both key stakeholders and the Families First manager indicates that this may be achievable if the appropriate time and resources are allocated.

Implementation

Staff, stakeholder and parent interview findings suggest that the implementation of Families First was an ongoing process of review and adaptation which aimed to meet the needs of families whom accessed the service. This flexibility of approach appears to have achieved its aims of being responsive to changing client needs, training and local developments. It is felt that in many respects this approach was successful due to the skill and dedication of staff and helped to improve observed outcomes for families over the evaluation period. The use of intervention models from both the NET Team project and Option 2 provided many of the procedures, intervention tools and protocols which often take time for interventions to develop. Despite being adapted to suit a local and case responsibility context many aspects of the service

model had already been previously tested with substance using families which greatly assisted the implementation process.

The main challenge during the early stages of the intervention related to how staff had been previously working in traditionally segregated children's services and therefore had to develop new skills to adjust to the holistic family approach. Many stated that learning from practical experience would be ongoing. The quantitative outcomes and Social Network Analysis findings demonstrated strong communication links between all staff members, and stand as testament to the skills of staff and their willingness to embrace change and adapt to new ways of working. What is clear is that the project manager has constantly reviewed the intervention model in order to identify improved ways of addressing any challenges that arise, this proactive and forward thinking approach suggests the need for ongoing evaluation to ascertain what may and may not work when additional aspects of the model are added. This is particularly pertinent due to the lack of evidence based practice in this area.

The use of SFBT aspects of the Option 2 model has provided new evidence of the effectiveness of this therapy approach in this setting. It is felt that there is potential for Families First to incorporate the more evidence based Motivational Interviewing to their work with substance using families. The use of Motivational Interviewing may provide an effective method of assisting the engagement of families at the first point by helping to develop a more trusting and equal social worker and parent relationship.

Interagency working

Social network analysis provided a visual representation of the wide range of agencies with whom Families First work to provide support for families. This strong interagency working has been vital to Families First's intensive intervention which may be challenging for other family support services intending to use this model to replicate as developing good working relationships between agencies takes commitment from all parties. Again, the persistence and commitment of the Families First team, particularly the project manager and staff in other Middlesbrough based agencies to work together, has enabled a high level of interagency working. Ensuring ongoing referral generation will remain a challenge despite the strong interagency working evident.

5. Strengths and limitations: lessons from the Families First evaluation and recommendations for future substance use intervention research design

The following section describes some of the key research lessons from this study. It is anticipated that these findings and recommendations will assist the future development and conduct of high quality evaluations of interventions for families affected by substance use in the UK.

Robust evaluations often contain a number of key components which are used to investigate the effectiveness of an intervention. These predominantly centre upon the processes involved in service delivery as well as the impact of participation against outcomes of interest (e.g. substance use, care entry); both elements form the basis of evaluation design and reporting structure. An evaluation of good methodological design will often include: a comparison group, a representative sample; quantitative and/or qualitative methods, and an economic (cost benefit) assessment (Rossi et al., 2004). Each of these areas are discussed in reference to our learning from the Families First evaluation with key recommendations made for future research with families affected by parental substance use.

Comparison group

Comparison groups are used to provide confidence that any observed improvements in client outcomes were not spontaneous, and to explore how outcomes might be related to particular characteristics of service design and delivery (Robson, 2002). Within the existing evidence on interventions targeted towards, or involving young people with a substance using family member, waiting lists, groups of delayed entry and those receiving alternative or no intervention are the most commonly utilized comparison groups (Nye et al., 1995; Short et al., 1995; Sarvela and Ford, 1993, Springer et al.,1992).

As a waiting or delayed entry list was not available for this evaluation, the original design incorporated two suitable comparison interventions which were identified through a mapping exercise. Comparison group criterion was based upon the broad client group descriptions made within the funding specification. When active research commenced however, it became clear that Families First was working with a younger age group of children than anticipated, and was using a specific service model which

had not been previously described. Both comparison groups were therefore deemed unsuitable.

Several attempts were then made to identify a more appropriate comparison group comprised of substance using families in contact with social welfare who met the research criteria. This involved presentations and visits to three separate social welfare departments in the northeast and west of England. A suitable group was identified in the northeast and consent and contact details were obtained through social workers based in locality teams. Despite making arrangements with social workers and parents directly and offering to conduct interviews in participants homes, with a £10 voucher incentive a sufficient sample size was not achieved (n=7). This lack of engagement was believed to have been a result of two separate issues.

The first was that comparison group participants did not appear to believe that the research process was of personal benefit to them. During baseline interviews with parents a common question was how they could access support from Families First or a similar project in their area as they felt the support they were receiving from social welfare was insufficient. For many, this appeared to have been the main reason for research participation, which generated concerns in the research team about the likelihood of such families being available for subsequent follow up interviews. The second issue related to a failure by some locality teams to identify any families and seek written consent to participation despite monitoring data having indicated that a sufficient number of families met the research criteria within such teams. Social workers who did engage with the research were based in teams that consisted of a gatekeeper who had attended evaluation meetings or whose manager had nominated them as the lead responsible for identifying families.

Sample size and attrition

The potential sample size for the primary research element of this evaluation was limited by the number of families in contact with the intervention at baseline interview stage (n=12) and field research time restrictions associated with a twelve month follow up design. Despite this, only one family was lost to attrition due to researcher safety concerns which prevented access. This low attrition rate is believed to have been directly attributable to a number of methods that were utilised to assist in the engagement of families.

Firstly, at the initial consent stage participants were given a written outline of the aims and objectives of the evaluation with its confidentiality and independence from the intervention emphasised. At least one set of contact details such as participants' and extended family members' (with consent) address, mobile and landline telephone numbers were requested. Often only one additional contact could be provided, however over the twelve month evaluation this additional contact proved vital in gaining access to participants as personal mobile phone numbers often changed or extended family members (usually children's grandparents) had knowledge of participant's change of address (one parent had no fixed abode), telephone number or appointments at support agencies where families could be contacted. A flexible approach was adopted by the research team, and letters were posted to contact addresses or support agencies stating the times researchers were available and highlighting the value of their participation. If mobile telephone numbers were switched off text messages were found to be a useful means of contacting some families. Only one attempt at each contact method was employed as it was felt that if parents had not responded through these means they had chosen to no longer participate. With all participants in this study however, this was not the case, and a change in telephone number or no mobile phone credit had been the reason for contact difficulty.

The relationship developed between the lead researcher and Families First staff is felt to have assisted researchers in gaining access to service users and safety related information with relative ease. Based upon experience gained from previous evaluations conducted by the lead researcher, provisional process based interviews were conducted with all staff at an early stage of the evaluation. This meant that all staff were immediately engaged in the research, had an opportunity to ask questions and were made aware of what would be required from them; this included the provision of information on contact and safety issues. Such interviews also helped the researcher gain knowledge about how the intervention worked, which was fed into service user and stakeholder interview question development.

Despite the use of research incentives being an ongoing issue of ethical research debate (e.g. Russell et al., 2000; Bentley and Thacker., 2004) it was felt that the voucher incentive (£10 high street shopping voucher) was important in gaining interest from comparison group participants who had less emotional investment in the evaluation than the intervention group who were keen to talk about their

experiences of Families First. As interviews lasted between one and two hours the vouchers provided a means of compensating all participants for their time.

Flexibility was also applied to where participants were willing to conduct interviews. Although the majority chose to be interviewed in their family home, some parents stated that they would prefer to hold interviews in grandparent's homes due to problems with neighbours. It was felt that this flexibility made participants feel valued and did not inconvenience them too greatly, which ultimately helped retention. Changes in the interview schedule, sometimes with limited notice, meant that researcher safety protocols required extra consideration. All researchers were trained in researcher safety protocols and field researchers were in constant contact with a designated office based researcher by mobile phone to provide updates on the addresses of interviews and expected end time. At all stages of the evaluation views on the safety of researchers interviewing each participant at home were sought from a number of sources, including Families First workers and locality team social workers. Due to the nature of this client group and the neighbourhoods in which some resided, researchers worked in couples and did not enter a private property alone or at night. The use of a car for travel rather than public transport also ensured that researchers could leave any problematic situations quickly and were able to add extra interviews to there schedule at late notice without difficulty.

How the researchers conducted themselves during interviews is believed to have assisted, although on a somewhat minor level, in the willingness of families to have stayed engaged with the research over the twelve month period. Every effort was made by researches to not intimidate families who at baseline were visually anxious, possibly due to the high level of engagement with social workers at the time who were assessing their ability to care for their children. A number of families commented that they had spent time cleaning their houses in preparation for the researcher's arrival which possibly indicated that parents felt that they were going to be judged. Researchers dressed casually, emphasized their independence from Families First, assured confidentiality and attempted to create a relaxed atmosphere within the first stages of interviews by chatting rather than jumping straight into the interview schedule. It was clear from body language and the willingness of parents to discuss personal issues that within a relatively short space of time, parent's apprehensions about the evaluation had been alleviated by such approaches.

Commissioning intervention research

Many of the sampling problems encountered in this research stemmed from a lack of detail in the original commissioners call for proposal. The intervention was initially described as a drug prevention intervention for young people and parents, rather than a social work intervention for children and families. Comparison groups, research tools and sample sizes were estimated and established accordingly but were later found to be inappropriate. This issue is not uncommon as such tender documents are often written without the input of service staff, and lack detail of client demographics and the intervention model being used in order to appropriately inform evaluation design. As described earlier in this report, a different evaluation methodology was developed, however the opportunities to establish collaborations between researchers and social welfare at the design stages were missed. Proposed interventions are often described as being suitable for a longitudinal between groups design, with a large number of clients, when in reality interventions such as Families First work on a case based approach with smaller sample sizes. There is clearly a desire shared by both commissioners and researchers to commission and conduct research of good methodological design in order to inform the UK evidence base on what works in supporting families. It is felt that by adding detail to tender documents such as a basic outline of the client group demographic, therapeutic model used by the intervention (if any) and intervention aims and objectives will assist the generation of robust evaluation design and conduct.

A multi method approach

The initial evaluation design incorporated a range of research methods, including questionnaires, interviews, community observer measures, social network analysis (SNA) and an economic assessment. Some of these methods were found to be more appropriate for use in the evaluation than others.

The use of both questionnaires, including previously validated outcome measures, and interviews over time (12 months), enabled an in-depth insight into a range of lifestyle, behavioural and attitudinal outcomes of involvement in the intervention. Without the longitudinal multi-method approach adopted, it is felt that an accurate portrayal of participants' involvement in the intervention, and associated outcomes, would not have been achieved. This is particularly pertinent to the qualitative interviews conducted, as findings from this small sample indicated that parent's views on the effectiveness of the intervention changed substantially over time and a snapshot method (one interview) would not have recorded this.

Also related to this was the finding that timing and readiness for change had an impact upon some participants' willingness to embrace support. It is felt that future research in this area would benefit from incorporating a more quantitative measure of participants readiness for change in addition to obtaining views on the timing of interventions and participants readiness for change though qualitative methods. Such findings would help practitioners to establish the most efficacious timing for an individual to enter an intensive intervention to prevent relapse and tailor appropriate support. Although it is acknowledged that longitudinal research is more costly, it is felt that future research in this area would benefit from a longer follow up period (> 18 months) in order to fully encapsulate whether the observed outcomes were maintained in the longer term.

The proposed community observer method aimed to generate views on any observed changes in parents' behaviour or attitudes over the evaluation period from non substance using family members, friends or colleagues. Unfortunately, this aspect of the evaluation was not possible to implement. Parents were often unable to provide full details (including telephone numbers) for two non-problematic drug users who would be suitable for interview. This was often due to them not knowing telephone numbers rather than a lack of willingness to provide the information. Many could only name and recall contact details for one family member and this was insufficient to continue with this element of the research.

Social Network Analysis was used to determine the levels of communication between staff members within and between Families First and external agencies. Although the use of SNA was successful in terms of obtaining the form and quality of data intended, on reflection it is felt that this method is more suited to the study of much larger communication networks. Design and implementation of the SNA questionnaires was extremely time consuming and it is felt that the data shown in sociograms could have been mapped through questions added to staff interviews and findings could have mapped using much simpler software programmes such as NVIVO or Microsoft based drawing tools.

6. Conclusions

There is very limited evidence on the types of services and interventions that work to prevent children of substance users' entry into the care system and to prevent the negative outcomes that literature has shown they are of risk, including problematic drug and alcohol use and an increased risk of physical harm. This evaluation builds upon the evidence presented by the Option 2 evaluation (Forrester et al, 2007) and presents an adaptation of the Option 2 model in the context of social worker case responsibility with a focus on the Solution Focussed Behavioural Therapy approaches to working with substance using families. These findings also present an intervention model which can be used to work with children at 'high risk' of care entry and adds to the existing literature that questions the appropriateness of short-term crisis intervention for substance using families with complex needs.

Evaluation findings suggest that the Families First model prevents the need for permanent placement of children into care and reduces the time spent in temporary care placements by helping parents to provide a safe home environment or by finding an alternative kinship care placement. These findings are limited by a small sample size and no comparison group and therefore implementation in other areas should be accompanied by an imbedded evaluation from the project's inception, based upon the current research model. However, the twelve month follow-up period of this evaluation would suggest that the intervention had a range of positive outcomes, including reduced parental substance use up to twelve months post intervention. The Families First model has potential to be used in both social work practice and wider community based family support services. The research based findings from this study should assist the future development and conduct evaluations of interventions for families affected by substance use in the UK.

7. Recommendations

For future practice

- Intensive family support interventions should adopt a holistic family approach which includes children, parents and wider family members.

- Staff secondments and training may provide an effective means of embedding new approaches and skills to working with both substance using and non substance using families.

- The potential for incorporating Motivational Interviewing within the intervention model should be explored. Appropriate training and supervised practice based experience should be sought.

- Intensive family support interventions should work closely with mental health services as well as GPs to ensure that the mental health needs of parents are addressed appropriately.

- In order to assist parents in achieving illicit drug abstinence or stabilised alcohol use, housing support should be made available to enable families to move away from former substance using social networks if necessary.

For intensive family intervention research and policy

- A follow up study is required to investigate whether outcomes observed in this study are maintained in the longer term (>12 months) or if there is a shift in parental substance use from heroin or crack cocaine to alcohol. Long term research is particularly important to assess the health, social behaviours and educational attainment of children. Such research should incorporate an evaluation of the new mentoring element of the intervention package.

- A focus on data collection at local authority level is required to determine the full costs associated with local authority children and adult services to help inform the setting of suitable budgets for services and help establish the cost effectiveness of drug prevention and social work interventions.

- A programme of research is required to evaluate UK support services for kinship carers who care for children of substance using parents. This research should also investigate the experiences of kinship carers in providing care in order to identify any gaps in service provision for both carers and children in their care.

- Further research is required to explore potential barriers to employment, education and training amongst substance users in order to inform the development of appropriate support to improve access to employment.

- Waiting lists may provide the most suitable comparison groups for intensive intervention evaluations. Where such lists are not available, gatekeepers need to be identified in comparative interventions or social welfare locality teams to ensure sufficient sample sizes are achieved to accommodate for potentially increased attrition rates in the intervention group.

For wider substance use related research design

- A detailed outline of the intervention to be evaluated should be made clear in funding commissioners' calls for evaluation proposals. This should include a basic outline of the client group demographic, therapeutic model used by the intervention (if any) and intervention aims and objectives. Such detail will enable the development of an appropriate evaluation design.

- Evaluation research benefits from a multi method, longitudinal design in order to fully encapsulate the outcomes and experiences of participants. Researchers should obtain at least two forms of contact details. Voucher incentives provide a means of engaging participants and compensating all research participants for their time.

- Process based interviews with intervention staff should commence during the early stage of the evaluation to ensure the aims, objectives and individual roles are clear from the onset and to assist in the development of service user and stakeholder interview questions.

- Researchers should adopt a flexible approach where interviews are conducted. Researcher safety, however, is paramount and appropriate protocols should be in place.

- Quantitative outcome measurement of substance use interventions would benefit from the use of a readiness for change outcome measure in order to establish if this is related to actual changes in substance use.

- Community observer methods may not be suitable for research with some populations of substance users due to an inability to identify or provide multiple contact details of non substance using friends and family.

- Social Network Analysis is more suited to the study of large social networks.

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9. Glossary

This glossary provides a brief overview of the terms relating to child protection and care status, referred to throughout this report. Only care orders which are relevant to the status of families involved in this evaluation are described, for further information please see the Every Child Matters website:
http://www.everychildmatters.gov.uk/deliveringservices/multiagencyworking/glossary

Care order

A care order is a court order (made under section 31 of the Children Act 1989) in which a child (under the age of 17 years) is placed under the care of a designated local authority whilst parental responsibility is shared with the parent/s. Such an order is only made if the court decides that the child is suffering, or is likely to suffer significant harm attributable to the care provided to that child. Whilst on a care order, the local authority is responsible for the child in question and decides the level of contact between parent and child (which is outlined in the child's care plan).

Care plan

When a child enters into the care system the designated social worker needs to ensure that the child's needs are outlined in a care plan. The services required to meet the identified needs are outlined. The care plan is drawn up before the child becomes looked after of if a child enters care in an emergency, within a fourteen day period. Care plans are used by the court to inform decisions made on the placement of the chid (i.e. children's home or foster care).

Child protection register

Each local authority maintains a register of children within its area who are thought to be at risk of significant harm. When a child is on the register they are provided with protection against harm by the local authority. An inter agency child protection plan is written for each child which describes how the child will be protected and expected outcomes. Progress of each child is monitored through child protection review conferences.

Interim care orders

After the initial care order is in place the court will often make a number of interim care orders whilst further investigations are made by the local authority into the family situation. Interim care orders only last a short period of time (for up to eight weeks in the first instance) and cease if a child is adopted or reaches 18 years of age.

Supervision order

The form of supervision order discussed in this report refers to when care for a child is no longer conferred on the local authority and the child normally lives at home. This order enables the child's designated social workers to make decisions on where the child lives and what activities they must undertake. The order lasts for one year although extensions can be made through the court.

Section 20 orders

Under section 20 of the Children Act it is the responsibility of the local authority to make accommodation available for children in need. Children may be accommodated in residential or foster care. No court proceedings are involved and the length of time a child accommodated may vary. The child's parents retain full parental responsibility.

Appendix A

Table 9: Beck Depression Inventory- 11 cut score guidelines for total scores of patients diagnosed with major depression and BDI Symptom scores t=0, t+6 & t+12

	t=0		*t+6*		*t+12*		
	Mean (Mean Rank*)	SD	Mean (mean Rank)	SD	Mean (Mean Rank)	SD	Sig?
Total BDI Score	26.0 (1.94)	9.76	22.8 (2.19)	11.6	21.5 (1.88)	12.39	No
Sadness	1.00 (2.31)	0.53	0.5 (1.75)	0.53	0.62 (1.94)	0.74	No
Pessimism	0.75 (2.19)	1.03	0.37 (1.94)	0.74	0.37 (1.88)	0.51	No
Past Failure	3.00 (2.44)	2.92	1.62 (2.06)	1.18	1.25 (1.50)	0.88	Yes**
Loss of Pleasure	1.37 (2.31)	0.74	1.00 (2.00)	0.75	0.75 (1.69)	0.70	No
Guilty Feelings	1.50 (2.00)	0.92	1.50 (2.00)	0.92	1.50 (2.00)	0.92	No
Punishments	1.12 (2.13)	1.12	0.75 (2.13)	0.88	0.50 (1.75)	0.53	No
Self-Dislike	1.37 (1.94)	0.51	1.37 (2.06)	1.06	1.37 (2.00)	1.18	No
Self-Criticalness	2.00 (2.50)	0.75	1.25 (1.75)	1.03	1.37 (1.75)	0.74	No
Suicidal thoughts or Wishes	0.62 (2.25)	0.74	0.25 (1.88)	0.46	0.25 (1.88)	0.46	No
Crying	1.37 (2.06)	1.18	1.37 (2.00)	1.40	1.25 (1.94)	1.16	No
Agitation	1.12 (2.19)	0.99	0.75 (2.06)	0.70	0.50 (1.75)	0.75	No
Loss of interest	1.25 (1.94)	0.70	1.50 (2.06)	1.14	1.25 (2.00)	1.03	No
Indecisiveness	0.875 (1.69)	0.64	1.62 (2.38)	1.30	1.12 (1.94)	0.83	No
Worthlessness	1.37 (2.19)	0.74	0.87 (1.81)	0.83	1.00 (2.00)	0.75	No
Loss of Energy	1.12 (2.06)	0.83	0.87 (1.81)	0.64	1.12 (2.13)	0.83	No
Changes in Sleeping Pattern	1.62 (2.31)	0.74	0.87 (1.63)	0.64	1.37 (2.06)	1.18	No
Irritability	0.75 (2.00)	0.70	0.50 (1.88)	0.53	0.87 (2.13)	1.12	No
Changes in Appetite	1.25 (1.88)	0.70	1.5 (2.19)	0.92	1.12 (1.94)	0.83	No
Concentration Difficulty	1.50 (2.19)	0.92	1.37 (2.06)	0.91	1.12 (1.75)	1.12	No
Tiredness or Fatigue	1.12 (1.81)	0.99	1.25 (1.88)	0.88	1.50 (2.31)	0.75	No
Loss of interest in sex	1.12 (1.75)	0.83	1.62 (2.44)	1.06	0.87 (1.81)	0.99	No

**Significant in both Friedman's ANOVA and Wilcoxin sign ranks tests

Table 13: Parental reports of child physical, emotional and social functioning mean ranks* t=0, t+6 & t+12 (n=11).

	t=0 mean rank (n)	t+6 mean rank (n)	t+12 mean rank (n)	Sig?
Physical functioning (problems with…)				
Having hurts or aches	1.85 (3)	2.15 (4)	2.00 (4)	no
Low energy levels	1.85 (2)	2.30 (3)	1.85 (1)	no

Toothache	2.00 (1)	2.00 (1)	2.00 (1)	no
Playing sports due to health reasons	1.85 (1)	2.15 (3)	2.00 (2)	no
Emotional functioning (problems with…)				
Feeling afraid or scared	2.05 (1)	2.05 (1)	1.90 (1)	no
Feeling sad	2.30 (4)	2.00 (2)	1.70 (0)	no
Feeling angry	2.25 (5)	2.10 (4)	1.65 (3)	no
Trouble sleeping	1.85 (0)	2.20 (2)	1.95 (2)	no
Worrying about what will happen to him or her	2.05 (1)	2.05 (1)	1.90 (1)	no
Worrying about what will happen to parent/s	2.35 (6)	2.05 (4)	1.60 (1)	Yes ($p<0.05$)*
Social Functioning (problems with…)				
Getting along with other kids	2.00 (2)	2.00 (2)	2.00 (2)	no
Other kids not wanting to be his friend	2.00 (2)	2.00 (2)	2.00 (3)	no
Getting bullied by other children	2.05 (2)	1.90 (1)	2.05 (2)	no
Not able to do things that other children his/her age can do	2.05 (1)	2.05 (1)	1.90 (0)	no
Keeping up when playing with other children	1.90 (0)	2.05 (1)	2.05 (1)	no
Hitting other kids	1.95 (0)	2.10 (1)	1.95 (1)	no
Getting kids by other kids	1.85 (0)	2.15 (2)	2.00 (2)	no

** Friedman's ANOVA*

*** Wilcoxin sign ranks*

**** Friedman ANOVA & Wilcoxin sign ranks*