

Title: M-PACT+: Supporting families affected by parental substance misuse

Abstract

Purpose. This paper presents the findings from an evaluation of an intervention (M-PACT+) aiming to address the effects of parental substance misuse in school settings. The paper considers the evidence of effectiveness, and goes on to explore how schools were involved with the intervention.

Design/methodology/approach. A theory of change was developed for the intervention, which identified key steps of change that were expected for the beneficiaries (family members and children). Mixed methods were then used to form a portfolio of data to support or refute the theory. This data included quantitative validated scale data and questionnaires at various points in time with staff, and participants (including children), and qualitative data obtained from school staff, intervention staff, families and children.

Findings. This paper concludes that the evidence supports the theory that providing M-PACT+ in school settings can begin to address the effects of parental substance misuse for the families that engage with it. Further, the paper shows that the ethos of the schools involved influences how families are identified and referred, and that interventions of this kind are most likely to succeed where they are integrated into an ethos where there is a shared responsibility for a broad child wellbeing agenda between schools and other community agencies.

Originality/value. This paper explores the evaluation of a unique family intervention. The findings will be of value to those seeking to implement such interventions in partnership with schools and/or community agencies.

Paper type. Research

The role of schools in providing therapeutic family services

This paper presents the findings of an evaluation of a unique family intervention, previously delivered in community settings and piloted in schools for the first time with the aim of addressing the effects of parental substance misuse (PSM) on children, young people and families. Although notions of community schooling have existed for decades, policy imperatives during the 1990s and 2000s in England provided the environment that incentivised schools to be able to extend their focus into communities, and the full service and extended school movement ensured that all schools started to think about becoming a central hub for services in their local community. As schools worked more closely with other agencies, many started to realise that they had been working on only partial understandings of children and their lives, and had largely ignored the ways in which children's lives outside of school impacted upon their development (Martin, 2016). Many head teachers of schools that were working in economically disadvantaged areas were convinced that schools had a key role to play in working with children, families and communities beyond the school day in order to address some of the inequality of opportunity in these areas and the day to day effects of poverty, and the associated clusters of problems that these families faced, that made learning more difficult for some children (Cummings *et al*, 2007; Carpenter *et al*, 2011). Despite a renewed focus on a performativity agenda espoused by policy, accompanied by a neo-liberal move towards competition and marketization of education (Apple, 2005; Ball, 2013) and the quiet withdrawal of governmental support for an extended services model from 2010 onwards, many schools have continued to work to a broader focus on child health and wellbeing, and multi-agency collaborative working (Martin, 2016).

Despite these shifts in policy direction, there is still an attainment gap between children from more-or less-affluent families, and a recognition that competitive school improvement efforts cannot tackle this gap in isolation, and this has led to a growing interest in schools seeking to intervene in other ways to influence children's life chances, including the adoption of a whole school approach (e.g. incorporating wellbeing into all aspects of a school, including its leadership, curriculum, ethos, and environment). In addition, evidence is growing that locating services for families in schools can normalise them and make them easier to access, and can reduce the stigma families can feel in accessing help (Segrott *et al*, 2013). Consequently, the need to explore how schools can work to meet these challenges is timely and necessary and school staff, particularly head teachers, might need help to think through what a wider role for their school might involve (Kerr and Dyson, 2016). Schools might have a wider role to play in improving family functioning in order to enhance children's wellbeing, sometimes going as far as to compensate for the failings of society (Gorard, 2010), and yet the resources and knowledge they need to undertake this role may be insufficient. When schools were encouraged to work together with their local communities and take on broader roles in respect of children as part of the extended services agenda, they often employed specific staff to act as brokers for what might be seen as more pastoral roles, for example, family support workers and extended services co-ordinators, with the result that less pressure was put on to teachers to fulfil these roles (Cummings *et al*, 2011). Such staff are now less prevalent, and so if schools are to take on a broader pastoral role, much of this broader 'work' needs to be done by teachers, in addition to their already increasing workloads. Evidence suggests that the more school staff and therapeutic services can work together, the better the outcomes for children (McWhirter, Boddington, and Barksfield, 2017). This means that teacher buy-in to family support interventions such as the one discussed here is essential to ensure any chance of success in implementation (Langley, 2010).

Addressing the effects of parental substance misuse on children

One of the key factors affecting children's life chances and, more specifically, their potential or capacity for learning, is the effects upon mental health and family functioning of parental substance misuse. Recent estimates suggest that over 90,000 children in England under the age of one (Cuthbert *et al*, 2011) live with a parent who is a problem drinker, and 335,000 children live with a parent who is addicted to drugs (Centre for Social Justice, 2013). The Centre for Social Justice has highlighted alcohol and drug addiction as one of five 'pathways to poverty', meaning that parental substance misuse is often not an isolated problem for families but one of a cluster of issues impacting on family functioning. Around one third of domestic violence incidents in the UK are linked to alcohol and parental substance misuse is a key factor in many child protection cases (Brandon, 2008).

Importantly, the children of parents who misuse drugs and alcohol are more at risk than their peers of under-achieving at school, developing emotional and psychological problems and engaging in anti-social behaviour (Alcohol Concern, 2010). Children may feel confused, rejected and abandoned by the parent and sometimes by other family members and siblings who 'escape' the problems at home; they may become carers to their parents and younger siblings; and may lack support for everyday activities such as getting to school on time or inviting friends home. They may spend periods of time away from their parent with other family members, or in the care of the locality. At the same time children can remain optimistic about the future and express love and concern for their parent (Houmoller *et al*, 2011; Adamson and Templeton, 2012).

Despite the mounting evidence, the harm caused to children by parental substance misuse remains largely hidden. The notion of ‘Hidden harm’, first highlighted in 2003, is defined by the ACMD (2003) as ‘parental problem drug use and its actual and potential effects on children’. The ACMD makes no distinction between children who are known to services and those who are not, suggesting that any child whose needs arising from their parent’s substance misuse are not being met is experiencing ‘hidden harm’. While the Hidden Harm report focused on misuse of illegal drugs, there is clear evidence that misuse of alcohol by parents is both widespread and damaging. Their needs remain hidden for a number of reasons: while some children come to the attention of services because of evident neglect or physical harm or poor attendance or behavioural problems at school, some children remain hidden by being quiet and cooperative at school, staying ‘below the radar’ and so below the threshold for intervention. The ACMD make reference to the protective effects of ‘empathetic and vigilant teachers’ and ‘unstigmatising support from relevant professionals’ to the development of resilience of children of parents who misuse illegal drugs (ACMD, 2003). However, working with families around this issue can be challenging due to the stigma experienced or perceived by adults and children, parental denial or a lack of awareness of the impact their use is having. There is also a lack of dedicated services for families in the community and universal services lack the expertise needed to recognise and meet the needs of children with respect to parental substance misuse (Adamson and Templeton, 2012)

The M-PACT+ pilot

M-PACT (Moving Parents and Children Together) is a family intervention designed by Action on Addiction (a charity providing specialist addiction services) to help families in which one

or both parents have a problem relationship with alcohol and/or drugs. The programme facilitates parents, children and other family members to talk about their feelings and experiences in a safe environment, and supports them in making sustainable changes in order to enhance family relationships and thus support children. The intervention was first piloted in 2006 (developed in direct response to the ACMD Hidden Harm report) and evaluations of the programme have shown benefits for the children and families that take part (Templeton, 2016; Templeton, 2014). M-PACT is usually delivered in the community, within, for example, drug/alcohol treatment services, or in the prison service. This has meant that the programme has been typically accessed by families where parental substance misuse is an acknowledged problem and help has been sought to address it.

One of the recommendations of the Hidden Harm report (ACMD, 2003), was that children of problem drug users should be enabled to express their thoughts and feelings safely. Another recommendation was that teacher training and development should include an understanding of the impact of parental drug or alcohol use on children. To further develop M-PACT in response to this recommendation, Action on Addiction formed a partnership with Place2Be (a UK charity that provides mental health therapeutic support in primary and secondary schools), to deliver M-PACT Plus (M-PACT+) in school settings. M-PACT+ built upon the existing M-PACT intervention, but several key differences in the model to be used in schools were noted, including: referral mechanisms (through school staff, Place2Be staff or self-referral rather than through drug treatment services); acceptance criteria (families were only accepted onto the programme if at least one child attended a participating school); staffing (M-PACT+ was delivered by Place2Be facilitators experienced in child counselling rather than addiction services); the availability of follow-on support (via Place2Be); and venue (the sessions were delivered on school premises, after school hours). In addition, training in hidden harm was

offered for all school staff. A pilot was conducted in four areas of England (North East, North West, London and the South East). Schools which had previously commissioned Place2Be to provide therapeutic services for their children were eligible to refer a family to M-PACT+, providing a child of the family aged between 7 and 17 attended their school. A total of 77 schools were eligible to refer a family to the pilot (72 primary and 5 secondary). Awareness raising sessions were held in each local area for Place2Be staff, teachers, Head teachers and local organisations at the beginning of the pilots, and M-PACT+ staff also shared information about referral mechanisms with schools via Head Teachers forums and similar channels as the pilots progressed. Place2Be staff in each school were also told about M-PACT+ and could also encourage referrals from the schools they were based in. All schools were offered training in Hidden Harm for their staff, and 201 members of teaching and Place2Be staff across the 77 schools took part. Each programme was delivered in a single local school venue and families were provided with transport in the event the venue was not the school that their child/ren attended. It was hoped that by providing M-PACT+ in these schools, support for children whose families were not otherwise known to services (i.e. those ‘under the radar’) would be enhanced.

The programme consisted of 8 weekly group sessions where active participants included using and non-using adults and their dependent children aged 7-17 years. Younger children were accommodated in a crèche. Transport and food were provided and there was no financial cost to the families who attended. The eight-week programme was preceded by a comprehensive assessment stage and followed by a family review session shortly after the final session and a group reunion approximately 3 months later. At the review, family members were, if appropriate, referred or signposted to further support. The eight-week programme employed a range of approaches incorporating group theory, cognitive behavioural therapy, systemic

family therapy, attachment theory and motivational interviewing and was focussed primarily on: improving communication in families; parenting; and developing strategies to draw on in difficult times. Sessions were delivered by facilitators who were experienced Place2Be counsellors, trained by Action on addiction to deliver the programme, which was identical to the programme delivered previously in the community, and followed a strict plan for each session. Staff had regular supervision sessions to discuss the delivery of M-PACT+ and ensure fidelity to the model outlined in the training and guidance materials. Evaluators were limited in the observations of sessions that they could undertake, due to the wishes of the delivering organisation that we not affect the delivery in any way. Nevertheless, researchers were able to observe some sessions. The researchers had access to the written guidance, and were able to compare that to their observations, and what they were told about the programme during interviews. During interviews with the supervisor, staff and family members the research team were able to explore how far the programme had been implemented according to the written guidance, and were satisfied that the programme was delivered as intended. The programme combined separate work with adults and children, and activities which brought all participants together, in family groups. Across the pilots, all sessions were delivered according to the programme guidelines. 100 families were referred to M-PACT+ and 60 families subsequently undertook an assessment. There were various reasons why referrals did not result in an assessment for 40 families, usually because they did not meet the criteria for the intervention or did not want to engage with the intervention. Of the 60 families who were assessed, some did not wish to engage further, some were unable to attend, and others intended to take part at a later date. 11 iterations of the programme were delivered across four sites, and 47 families took part. All were invited to take part in the evaluation.

The evaluation methodology

A theory of change approach provided the framework for the evaluation design. It is an approach in which a theory is articulated about how an intervention is expected to reach its intended outcomes. Once the theory is in place, it can then be tested through a variety of quantitative and qualitative methods, appropriate for evidencing the steps of change outlined in the theory (Laing and Todd, 2015; Dyson and Todd, 2010; Funnell and Rogers, 2011). It also encourages stakeholders to articulate any assumptions underpinning the intervention and enables the early identification of threats to successful implementation. A theory of change was developed for the evaluation based on interviews with funders and delivery partners. These interviews explored issues such as: the presenting issues and context; the actions to be taken; the short-, medium- and long-term changes predicted for beneficiaries; and, any risks to the programme faced or opportunities possible. Some interviewees had previous knowledge of the original M-PACT+ programme and were able to draw upon that knowledge. These interviewees were adamant that the M-PACT+ programme would encourage change in the same way that the M-PACT programme had done, as the programme content was not changed. For them, the difference was that the client group were different (i.e. identified at an earlier stage before they were involved with statutory services or ‘under the radar’) and that identifying the families would be done by upskilling school and Place2Be staff to raise the issue of substance misuse with the families they worked with. The interviews were analysed to identify chains of linked processes, and a diagram produced by the evaluators which was then modified and adjusted in dialogue with the funders and delivery partners until the group reached consensus about how they expected changes to happen. The steps of change that they articulated are presented in Figure 1.

Figure 1 Theory of change of M-PACT+

[INSERT FIG 1 HERE]

A variety of methods were then used to collect evidence to support or refute the theory of change, incorporating both methodological triangulation (where different measures are used to examine similar outcomes) and respondent triangulation (where different respondents have contributed data about the same outcome). Survey data were collected at three points in time: at week 1, week 8, and three months later at the reunion for all attendees. Alongside feedback about the programme the surveys incorporated: measures of self-esteem, resilience and family functioning; the coping efficacy scale (Chesney *et al*, 2006); the parent coping scale (Ghate and Moran, 2013); and the strengths and difficulties questionnaire (Goodman, 1997). 45 families comprising 58 adults (31 of whom self-identified as substance misusers) and 59 children and young people aged between 7 - 19 years (mean age = 10 years) provided questionnaire data for at least one point in time. Only two families declined to provide evaluation data. Table 1 demonstrates the number of participants for whom quantitative data was available at each time point.

Table 1 Quantitative data available for each time-point

	Adult users	Children	Adult non-users
Session 1 (N=115)	31	59	25
Session 8 (N=77)	22	37	18
Reunion (N=51)	13	26	13

Statistical analyses of the participant data was necessarily limited by the amount of data available. It was not possible to conduct analyses across the four pilot sites, or across the 38 schools that the participants had been referred from. Issues with missing data further reduced the available dataset. Analyses therefore concentrated on comparing mean scores over time.

Interviews were conducted at several points in time with Action on Addiction and Place2Be Senior Managers (N=10); M-PACT+ trainers (N=3); M-PACT+ Co-ordinators (N=24), facilitators and volunteers (N=16); Place2Be staff, including school project managers (SPMs) whose role was to coordinate the programme in each area (N=12); and school staff such as pastoral staff, teachers and Head teachers (N=9). In addition, school staff and Place2Be staff were invited to take part in an online survey (N=40). Evaluation forms were collected from those undertaking training in recognising ‘hidden harm’, which included school staff and SPMs (N=72). Semi-structured interviews were conducted with families (N=13) including parents, family members and children and young people aged between 7 and 17 soon after week 8, and where possible, again at around the time of the reunion. Interviews with children were supported by the use of visual methods which invited children to write and draw to aid conversation and make participation in the research a more accessible process (Thompson, 2008). Not all children wished to do this but where they did, they were given a choice of activities in order to create a ‘visually mediated encounter’ (Clark *et al*, 2013). The different visual activities were varied enough to target children and young people at differing levels of literacy and understanding, and encouraged participation across the wide age range. All families were invited to take part in the evaluation and data reported here were collected from all respondents (adults and children) who gave informed consent to participate on the understanding that they would not be identified. Where children could not give informed consent they were not interviewed. Parents gave permission for attainment data about children

to be collected from schools. Interview data was analysed thematically by two researchers who then compared and discussed analyses to enhance validity.

Limitations of the evaluation

A wide variety of methods were used to evaluate M-PACT+. An experimental design was not possible due to the lack of an adequate control group. The M-PACT+ intervention was targeted at families ‘below the radar’ and delivered by Place2Be staff. These were families not previously known as experiencing issues with substance misuse, and usually not previously involved with services. On identification, the offer of help was appropriate, and no other similar services to M-PACT+ existed. Those who declined an M-PACT+ referral were likely to be different in some ways to those who accepted. Given these issues, a pre and post design for the collection of quantitative data was used in order to assess the immediate and medium-term impacts of the intervention. Of course, with such a design, there are risks to internal validity over time, but this was felt to be the most appropriate methodology in the absence of an appropriate experimental control group. For this reason, it was particularly important to collect qualitative data from M-PACT+ participants both immediately and medium term, and supplement this with the views of intervention staff and stakeholders. In addition, the theory of change that was developed included consideration of the wider contextual situation and the risks to the M-PACT+ programme, and was reviewed at regular intervals to ensure that possible threats to validity were identified early.

It is always challenging to collect data from those who are critical of any intervention. All participants were given the opportunity to talk to evaluators but not all were able or willing to take that opportunity. It may be that practitioners and family members inclined to be positive

about an intervention are more likely to give their time for interviews or to complete surveys or questionnaires. Families who were referred but not assessed or did not attend the programme have not been asked to participate in this study. In this way, families participating in this evaluation are not likely to be representative of all other families affected by substance misuse.

The design of this study did not allow for a control or even a 'wait' group so attributing observed outcomes entirely to M-PACT+ is difficult. The dataset on which this report is based is smaller than anticipated and there was considerable missing data, both within the questionnaires and at different time-points. There are no data to explain attrition rates. Families may not have been willing to complete the forms at all times, while completion at Week 1 is high, participants may not have attended Week 8 for a variety of reasons not connected to their perception of value of the programme. Similarly non-attendance at reunion could be because things had got worse, because participants did not want to revisit bad times or because of other commitments.

Practitioners and family members complained about the number of questionnaires they were asked to complete and in particular that some were difficult to understand, especially if there were learning difficulties or where English was not the first language. While evaluators and practitioners did their best to help the participants understand the questions used in these externally validated measures, this may also be a threat to the interpretation of the quantitative data when looked at in isolation.

There was not enough data from participants at all 3 time points to be able to conduct meaningful statistical analyses and analyses therefore concentrated on comparing mean scores over time. This means that we are unable to say whether changes in mean scores are a direct

result of the programme, or whether they are a result of participant attrition, or would happen by chance. The mean scores we did obtain were compared to the results of statistical analyses from previous evaluations of M-PACT in the community (see, e.g. Templeton, 2014, 2017), and appeared to be in line with these previous findings, which although does not disprove the effects of attrition, certainly does not raise any inconsistencies.

Nevertheless, the use of a theory of change approach relies on the collation of a portfolio of evidence from difference sources that serves to support, or refute, the theory. In essence, the more data that demonstrates that individual steps of change in the chain are happening as they should (in the absence of data to the contrary), then the more warrant there is for claiming that the intervention will produce the desired effects (or outcomes) in time. Each source of data was not, therefore, looked at in isolation, but formed part of a portfolio of evidence that enabled the theory of change to be tested. In the absence of a reliable and valid counterfactual, this meant that the limitations of one method could be counteracted by the use of another, in order to see where the M-PACT+ programme led to change, and for whom. The evaluation team were most confident in their conclusions where qualitative and quantitative sources of data gave similar results (methodological triangulation).

The following section briefly presents some of the headline findings that enables a conclusion that M-PACT+ was largely working as it should to support children and families and seemed in some cases to be of positive benefit (and at the very least, did no harm), before moving on to look at the implications of the implementation in school settings.

Key findings from the evaluation

The M-PACT+ programme was delivered on 11 occasions during 2013-2015, and 47 families engaged, comprising 64 adults, and 61 children and young people aged between 7 and 19. A further 33 younger children attended the crèche provided. The majority of those families (67% of families) completed the programme. Overall attendance rates were high, although few family members managed to attend all 10 sessions. It was possible to miss a session (for example through illness) and still re-join and complete the course. Prior to attending M-PACT+, none of the children and young people were receiving a service specifically aimed at addressing their needs arising from parental substance misuse. In addition, approximately half of the children and young people attending had no recorded involvement with any agencies beyond universal services or accessing Place2Be at their school and so could be described as ‘below the radar’. Nevertheless, part of what distinguishes M-PACT+ from M-PACT was the availability of services for parents and children in school provided by P2B, which could be accessed before, during or after their engagement with the M-PACT+ programme. 60% of children were already attending P2B prior to the family attending M-PACT+, and by the close of the pilot, nearly three-quarters of children were receiving one-to-one counselling. Table 2 presents the demographic profile of the M-PACT+ participants.

Table 2 Demographic profile of participants

	Children (N=61)	Adult users (N=31)	Other adults (N=27)
Sex	Male = 27 Female = 34	Male = 7 Female = 24	Male = 5 Female = 22
Age	Range 7-19 years Mean 10 years	Range 27-45 years Mean 33 years	Range 24-55 years Mean 38 years

Outcomes for children

The theory of change for the programme indicated a number of long-term outcomes anticipated for children concerning their health and wellbeing and educational outcomes. The evaluation was only able to track participants for a maximum of six months, and so attention was primarily focused on evidencing the intermediate steps that were hypothesised to lead to those longer-term outcomes. These intermediate steps of change included improved family communication, ‘knowing addiction is not your fault’, increases in self-esteem, greater resilience and improved attendance at school. Both qualitative and quantitative evidence suggests some modest benefits occurred in these domains, for the children and young people participating in M-PACT+. At week 8 of the programme, most children (83%, N=29) agreed that their family was able to talk more openly, but children and young people did not report such positive improvements on the family functioning scale. Nevertheless, during follow-up interviews some children indicated that communication had improved in their families:

Before we went to that group, the M-PACT, we never used to talk, we always used to shout at each other... (Boy, primary school age)

I wasn't so confident with me mam, but I talked to her [at MP-PACT+] and I got used to talking to her (Boy, primary school age)

After attending M-PACT+ at week 8, most children and young people also reported a greater understanding of drugs and alcohol misuse (67%, N=31)); an understanding of the effects on their family (66%, N=31); and an understanding that the families' problems were not their fault

(69%, N=29). This was confirmed by children and young people during interviews, and one young person explained how that understanding had come about:

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

Two boys explained during an interview how M-PACT+ had helped them to understand why their mother had been admitted to hospital for treatment, and that they thought ‘she was very brave’ to do that.

The mean coping efficacy score increased at all time points, indicating that children and young people were reporting improved coping strategies. At session 1 the mean coping efficacy score was 22.50 (N=54), by session 8 it was recorded as 23.43 (N=30) and by reunion it was 24.08 (N=24). Most importantly, children and young people’s scores on the strengths and difficulties questionnaire did not deteriorate at any point suggesting that talking about parental substance misuse during M-PACT+ sessions did not upset or emotionally harm children to any extent (as some parents had originally feared). Indeed, during interviews, children and young people reported feeling more confident, feeling more able to ask for help if they needed it, and feeling less isolated:

It [attending M-PACT+] really helps you to build your confidence. First when I went there I was really shy – even though I didn’t know anything. The second week I was still really shy but when we were ending I was really confident. I felt like in English I can actually read out loud! (Girl, secondary school age)

Teachers and Place2Be staff also reported observing these changes in some of the children they were working with:

He got a lot from it, and he still talks about it now... he felt he wasn't isolated any more, there were other kids with the same problem – it wasn't just him (Place2Be project manager)

[He is] more outspoken about substance misuse issues and, if anything, a little too boisterous – which is a good thing! (Deputy Head teacher)

An exit questionnaire was administered to children and young people at the end of the intervention (week 8) to assess their views on whether M-PACT+ had facilitated change in one or more areas aligned with the central aims of the programme. There appears to be a general trend towards reporting positive change (table 3).

Table 3 Views on whether M-PACT+ facilitated change (children)

	Definitely or maybe not (%)	Maybe yes (%)	Definitely yes (%)	N (100%)
Understanding drug/alcohol problems	14	19	67	36
Understanding problems are not your fault	17	14	69	36
Understanding how problems affect family	17	17	66	35
Talking more openly as a family	17	26	57	35

Coping better with how problems affect family	17	19	64	36
Helped things to change so life is better for family	9	26	66	35

Outcomes for parents and carers

Outcomes for the adults participating in the programme largely mirrored those of the M-PACT intervention delivered in the community. According to the theory of change improving family communication was a key step of change in realising good outcomes for adults and children. After 8 weeks, all adults participating in the programme, like the children, reported that they talked more openly as a family (95%, N=21). Being able to talk to others during the programme, and talk to their children and other family members helped them to express their feelings and understand the effects of substance misuse on family members.

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

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

M-PACT [+] has made me realise what I was doing to these children. (Mother)

During interviews, parents expressed that being able to communicate effectively with their children had led to further family changes such as improved behaviour by the children, and better relationships, which they attributed to the M-PACT+ programme.

Adults completed the coping efficacy scale and the parent coping scale, and both measures indicated that adults' coping improved over time, and this was particularly evident for the substance misusing adults. Table 4 indicates the changes in the coping efficacy scores, and table 5 demonstrates the changes in the parenting coping scale.

Table 4 Changes in coping efficacy scores

	Session 1	Session 2	Reunion
Substance misusing adults	22.30 (N=27)	26.05 (N=20)	25.25 (N=12)
Non-using adults	22.67 (N=21)	24.78 (N=18)	23.42 (N=12)

Table 5 Changes in Parent Coping Scale

	Session 1	Session 2	Reunion
Substance misusing adults	3.18 (N=28)	3.17 (N=18)	3.67 (N=12)
Non-using adults	3.43 (N=21)	3.50 (N=14)	3.67 (N=12)

Furthermore, there were small positive improvements in adults' perceptions of family functioning between the beginning of the programme and the reunion at 12 weeks. Better

relationships within the family were reported, and different parenting strategies had been implemented in the home, meaning that family life seemed smoother for many families.

It feels like we're a proper family now. (Mother)

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

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

An exit questionnaire was administered to using and non-using parents and carers at the end of the intervention (week 8) to assess their views on whether M-PACT+ had facilitated change in one or more areas aligned with the central aims of the programme. As with the exit questionnaire for children and young people, there appears to be a general trend towards reporting positive change (table 6 and table 7).

Table 6 Views on whether M-PACT+ facilitated change (using adults)

	Definitely or maybe not (%)	Maybe yes (%)	Definitely yes (%)	N (100%)
Understanding drug/alcohol problems	5	32	64	22
Understanding problems are not your fault	9	14	77	22

Understanding how problems affect family	5	23	73	22
Talking more openly as a family	5	18	77	22
Coping better with how problems affect family	0	32	68	22
Helped things to change so life is better for family	5	24	71	21

Table 7 Views on whether M-PACT+ facilitated change (non-using adults)

	Definitely or maybe not (%)	Maybe yes (%)	Definitely yes (%)	N (100%)
Understanding drug/alcohol problems	0	22	78	18
Understanding problems are not your fault	6	22	72	18
Understanding how problems affect family	0	22	78	18
Talking more openly as a family	11	28	61	18
Coping better with how problems affect family	0	50	50	18
Helped things to change so life is better for family	6	41	53	17

Further detail about the outcomes for parents, carers and children can be found in the final report of the evaluation (McWhirter et al, 2015).

The role of school staff and SPMs in the delivery of M-PACT+

A total of 77 schools were commissioning Place2Be in the pilot areas, and were thus entitled to make a referral to M-PACT+. Of these 77 schools, 38 made at least one referral, with 18 of those making multiple referrals. These referrals were primarily made by Place2Be staff, and there were few referrals directly from teachers. Findings from the survey and interviews with Place2Be staff and school staff indicated that referrals were not a straightforward process. The theory of change implicit in the model of delivery predicted that by providing training to school staff and Place2Be staff in Hidden Harm, they would have an increased awareness and knowledge to be able to recognise the early signs of Hidden Harm in respect of the children they were working with. An evaluation form was designed that asked training participants to reflect upon their knowledge and understanding across relevant domains on a 'before' and 'after' basis, using a five point likert scale of agreement. They were asked to reflect on the following statements:

- I had a good understanding and knowledge base about hidden harm
- I knew about the impact of substance misuse on families, particularly on children and parents
- I knew about the types of services locally that support families
- I could identify families who might benefit from M-PACT+
- I could support families to access the M-PACT+ intervention.

72 members of school staff and 70 Place2Be staff completed the evaluation form and demonstrated an increase in their knowledge and awareness. While all scores improved over time, the greatest benefits for staff were seen to be for changes in hidden harm knowledge (table 8).

Table 8 Magnitude of change in ratings after training for school (N=72) and Place2Be (N=70) staff

		Improvement in score	No change – score still high	No change – score still low	Deterioration in score
Change in understanding and knowledge of Hidden Harm	School staff %	56.9	38.9	0.0	4.2
	Place2Be staff %	65.7	31.4	0.0	2.9
Change in knowledge about impact of substance misuse on family	School staff (%)	55.6	40.3	0.0	4.2
	Place2Be staff (%)	55.7	42.9	0.0	1.4
Change in knowledge of local support services	School staff (%)	52.8	34.7	8.3	4.2
	Place2Be staff (%)	57.1	27.1	11.4	4.3

Change in ability to identify families who might benefit	School staff (%)	54.2	12.5	31.9	1.4
	Place2Be staff (%)	41.4	12.9	40.0	5.7
Change in ability to support families to access M-PACT+	School staff (%)	51.4	20.8	25.0	2.8
	Place2Be staff (%)	65.7	15.7	14.3	4.3

Note: A high score indicated agreement with the statement, a low score indicated disagreement, or a 'not sure' response.

Some scores stayed low, and even deteriorated after training. Although the processes may have been explained during training, staff told us that there were still complexities involved in identifying and supporting families, and ability was not just about knowledge, but about having the confidence to apply it. During interviews, many staff explained that they felt that knowledge and awareness of a substance misuse issue was not enough, but that there needed to be a trusting relationship between the parent and the person making the first approach about M-PACT+. They stressed that these relationships needed to be built over time, and that it was often quite difficult to know how, and when, to raise the issue of hidden harm. For some, this was straightforward:

I tend to be quite blunt about it. (School staff member)

This was most often possible when families were open about the effects of parental substance misuse on their families and were actively seeking ways to help their children. In other cases, raising the matter could take a considerable time:

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

In some cases, school staff believed that speaking about M-PACT+ could damage what might be an already fragile relationship between the parent and the school. Some staff said that they lacked confidence in how to approach a family and appreciated opportunities to seek more training, discuss potential referrals with a colleague, or consider who else might have a better relationship with a parent and might, therefore, be in a better position to be able to suggest a referral. School staff sometimes felt that even if the issues were raised, parents would deny them and feel stigmatised. Nevertheless, these conversations were started with almost 100 families, many of whom may never have spoken about issues to do with drug and alcohol use in a school setting before.

During our interviews with families who had taken part in M-PACT+, we found they seemed to value the school as a means of accessing it. There was often an existing relationship with the staff member who raised the idea of M-PACT+ and parents felt it was natural for schools to get involved if they had concerns about children. They thus felt a lack of stigma in being approached in this way, and appreciated the legitimacy of being on school premises to engage in the process:

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

Approaches to delivering family services in school settings

It seems that delivering M-PACT+ in a school setting led to benefits for children and their families in tackling the effects of parental substance misuse. However, the intervention was being delivered in school settings that were already commissioning Place2Be to meet some of the social and emotional needs of their pupils. It remains to be seen how readily this model could be implemented further.

In addition to the evidence for intermediate outcomes for families there was also evidence that the characteristics of a school exerted a strong influence over whether or not professionals were able to use their knowledge and understanding of hidden harm and the relationships they have with families to talk about M-PACT+, and to recruit them to a group. During analyses of school staff data, different responses were found towards the M-PACT+ intervention that resulted in different approaches to referrals which were classified as: the partnership model; the integrated model; and the commissioning model (Figure 2).

Figure 2 Typology of approaches in school’s engagement with Place2Be and M-PACT+

[INSERT FIG 2 HERE]

In the schools that were categorised as adopting a ‘partnership’ approach, the mental health and wellbeing of children was seen primarily as the responsibility of Place2Be staff, who were

providing counselling and drop in services. The school and Place2Be were operating in parallel. School staff would identify children who needed support and would refer them to Place2Be, who would provide a service. The school very much valued the expertise that Place2be provided on their premises and thus left the offer of intervention up to them.

[There is a sense that] we brought you in to do it...we trust this is fantastic. (SPM)

This same approach was taken with M-PACT+, and it was seen as the responsibility of Place2Be staff to make referrals to M-PACT+ as they saw fit. They were trusted by the school to do this.

The school sees it as my job to make the referrals. (SPM)

In a school that took this kind of approach, the interaction between Place2Be staff and school staff was business like and matters of shared concern such as safeguarding were dealt with appropriately but communication about new initiatives such as M-PACT+ took time, as the school staff were happy to leave such matters to Place2Be. Even where school staff had the opportunity to attend hidden harm training, involvement with M-PACT could be seen negatively:

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

In the partnership model M-PACT+ operated as a bolt-on intervention.

In what was termed as the integrated model, Place2Be (and other community based services) was integral to the school's support for children and young people. These schools took responsibility for ensuring that children and families were supported and took action to ensure their wellbeing was promoted.

The ethos of [this school] is to help students to develop as people, not just academically. (School staff member)

These schools were characterised by regular, scheduled discussion between SPMs and school staff about children and young people who might be supported by Place2Be or who were receiving support from Place2Be. This meant that the possibility of a referral to M-PACT + was considered and there was a discussion about who was best placed to approach families with the suggestion of a referral, rather than seeing it as the job of Place2Be staff.

Being part of a team means it is possible to choose the person with the best relationship with the family. (SPM)

These schools often offered other well publicised services for families such as parenting classes and some hosted some external agencies such as CAMHS (Child and Adolescent Mental Health Services). Senior staff had usually been in place for some time. Information about new initiatives like M-PACT+ was readily communicated through established relationships, and understood and acted upon in the most appropriate manner. In schools with an integrated model M-PACT+ was a built-in intervention.

In schools with a commissioning model, there were a range of barriers to communication about M-PACT+ and hidden harm. Some school and Place2Be staff asserted that there were more

pressing concerns than parental substance misuse, for example, poverty or homelessness, which was impacting on children's attainment. Conversely the problem with parental substance misuse was seen in some cases as so ubiquitous it appeared normal in their community:

Drugs and alcohol are so prevalent here and they will tell us about everything else but that.
(SPM)

Senior leaders were also unwilling to openly identify, and thus tackle, sensitive issues,

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

These schools had sometimes experienced challenges such as a poor Ofsted report or recent changes to senior staff, which diverted their attention away from a more general focus on children's wellbeing. There was also some resistance to engaging with M-PACT+ until it was a proven technique:

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

We would like to see the evidence. (School inclusion lead)

These schools were much less likely than other schools to make referrals to M-PACT+ via either school or Place2Be staff. It is important to note that the picture this represents is not static and these types of school could adopt a partnership model given the right circumstances. However, the relationship between M-PACT+, Place2Be and the school was driven largely by

the senior leaders in the school and was not in the control of SPMs who were not in a position to change school ethos or policy.

Discussion: delivering family services in school settings

It would seem, from the findings presented, that the evidence generally supports the theory that providing M-PACT+ in schools can begin to address the hidden harm of parental substance misuse for the families that engage with it and complete the programme. There was evidence of the programme delivering opportunities for families to communicate with each other, and share experiences. Children felt that they could safely express their views, they understood more about addiction and that communication and family functioning were better. During interviews many of them directly attributed this to the M-PACT+ programme. There was evidence that families' health and wellbeing were enhanced, and that, in some cases, harmful patterns of behaviour were reduced. These encouraging findings mirror those identified in studies of the original model of M-PACT delivered in a range of community settings (Templeton, 2014; 2016). Although the evaluation did not manage to collect enough data about educational outcomes, evidence from the steps of change involved in the theory of change may suggest that, in time, educational outcomes have the potential to be influenced positively.

Nevertheless, the evidence suggests that the access of families to M-PACT+ also depended on the ethos of the schools participating. The schools that tended to make most referrals were those engaged in what was termed an integrated model, in other words, those schools within which M-PACT+ and other community services were integrated into the normal processes of the school. Previous studies suggest that the sustainability of interventions aimed at well-being

are very much dependent on their integration into the core mission of the school (Barry *et al*, 2017). Segrott *et al* (2013) indicate that poor integration of an intervention into school processes can undermine therapeutic relationships, and further state that relationships between practitioners and schools are critical barriers and facilitators for effective implementation of services and:

‘where schools focus on individualised problems at the expense of school environments, external agencies may occupy a peripheral space to which pupils with problems can be referred, but lack the necessary integration to influence school policies, secure suitable accommodation, or achieve teacher’s awareness of their aims’ (p.222).

In those schools engaged in what are described here as a commissioning model, M-PACT+ tended to occupy such a ‘peripheral space’, and these were the schools least likely to identify children and make referrals to M-PACT+. West *et al* (2012) advocate a ‘shared agenda’ so as to improve support for children, and point out the difficulties inherent in this, but emphasise that promoting relationships between professionals, and providing opportunities for teamwork and co-ordination is vital. In order to achieve this, teachers need ongoing support and capacity built in to their roles. However, the introduction of M-PACT+ by Place2Be coincided with a trend to decentralise support for schools through academisation. Structures of training and support offered by local authorities, public health and other bodies were being, or had already been, restructured or scaled back and this has had a widespread effect on how organisations such as Place2Be and Action on Addiction could communicate information, and organise training and support for school staff. It was clear from interviews that there were lots of other issues vying for attention that placed demands on teacher’s time in respect of training and awareness, such as domestic violence, bereavement and physical and mental health issues.

The result of this for the M-PACT+ pilot was that Place2Be and Action on Addiction had to find other ways to identify key contacts within schools and to encourage staff to take up the opportunity for awareness raising, and this tended to have to happen on a school-by-school basis. Managers, coordinators, cluster managers and SPMs were all enlisted in this effort, which became crucial to the identification and referral of families for whom M-PACT+ was intended, but was extremely labour intensive, and relied upon building up relationships over time. These strong relationships and a sense of shared values were crucial to ensuring that M-PACT+ became embedded as part of school practices. Nevertheless, it is far easier for schools to implement fragmented initiatives, rather than embed them into school culture (Spratt *et al*, 2006). In findings similar to ours Spratt found that schools primarily deal with family issues in three ways, by referral to external workers outside the school (exporting), by inviting external workers to work inside the school (importing), or by seeing those issues as ‘whole school’ issues that need to be tackled by everyone working together, sharing ownership and responsibility (Spratt *et al*, 2006). Issues cannot be tackled effectively unless schools are clear about their purpose and values:

‘There is little point in providing specialist interventions for those experiencing difficulties if the progress made in the targeted sessions is not supported (or even undermined) by the wider school environment’ (p.20)

Place2Be was already working in the schools that were part of the M-PACT+ pilot, but the extent to which those schools took ownership and integrated Place2Be, and ultimately M-PACT+ differed. Indeed, the ethos of Place2Be is one of independence and autonomy, and the organisation needs to retain this in order to reach those families who may not have good trusting relationships with the schools. If the chances of success of school-based intervention is

influenced by the ethos of that school, this has implications for school leadership, and for the communities they serve. Schools working in a much more holistic way, with a broader emphasis on child wellbeing from cradle to career, may be a way forward from the performativity culture that pervades school action and decision-making. Such initiatives are gaining traction in the UK, following the promising evidence emerging from studies of Children's Zones in the US (Dyson and Kerr, 2013; Dyson *et al*, 2012; Laing and Todd, 2014)

Conclusion

In conclusion, the evaluation evidence suggests that M-PACT+, has potential in tackling the hidden harm arising from parental substance misuse, and parents welcomed services being provided in school settings which they found convenient and non-stigmatising, but engagement and recruitment was often out of the control of the intervention, relying on schools taking ownership of encouraging referrals and identifying families. In future iterations of the intervention, attention needs to be paid to developing relationships with schools in order to encourage more engagement over time. Given the benefits arising to some families, is there a case to recommend implementation more widely in schools?

The evidence points to a conclusion that this kind of intervention is more likely to succeed in schools where it is integrated into an ethos where there is a shared sense of responsibility for a broad child wellbeing agenda. This is akin to the Whole School approach, which advocates suggest can enhance student outcomes (Public Health England 2015), but we suggest that what

is needed is rather an integrated model in which a school is more than about learning outcomes and in which provision is encouraged in order to remove barriers to learning, but that schools engage with providing families with an opportunity to access services in a way which is non-stigmatising.

This kind of ethos could be encouraged by drawing schools into a collaborative whole-child approach from cradle to career and across all aspects of life. Nevertheless, not all schools will identify with such an approach, and current pressures on them in respect of performativity and high stakes testing mean that attention is often focused more specifically on attainment and the kinds of activities designed to raise attainment scores rather than on longer-term transformational family and community change that can enhance their wellbeing and life chances. Further evidence is needed to see if school attendance or performance are enhanced by this approach, and as M-PACT+ delivery expands, experimental methods may provide further evidence of effectiveness that may persuade schools to refer. Staff of similar interventions should consider carefully how best to communicate evidence of effectiveness to schools in order to engage them. Current evidence seems to suggest that delivering M-PACT+ in school settings has the potential to be an effective approach to helping children and young people experiencing the hidden harm of parental substance abuse, but there is also room for a range of potential responses that can reach families in a variety of ways in the community.

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Figure 1 Theory of change of M-PACT+

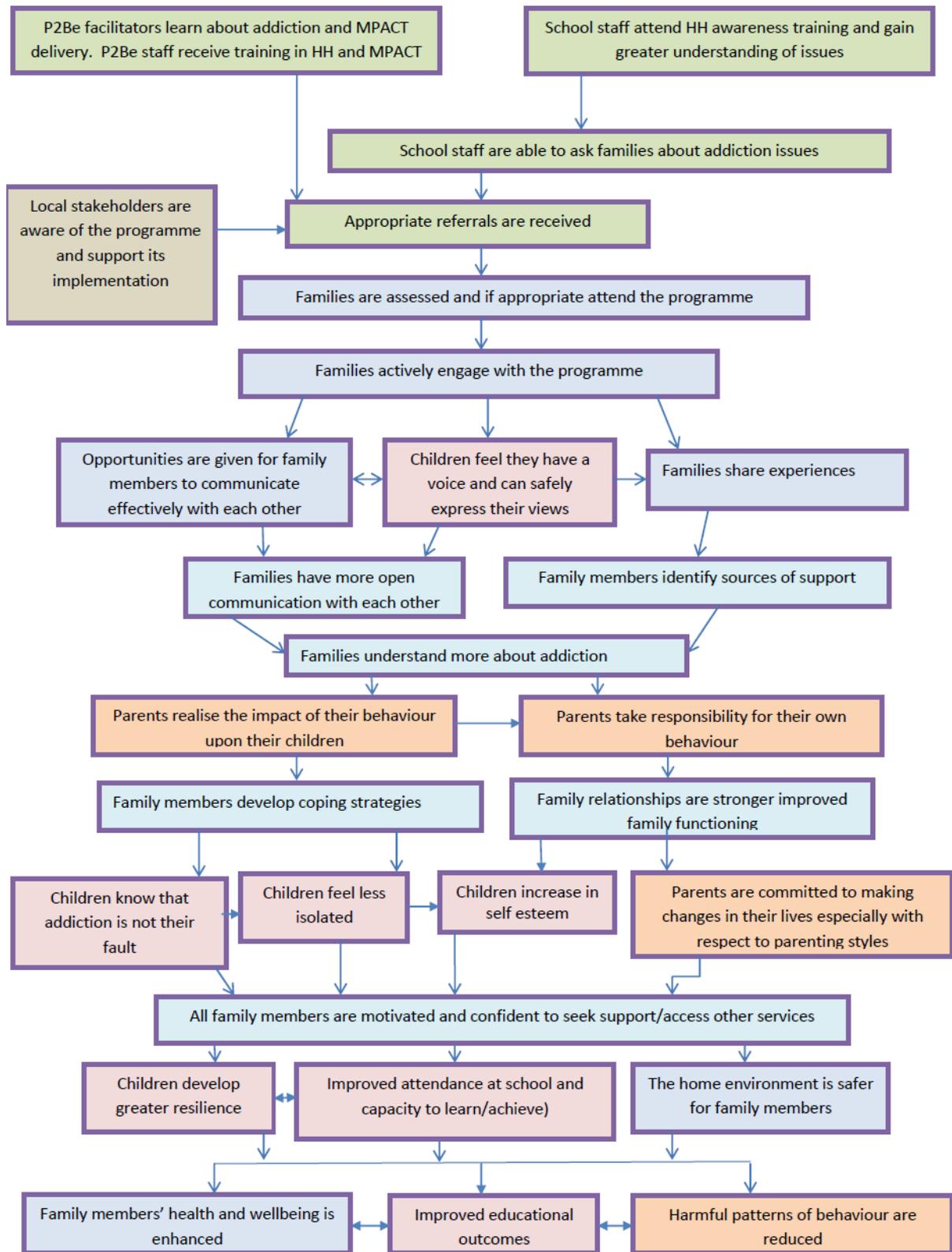


Figure 2 Typology of approaches in school's engagement with P2Be and M-PACT+

