



SUPPORTING FAMILIES WHERE PARENTS HAVE SUBSTANCE MISUSE PROBLEMS

FINAL EVALUATION OF OUR FED UP SERVICE

Rachel Margolis and Prakash Fernandes
NSPCC Evidence team

November 2017

NSPCC

EVERY CHILDHOOD IS WORTH FIGHTING FOR

Impact and Evidence series

This report is part of the NSPCC's Impact and Evidence series, which presents the findings of the Society's research into its services and interventions. Many of the reports are produced by the NSPCC's Evaluation department, but some are written by other organisations commissioned by the Society to carry out research on its behalf. The aim of the series is to contribute to the evidence base of what works in preventing cruelty to children and in reducing the harm it causes when abuse does happen.

Contents

| | |
|--|----|
| ACKNOWLEDGEMENTS | 5 |
| EXECUTIVE SUMMARY | 6 |
| MAIN REPORT | 11 |
| Chapter 1: Introduction | 11 |
| 1.1 Background | 11 |
| 1.2 Theory of change | 13 |
| 1.3 Evaluation aims and methodology | 18 |
| Chapter 2: Outcomes for children and young people | 28 |
| 2.1 Change in emotional and behavioural problems | 28 |
| 2.2 Change in children and young people's self-esteem | 33 |
| 2.3 Changes in children's ability to process their thoughts and feelings | 35 |
| 2.4 Factors affecting outcomes for children and young people | 37 |
| Chapter 3: Outcomes for parents | 45 |
| 3.1 Parents' perceptions about their parenting and impact of substance misuse | 45 |
| 3.2 Change in behaviours that contribute to risk | 47 |
| 3.3 Examples of changes for parents | 49 |
| 3.4 Factors affecting outcomes for parents | 51 |
| Chapter 4: Exploring sustained change | 58 |
| 4.1 Sustained changes for children and young people | 58 |
| 4.2 Sustained changes for parents | 60 |
| Chapter 5: Conclusion and discussion | 63 |
| 5.1 Suggestions for improvement | 64 |
| 5.2 Discussion | 64 |
| Bibliography | 69 |

| | |
|--|----|
| APPENDICES | 72 |
| Appendix 1: Programme details | 72 |
| Appendix 2: Interview schedules | 77 |
| Appendix 3: Ethics overview | 82 |
| Appendix 4: Standardised measures | 84 |
| Appendix 5: Characteristics of children and parents at each point of the referral journey and the evaluation | 86 |
| Appendix 6: Statistical analysis and qualitative data management | 89 |

ACKNOWLEDGEMENTS

The authors would like to thank:

- The children and parents who consented to take part in the evaluation and gave their time to complete questionnaires through the programme.
- The children, parents, NSPCC practitioners and referrers who consented to take part in the interviews and share their perspectives and insights about the programme.
- The team managers, practitioners and admin staff in the FED UP service centres of Blackpool, Cardiff, Coventry, Crewe, Foyle, Glasgow, Grimsby, Hull, Lincoln, Liverpool, Manchester, Sheffield, Stoke, Swindon, Warrington and West London who have supported the implementation of the evaluation by explaining its importance to children and parents, and ensuring that data has been captured for analysis.
- Linda Crosskill, Di Jerwood, Neil Peake, Sue Proudlove, Tom Rahilly, Peter Richards, Fiona Richards and Julie Taylor for their advice, suggestions and encouragement, and for promoting the evaluation within the service.
- Matt Barnard, Richard Cotmore and Mike Williams for reviewing the evaluation plans and reports.
- Helen Fisher for her help and support with the statistical analysis of the evaluation data.

EXECUTIVE SUMMARY

FED UP programme

Family Environment: Drug Using Parents (FED UP) is an intensive intervention for families with children aged five to 12 years, in which there is parental substance misuse. It aims to reduce the negative impact of parental alcohol and drug misuse on children and ensure they are kept safe. It consists of 10 weekly group sessions for children: eight individual sessions for the parent and two joint sessions for the parent and child together. An assessment (of up to four sessions) takes place prior to this to determine eligibility for the programme.

This final evaluation report is based on the evaluation data collected from when the project began in September 2011 until December 2015. During this time period, the service was run in 16 NSPCC sites, although not all sites ran the service for all four years, and was completed in full by 196 parents and 341 children. This evaluation is based on the experiences of 59 parents and 253 children. Unfortunately, there is limited information available on families' characteristics, including family structure and ethnicity, and greater consistency in case recording is, therefore, essential for future evaluations.

Aims and methodology

The evaluation sought to evidence whether the following key outcomes were achieved for children and young people: increased self-esteem; reduced emotional and behavioural difficulties; and improved ability to process thoughts and feelings. Key outcomes for parents were having greater insight into the impact of their substance misuse on their child and enhanced protective parenting behaviour. It was expected that these changes would strengthen the parent-child relationship by improving communication within the family and contribute towards keeping children safer. These outcomes are highlighted through a theory of change that was developed for the programme.

The key elements of the evaluation design include the following:

- An impact evaluation using pre-, post- and follow-up measures to gather quantitative data from the perspectives of children, parents and practitioners. Quantitative findings were described in terms of their: statistical significance – whether there was a clear trend in changes for the average scores of the sample; and clinical significance – whether scores crossed thresholds defined by developers of the standardised measures relating to clinical need.

- A comparison group formed from a naturally occurring waiting list. Families who were part of the comparison group had gone through the assessment for the programme but were waiting to be allocated to an appropriate group.
- Qualitative interviews with samples of children, parents, practitioners and referrers, exploring their perceptions and experiences of the FED UP programme, its outcomes, and factors that helped or hindered the achievement of those outcomes.

Key findings

Positive outcomes for children and parents by the end of FED UP

There was a small but statistically significant improvement in children's emotional and behavioural wellbeing, according to the Strengths and Difficulties Questionnaire (SDQ), which was the key outcome measure used. Most children did not start the programme with the highest level of need (defined as "clinical need"). Nevertheless, the shift in the proportion of children who had the highest levels of need at the beginning of the programme to a lower (non-clinical) level at the end was statistically significant, indicating that this is unlikely to have happened by chance. More specifically, there were significant improvements in children's emotional difficulties and peer problems at the end of the programme. These were areas of difficulty that deteriorated for children in the comparison group.

While there was a bigger overall improvement for children in the comparison group (more children had SDQ scores that improved), there was greater improvement for those with the highest levels of need who had taken part in the whole programme: more children moved out of the clinical range in the FED UP group than the comparison group.

There was also a small but statistically significant improvement in children's self-esteem and ability to process their thoughts and feelings.

Qualitative findings highlighted what some of these changes looked like for children: feeling less angry and anxious; realising that they were not responsible for their parents' behaviour; and being more able to talk to their parents about their concerns.

There were improvements in parents' protective parenting that were statistically significant. Parents also reported greater insight into the impact of their substance use on their children. Interview data highlighted changes in parents' abilities to communicate with their children and to establish calmer home environments.

There were no improvements for parents waiting to receive the service in the comparison group.

Parental engagement leads to better outcomes for children

Where parents were engaged in the programme, there were more positive outcomes for their children, compared with outcomes for children whose parents did not engage. Children whose parents did not engage started the programme with a higher level of need and this deteriorated slightly by the end.

Varied findings around sustained change

Improvements in children's self-esteem were sustained six months after completing FED UP; remaining at post-programme levels rather than continuing to increase.

Improvements in children's emotional and behavioural problems or parents' protective parenting did not, however, appear to be sustained six months after completing the programme. This could be for several reasons, including:

- methodological – that the numbers of children and parents studied were too small to detect change, or because the levels of child needs were not very high to start with
- the nature of the challenges faced by families, some of whom will endure high levels of chaos and transience that may continue beyond their engagement with FED UP
- the nature of the programme, as the input may not be substantial enough and may require a higher “dosage”. This would require reviewing the FED UP theory of change.

Facilitators and barriers in achieving change for families

Children valued the group work element of the programme that allowed them to meet other children facing similar difficulties, have a confidential space separate from their parents, and learn strategies to improve their emotional wellbeing. Children also described how it was important for them to know that their parents were engaged in the parenting element of the programme. Parents placed importance on having time to reflect on the impact of their substance misuse on the family, gaining an insight into children's challenging behaviour and engaging in a programme that focused on their strengths and developing their confidence as parents.

Barriers experienced by some children to achieving outcomes included facing ongoing difficulties in the home environment, their loyalty to substance misusing parents and not having a level of knowledge about substance misuse that matched their peer group. For parents, barriers to benefitting from the programme were often associated with struggling to reflect on the past and not being ready to acknowledge the impact of substance misuse on their child.

Implications

Programme design key for enabling families to achieve outcomes

The structure of the programme, involving a mix of group work with children, individual sessions with the parents and joint work between the parent and child, was viewed positively by all interview participants. This suggests the relevance of a family oriented approach in supporting children and parents with problematic drug or alcohol use.

Bridging the gap between children's and adults' services

In addressing the needs both of children and their parents, the family-oriented approach could potentially bridge a gap between adult drug and alcohol treatment and children's services by creating a safe space for parents and children to explore the impact of alcohol and substance misuse on the family. FED UP received referrals from a range of organisations including local authority children's services, schools, and adult drug and alcohol treatment services, thus showing that it was establishing itself in local service networks. However, it had been set up as a stand-alone service, which may undermine its potential for bridging the gap between adult and child services.

Importance of the first point of contact

The comparison group design has highlighted that positive (but non-clinical) change does occur for children during the assessment period. This suggests that the assessment period marks the starting point for practitioners building relationships with children and supporting them to begin addressing emotional and behavioural difficulties. It also raises questions about the extent to which the assessment is seen as part of the FED UP intervention itself. The evaluation did not include the assessment period as part of the intervention.

Programme benefits for children with clinical and non-clinical needs

Children do not need to be in the highest levels (clinical) of need to be able to benefit from the programme. There is indeed a benefit for children to receive support and to experience positive change in their family relationships before they have endured too much harm. Further, there is a value to there being varying levels of need within the children's groups to ensure that they function effectively and that children are able to learn from one another.

Parental engagement key for improving outcomes for children

Children who do not feel that they have been given permission by their parents to talk openly in the group and who are loyal to keeping family secrets may struggle to engage in and benefit from FED UP. This is further reflected by the key finding that parental engagement is the key criterion for promoting improved outcomes for children.

Parental engagement should be considered as an important factor in the assessment, for example by incorporating the use of a parental capacity to change tool to help determine suitability for the programme. Parents who are not able to acknowledge the impact of their behaviour on their children or to reflect on their substance misusing past are likely to struggle to engage in FED UP. The way in which the needs of these children are addressed should be considered beyond the existing model of the FED UP programme.

MAIN REPORT

Chapter 1: Introduction

Family Environment: Drug Using Parents (FED UP) is an intensive intervention for families where there is parental substance misuse. It aims to reduce the negative impact of parental alcohol and drug misuse on children and ensure that they are kept safe. This final evaluation report is based on the evaluation data collected from when the project began in September 2011 until December 2015. The FED UP programme and evaluation design are summarised in this introductory chapter.

1.1 Background

It is estimated that there are between 250,000 and 350,000 children of problem drug users in the UK (ACMD, 2003). More recent research (Manning et al, 2009) concludes that the number of children living with substance misusing parents exceeds earlier estimates. Although parental substance misuse does not always result in harm for children, research indicates that there is an association between parents misusing drugs or alcohol and a range of negative outcomes for children, including emotional and behavioural difficulties and social and relationship problems (Velleman and Templeton, 2007). There is also a higher risk of neglect and physical abuse (Forrester & Harwin, 2011), with parental substance misuse a common factor in both serious case reviews and for children on child protection plans (Forrester & Harwin, 2006; Brandon et al, 2010). In case reviews where a child had died or been seriously injured, parental substance misuse was identified in 42 per cent of those families in England (Barlow & Schrader McMillan, 2010), in 64 per cent of such families in Scotland (Barlow & Schrader McMillan, 2010), and 58 per cent in Northern Ireland (Devaney et al, 2013).

However, this should not be taken to mean that alcohol and drug abuse invariably leads to poor outcomes for children. For example, Holland et al (2014) state:

“The findings from one large longitudinal study suggest that most children whose parents misuse alcohol go on to have no serious problems.”

(p1492, citing Velleman & Orford, 1999)

Families with drug and alcohol misusing parents can live in very challenging circumstances, as in this study:

“The situations of these families were in general quite extraordinarily difficult. The stories told by mothers wove strands of abuse and neglect in childhood, low self-esteem, poverty and abusive relationships often characterised by substantial and frequent violence into powerful webs of ongoing disadvantage.”
(Holland et al, 2014, p1503)

As a consequence, the drug and alcohol misuse could be a response to underlying difficulties, but in turn generated further problems for families and a significant barrier to change. Dawe and Harnett (2007) for example have suggested that it may not be substance misuse as a single factor that generates poor outcomes but rather its interplay with a range of individual, family and socioeconomic factors. These complexities generate challenges in practice for engaging with families. O’Connor et al (2014), for example, discuss the importance of early and ongoing support that adopts a wider perspective than just the parent or just the child, but instead recognises the “interwoven needs” (p66) of family members and of attachments within their wider family networks. Sawyer and Burton (2012) similarly have called for a more joined-up approach between children’s and adult services and Dawe and Harnett (2007) have developed the Parents under Pressure programme within a “multisystemic framework”. But challenges remain in engaging with some families, even on a voluntary basis. From their qualitative research, Barnard and Bain (2015) identified various strategies parents could adopt for resisting the interventions, both support and scrutiny, of formal services.

The FED UP intervention is based on a programme originally developed by the NSPCC in Grimsby and subsequently delivered by the SMART group in Selby (also an NSPCC service), which provided support to children but did not include a parenting element. FED UP adopts a whole family approach, combining group work with children and individual work with their parents or carers as well as joint working sessions for the parent and child to address key issues together at the end of the programme.

FED UP is delivered over 12 weeks. The individual work with parents aims to help them to understand the impact of their substance misuse on their child, develop skills to meet the needs of their child and reduce the risks children may face. The 10 weekly group sessions with children aim to provide them with a safe space, mutual support to build self-esteem, a better understanding of drug and alcohol problems, and the opportunity to develop life skills to increase their resilience. Sessions centre on structured tasks involving discussions, games, role-plays and craft activities but also let the children relax and have fun. Siblings are allocated to separate groups to provide them with the space to engage independently in the programme. Group

work topics include family secrets and domestic violence, first aid, healthy eating, safety in the home and bullying. The final two sessions include the parents as well so that they can develop a safety plan with their children. An overview of the session contents can be found in Appendix 1.

An assessment, of up to four sessions, takes place with each family before commencing on the programme to determine their eligibility for FED UP. Criteria for accessing the service do not require that parents have to be on a substance misuse treatment programme in order to take part in FED UP, although many will be. Further, the parenting work aims to involve all adults involved in the care of the child, with the focus being on the primary care giver, whether or not they are the substance user. Children are required to demonstrate that they do not have any severe behavioural difficulties in order to be part of a group and need to be aged between five and 12 years in order to join FED UP. Children can be referred across the spectrum of need but the minimum expectation is that they are subject to a Common Assessment if not a Child in Need plan, Child Protection registration or a Child Protection plan. Full details of programme inclusion and exclusion criteria can be found in Appendix 1.

Throughout the programme, practitioners assess whether the child is safe at home or whether further child protection measures are necessary, including referring back to local authority children's services when appropriate. Practitioners work with each family to produce a personal safety plan for the child. The NSPCC have run the FED UP programme in Blackpool, Cardiff, Coventry, Crewe, Foyle, Glasgow, Grimsby, Hull, Lincoln, Liverpool, Manchester, Sheffield, Stoke, Swindon, Warrington and West London. Some of these sites ended delivery of FED UP earlier than December 2015 or began running the service later than September 2011.

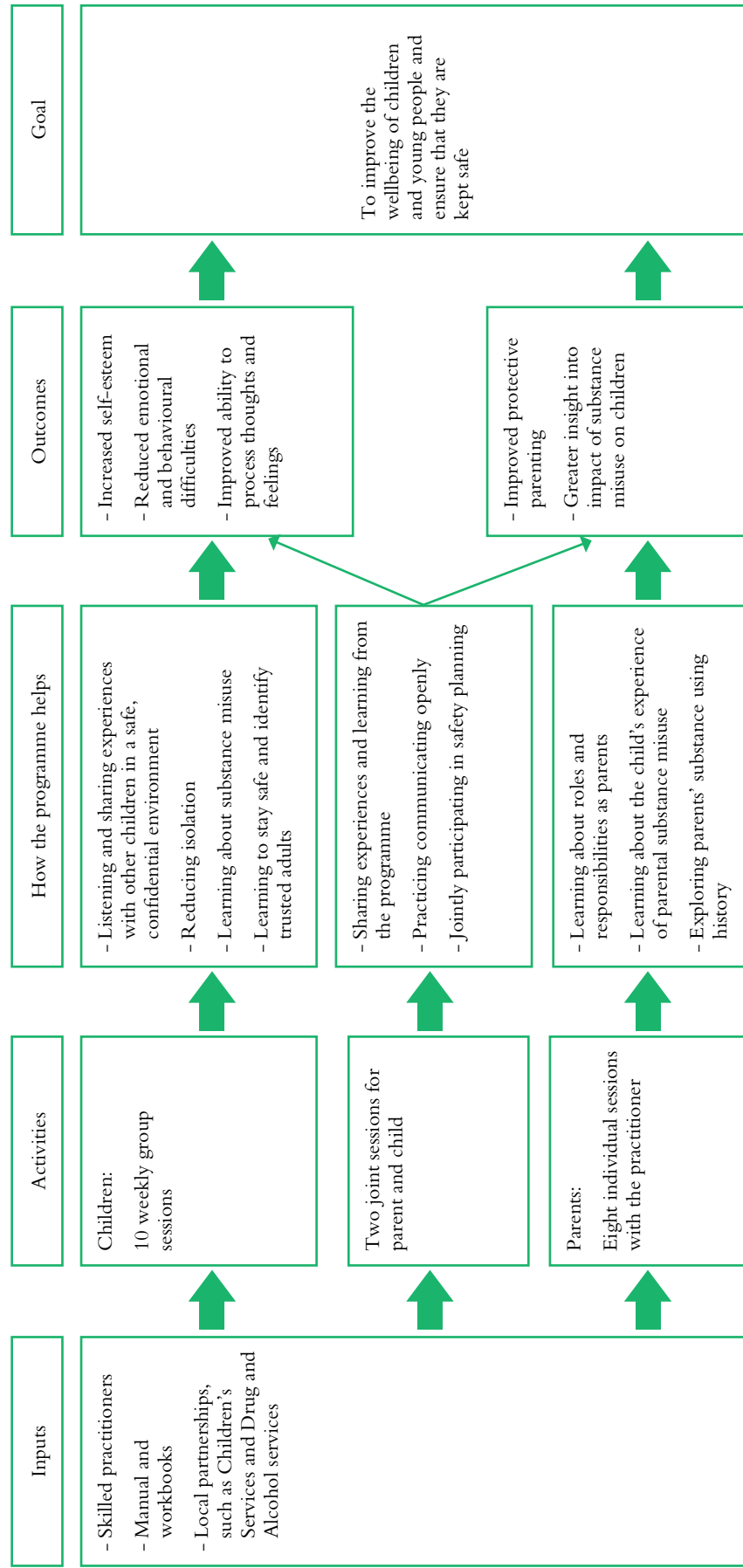
1.2 Theory of change

The theory of change was developed internally within the NSPCC and conceptualises the programme in terms of inputs, activities, the ways in which the programme helps and the outcomes that it achieves.

Key outcomes for children and parents

As outlined in Figure 1, the key primary outcomes for FED UP are for children and young people to have increased self-esteem, reduced emotional and behavioural problems, and an improved ability to process their thoughts and feelings. The key outcomes for parents are having a greater insight into the impact of their substance misuse on their child and enhanced protective parenting behaviour. These primary outcomes should lead to children's improved wellbeing and being kept safe from harm.

Figure 1: Theory of Change



This section draws on evidence to highlight the pertinence of these outcomes for children and parents from households where there is parental substance misuse.

Children's self-esteem

Isolation and lack of support often experienced by the children of substance misusing parents can contribute to low self-esteem (Kroll, 2004). Children's sense of self-worth is affected by feeling that their parents' main attachment is to a substance. This perception that they are not their parents' primary interest frequently leaves children feeling rejected, unwanted and unimportant (Kroll, 2004).

Children's emotional and behavioural difficulties

Secrecy at home around substance misuse and parents appearing to prioritise something that is hidden from their children contributes to the prevalence of depressive symptoms and feelings of anxiety, worry and tension among children (Barnard & McKeganey, 2004; Adamson & Templeton, 2012; Templeton, 2012). Children of substance misusing parents are also likely to be seen by their teachers as having behaviour problems (ACMD, 2003).

Protective parenting behaviours

Being under the influence of substances can cause parents to feel tense, unhappy and irritable (Scottish Executive, 2003). This can lead to them being unavailable to their children and struggling to provide warmth or consistency in their parenting approach (Barnard & McKeganey, 2004; Barlow & Schrader McMillan, 2010). Greater drug use has been linked to less parental supervision of children, less discussion and positive involvement of children and more punitive forms of discipline (Cleaver et al, 2011; Hogan & Higgins, 2001; ACMD, 2003).

Parental insight into the impact of their substance misuse on children

Parents with substance misuse problems often fail to realise the extent of what their children see and understand at home (Adamson & Templeton, 2012). This has both a negative impact on outcomes for children, such as their emotional and behavioural difficulties, and on adult's protective parenting behaviour.

Children's ability to process thoughts and feelings

The lack of acknowledgement of parents' substance misuse in the home is often described as 'the elephant in the room' (Kroll, 2004; Brooks & Rice, 1997). By denying children the opportunity to ask questions and voice their feelings and worries about the 'elephant', children are left uncertain about how to deal with their emotions (Kroll, 2004). The consequence of this is described by Brooks and Rice (1997) as the "don't feel" rule, which leads to children being unable to process or talk about their thoughts and feelings

How FED UP seeks to help children and parents to achieve better outcomes

The ways in which the FED UP programme seeks to enable children and parents to improve against these outcomes are outlined below.

Group work for children

Listening and sharing experiences

The group work provides an opportunity for children to share their experiences with other children living in substance misusing environments. This normalises what they have experienced and enables them to realise that they are not alone in the difficulties that they face (Templeton, 2012). Having their experiences validated by others can offer children relief that the 'elephant in the room' has been acknowledged, allowing them to feel believed and listened to (Kroll, 2004). In this way, it supports children to process their thoughts and feelings and to be more able to manage their emotions and behaviour.

Reducing isolation

Bringing children together in small groups provides them with the opportunity to build new friendships (The Coram Family, 2002). This can reduce children's sense of isolation and contribute to an improved sense of self-esteem.

Learning about parental substance misuse

Receiving age-appropriate information regarding substance misuse enables children to reflect on their own situations and to realise that their parents' substance misuse is not their fault or their responsibility (Kroll, 2004). Being provided with this information enables children to regain a sense of control in their lives, allowing them to be children again (Kroll, 2004).

Learning to stay safe and identify trusted adults

The Advisory Council on the Misuse of Drugs (ACMD) (2003) has highlighted the importance of children being aware of who they can turn to in order to receive non-stigmatised support. The group work helps children to learn to recognise when they need to speak to someone, who they can speak to and how to express the thoughts and feelings that they are having.

Individual work with parents

Learning about their role and responsibilities as a parent

By developing parents' understanding of their children, in particular regarding care and supervision, the parenting work supports parents to prioritise their children's needs.

Learning about the child's experience of parental substance misuse

Providing parents with advice and information regarding the ways in which their substance misuse affects their children and impacts on their child care responsibilities can provide parents with the starting point for improving their protective parenting behaviours (Scottish Executive, 2003).

Exploring parents' substance using history

Exploring their pasts and beginning to reconcile experiences relating to their substance use or events in their own childhood is an important element of the parenting work. In helping parents to start to come to terms with past adversities, they are enabled to more readily focus on their present parenting responsibilities (Child Welfare Information Gateway, 2004).

Joint work

Jointly developing a safety plan enables parents and children to develop their communication skills and to clearly set out ways in which the child will be kept safe. Taking a holistic approach and bringing parents and children together to discuss how parental substance misuse has affected life at home has been identified as an effective mechanism for promoting the safety of children living in environments where substances are misused (ACMD, 2003; Houmoller et al, 2011).

1.3 Evaluation aims and methodology

The key questions that the evaluation sought to answer were largely outcomes focused and were as follows:

- 1) Does children and young people's self-esteem improve by the end of FED UP?
- 2) Do children and young people's emotional and behavioural problems improve by the end of FED UP?
- 3) Are children more able to process their thoughts and feelings by the end of FED UP?
- 4) Do parents' protective parenting behaviours improve by the end of FED UP?
- 5) Do parents have a greater insight into the impact of their substance misuse on their children by the end of FED UP?
- 6) Are outcomes for children and parents sustained beyond the end of the programme?
- 7) What are the key facilitators and barriers to achieving the outcomes for parents and children set out in the Theory of Change?

FED UP was evaluated using a mixed method quasi-experimental design that included:

- a pre- and post-test element to examine the extent to which the programme's intended outcomes were achieved;
- a comparison group to help understand the impact of the intervention;
- a six-month follow-up to gain an insight into sustained change for children and parents;
- and qualitative interviews to identify the key facilitators and barriers to change.

The comparison group for the evaluation drew on a naturally occurring waiting list of children and parents who had been referred to the programme but who had to wait a minimum of eight weeks to be allocated to an appropriate group. It was important from a service perspective that families were not asked to wait to start the programme if there was a group ready for the child to join; hence the comparison group only consisted of those who had no choice but to wait.

It should be noted that the comparison group was not introduced at the start of the study – but at a later point. As a result, it is very small and caution, therefore, needs to be taken in using this data to draw firm conclusions about the impact of FED UP. It is also important to note that during the waiting period for families who were part of the comparison group, the assessment took place. The comparison is, therefore, between families that received the assessment and intervention and those who received the assessment only; it is not a comparison with no support at all.

Impact evaluation

Evaluation measures

The evaluation measures used to understand change for each outcome identified in the Theory of Change are summarised below – a more detailed overview of these measures can be found in Appendix 4. These standardised measures were not specifically designed for use with adults with substance misuse problems, but rather were selected due to their robustness in the outcomes that they measure.

The Strengths and Difficulty Questionnaire (Goodman, 1997)

The Strengths and Difficulties Questionnaire (SDQ) measures the emotional and behavioural problems of children and young people. The higher the total score, the higher the level of difficulty. Four scoring bands have been defined for the SDQ: very high; high; slightly raised; and close to average. The very high and high scoring bands have been used to describe clinical difficulty in this report and the remaining two bands to describe non-clinical difficulty. Young people aged 11 years or over, and younger children who practitioners felt were able to complete the SDQ, were offered the self-complete version of the questionnaire. The SDQ was completed by the parent/carer if the child was younger than 11 or unable to complete it themselves.

Health of the Nation Outcome Scales Child and Adolescent Mental Health (Wing et al, 1996)

The Health of the Nation Outcome Scales Child and Adolescent Mental Health (HoNOSCA) captures practitioners' perspectives on children's behavioural and emotional difficulties. Practitioners provided a score between 0 and 4 for each of 13 criteria set out in the HoNOSCA covering four broad categories: behavioural problems; impairment; symptomatic problems; and social problems.

Rosenberg Self-Esteem Scale (Adapted)

The self-esteem questionnaire is based on the Rosenberg Self-Esteem Scale (Morris, 1981) and was adapted by the NSPCC for use with children. Total scores range from 0–30 with a higher score indicating a higher level of self-esteem.

Child Abuse Potential Inventory (Milner, 1986)

Used for FED UP as an evaluation tool only and not for predicting abuse, the Child Abuse Potential Inventory (CAPI) is a reliable tool for measuring change in protective parenting and includes six validated subscales relating to the parent's attitudes and interpersonal problems. The CAPI also has inbuilt validity scales to filter out parents who may be faking good responses or being inconsistent or random in their responses. It consists of 160 questions with a cut off score of 215 defining the threshold for poor protective parenting behaviours.

Evaluation wheels

Evaluation wheels were completed by parents and children and are not standardised measures. Respondents rated themselves between 1 and 5 (1 being low, 5 being high) against 5 criteria (parents) and 6 criteria (children).

Service and evaluation attrition

The FED UP programme was completed, in full, by 196 parents and 341 children. A further 59 parents completed the FED UP work appropriate to them, but not necessarily the whole programme – for example, they may have completed fewer sessions covering all the issues that practitioners identified as relevant to that family. Similarly, a further 47 children completed the FED UP work, agreed with their practitioner, but not the programme in full. Some of these children may not have completed the joint work with a parent or carer, or may have undertaken some of the sessions individually with a practitioner rather than in the peer group. An overview of the number of cases that moved from referral to programme completion is described below in Figure 2. It is disappointing that little information about the children's and families' characteristics, such as family structure and ethnicity, is readily available, because of gaps and inconsistencies in case recording. It is important that this is addressed, so that it is possible to identify not just what seems to work, but for whom.

Figure 2: Analysis of referrals (Parents n=612, Children n=583)

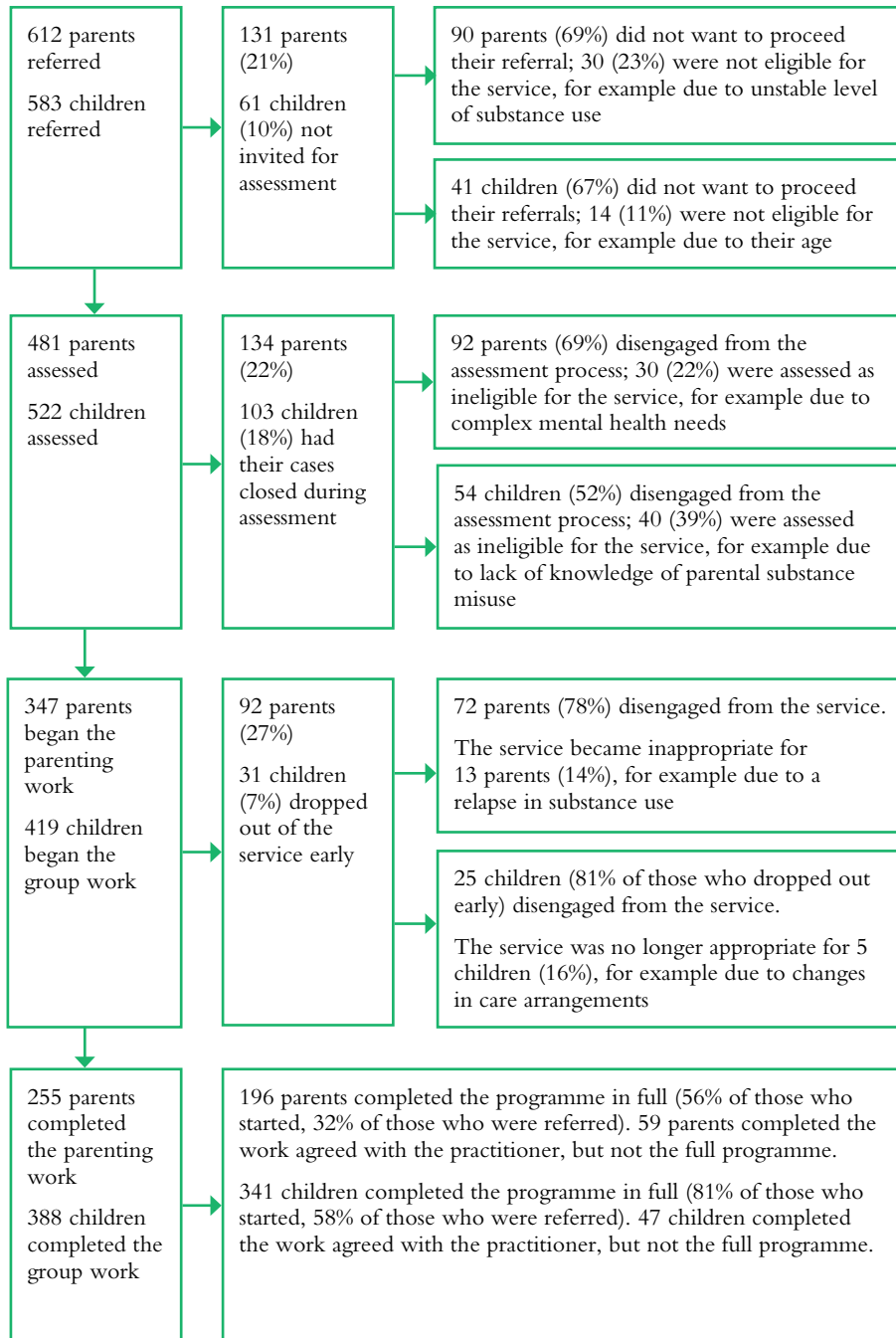


Figure 2 indicates that 56 per cent of parents who started FED UP went on to complete the programme in full, representing 32 per cent of parents who were referred to the service. This suggests fairly high levels of attrition for parents. Levels of attrition were much lower for children, with 81 per cent of children who commenced the group work going on to complete the programme in full; this represents 58 per cent of all children referred to FED UP.

Of those parents who completed the programme in full, 52 per cent were alcohol users, 31 per cent were drug users, 12 per cent used both drugs and alcohol, and, for the remaining 5 per cent, the type of substance misuse was not recorded. The large majority of parents who completed the programme in full were mothers rather than fathers or another family member or carer (who were the primary carers but may or may not have been the substance misusing parent).

The characteristics of the evaluation sample were very similar to that of all children who accessed FED UP. For example, there was a similar number of boys and girls who were part of the evaluation and who completed the service, and most children fell into the 8–10 years age category. Characteristics of the adults who accessed the service and who took part in the evaluation were very similar, with most parents being mothers and alcohol misuse being the most common type of substance misuse.

An overview of the completion of the evaluation measures at the different time points is provided in Table 1. Three measures represented the child's perspective: the Adapted Rosenberg Self-Esteem Scale; the children's evaluation wheel and the Strengths and Difficulties questionnaire. The evaluation wheel was administered at programme start (Time 1) and completion (Time 2) only, whereas both of the other measures were also in addition completed at follow-up (Time 3). There is a complexity with the SDQ that although a large majority of the forms were completed by the children themselves, in three in ten cases the measures were completed by their parents: of the 180 SDQs analysed for Time 1 and Time 2, 128 were completed by children and 52 by parents or carers. The analysis required that the same person completed the measure at Time 1 and Time 2, so in the few cases where the SDQ was completed by a different person across the time points, those measures were not included in the analysis.

There was significant evaluation attrition between the end of programme and the follow-up six months later. Practitioners could find it hard to achieve the follow up and this was for various reasons, including that the families' circumstances had changed. Of the three child-focused measures, only the SDQ was used in the comparison group. The low numbers at Time 0 (following referral and during assessment for the programme) reflect the late introduction of the waiting list comparison group.

Just under half of the parents who started the programme completed a CAPI at Time 1 (48 per cent, n=166) and less than three quarters of these (73 per cent) were valid for analysis. Just under one third of parents (30 per cent) who completed the programme in full completed a valid CAPI at both Time 1 and Time 2. Similar to the children, there was significant attrition at follow-up. The parents'

evaluation wheel was the second measure to be included at T0 for the comparison group.

To summarise, the pre/post evaluation sample (T1 and T2 measures) therefore represents 30 per cent of parents who completed the programme in full (based on the CAPI) and 53 per cent of children who completed the programme in full (based on the SDQ). Appendix 5 outlines in full the numbers of completed measures for children and parents at each stage of the evaluation and their key characteristics, including those for the comparison group.

Table 1: Overview of completed questionnaires

| Outcome | Tool | Perspective | Comparison Group (T0 & T1) | Pre- & post-programme (T1 & T2) | Six-month follow-up (T1, T2 & T3) |
|--|--|--------------|----------------------------|---------------------------------|-----------------------------------|
| Increased self-esteem among children | Adapted Rosenberg Self-Esteem Scale | Child | N/A | 216 | 88 |
| Reduced emotional and behavioural difficulties among children | Strengths and Difficulties Questionnaire (SDQ) HoNOSCA | Child/Parent | 27 | 180 | 65 |
| | | Practitioner | N/A | 180 | N/A |
| Children have an improved ability to process thoughts and feelings | Children's evaluation wheel | Child | N/A | 253 | N/A |
| Improved protective parenting/improved safeguarding of children | Child Abuse Potential Inventory (CAPI) Parents evaluation wheel | Parent | N/A | 92 (59 of which are valid*) | 32 (19 of which are valid*) |
| | | | 24 | 95 | N/A |

* Invalid measures due to respondents not completing the questionnaire in full, 'faking good', 'faking bad' or giving inconsistent responses.

Qualitative interviews

This report also draws on qualitative data from interviews with children and parents who completed the programme, practitioners who delivered the programme and professionals who referred parents and children to FED UP.

The aim of the qualitative interviews was to understand any changes for children and parents after attending FED UP, to identify the facilitators and barriers to service users achieving positive outcomes and to understand their experience of the programme.

Sample of children and parents

A total of 13 interviews with children and 12 interviews with parents/partners/carers were undertaken. Children and parents were selected purposively. Purposive sampling involves using criteria that reflects key differences in the study population that are relevant to the study’s objectives, rather than trying to ensure that the sample is statistically representative.

Our key criterion in choosing children or parents to be interviewed was whether they perceived an improvement (on one or more of the standardised measures) or not. In addition, we included: children and parents who had refused consent to complete evaluation measures; and the non-substance misusing parents/carers, to understand their experiences of the programme.

While we attempted to get equal numbers across categories, this was not possible due to difficulties in contacting children for whom there had not been an improvement (according to one or more standardised measure) or parents who had not agreed to complete the evaluation measure (see Table 2).

Table 2: Numbers of children and parents interviewed based on pre-/post-change

| Pre-/post-change reported on measures | Children | Parents/carers |
|--|-----------------|-----------------------|
| Improved | 7 | 2 |
| Same/Got worse | 5 | 4 |
| Refused consent to complete measures | 1 | 5 |
| Partner/Carer (who did not need to complete evaluation measures) | 0 | 1 |
| Total | 13 | 12 |

The type of parental substance misuse, whether drug or alcohol, was also considered in selecting a diverse sample, as reflected in Table 3.

Table 3: Nature of parental substance misuse

| Diagnosis | Number |
|------------------|---------------|
| Drug | 4 |
| Alcohol | 7 |
| Partner/Carer | 1 |

The age of children and geographic distribution of children and parents can be found in Tables 4 and 5. The sample includes children of a mix of ages, although a larger number of older children were interviewed in comparison to those aged 10 years or under.

Table 4: Age and gender of interviews with children

| | 10 years and under | 11 years to 13* years | Total |
|-------|---------------------------|--|--------------|
| Girls | 2 | 4 | 6 |
| Boys | 2 | 5 | 7 |
| Total | 4 | 9 | 13 |

* Children aged 13 years may have been younger at the time of participation in the programme

Table 5: Geographic distribution of children and parents interviewed

| Location | Number of children | Number of Parents/Carers | Number of families |
|-----------------|---------------------------|---------------------------------|---------------------------|
| Blackpool | 1 | 0 | 1 |
| Cardiff | 3 | 1 | 3 |
| Coventry | 2 | 3 | 2 |
| Grimsby | 3 | 4 | 3 |
| Warrington | 1 | 1 | 1 |
| West London | 3 | 3 | 3 |
| Total | 13 | 12 | 13 |

The interviews with each child and parent were done individually and lasted approximately 45 minutes. The interview schedules are attached in Appendix 2.

Sample of referrers and practitioners for qualitative interviews

Nine interviews with referrers took place and are reported on in this final report.

Referrers were also sampled purposively. The key criteria for sampling referrers was to ensure that they represented the breadth of referring agencies to the programme and also that they reflected different locations from across the UK (see Table 6).

Table 6: Types of referring agencies included in the sample

| Referring agency | Number of professionals |
|-------------------------------------|--------------------------------|
| Adult drug and alcohol services | 2 |
| Schools | 3 |
| Local Authority Children's Services | 4 |
| Total | 9 |

Referrers from the following geographic locations were included in the sample: Coventry, Crewe, Grimsby, Hull, Manchester and Warrington. All referrer interviews took place over the phone and lasted approximately 25 minutes. The interview schedule can be found in Appendix 2.

Ten interviews with NSPCC practitioners took place; practitioners were sampled to represent the views from a geographic spread of NSPCC service centres. Practitioners from the following service centres were included in the sample: Cardiff, Coventry, Grimsby, Liverpool, Stoke, West London and Warrington.

These interviews also took place over the phone and took about 50 minutes. The interview schedule used with practitioners is attached in Appendix 2.

Ethics

The key ethical considerations that influenced the evaluation included ensuring that:

- service users could give informed consent;
- confidentiality and its limits were understood by participants;
- participants were aware of their option to withdraw from the evaluation or any aspect of it;
- the principle of no harm to participants as a result of the evaluation was kept in mind while explaining measures or conducting the interviews;
- participants had access to advice or support related to the evaluation; and
- participants, practitioners and the evaluation officers had access to debrief sessions to process any concerns raised through the evaluation.

A note on the ethical considerations is attached in Appendix 3.

Prior to the study commencing it was approved by the NSPCC's Research Ethics Committee (REC). The REC includes external experts and senior NSPCC staff members. This ethics governance procedure is in line with the requirements of the Economic and Social Research Council and Government Social Research Unit Research Ethics Frameworks.

Analysis

The responses to the evaluation measures were analysed using a range of statistical tests. This report uses the convention that a change is considered statistically significant if there is less than a five per cent chance of it happening randomly. Statistical significance indicates whether scores at one point in time are statistically different from those obtained at another point in time. This is important to ascertain to minimise the likelihood of the difference occurring by chance.

It is also useful to explore whether there are clinically-relevant changes in scores on standardised measures, such as the SDQ, to aid our understanding of whether the difference found is actually meaningful in the real world. For instance, if a child was initially considered to be scoring very high on the SDQ, this would suggest the way they are feeling or behaving is cause for concern and they may need additional support or treatment. If the next time they are assessed their score had dropped substantially to a much lower level (below the clinical threshold) then they can be considered to have made sufficient improvement. This real-world difference is called a clinically significant difference and thus is helpful for interpreting results in addition to statistical significance. Further information about the analysis of measures is outlined in Appendix 6.

The qualitative data from the interviews were analysed using a framework 'case and theme' approach (Ritchie & Lewis, 2003). The list of themes developed is attached in Appendix 6.

Limitations of the research

There were some gaps in the case data that were routinely collected in the context of practice and which compromised the analysis. The most glaring one concerned ethnicity and others concerned the gender of parents.

There were a number of challenges associated with collecting CAPI data from parents. Some practitioners expressed concerns about offering the CAPI due to the length of the questionnaire and the language it used, which they felt might act as a barrier to establishing positive relationships with parents. These challenges contributed to slightly lower numbers of completed and valid questionnaires at T1 and T2 than anticipated. An additional issue is that the number of valid evaluation returns from parents (CAPI) at T3 (six month follow-up) is low. It has, therefore, only been possible to undertake descriptive analysis of this data rather than applying statistical tests to understand trends in sustained changes for parents.

Chapter 2: Outcomes for children and young people

This chapter explores the changes experienced by children who went through the FED UP programme. In addition to pre- and post-intervention data, it provides an insight into what these changes felt like for children by drawing on qualitative data from interviews, as well as measures. It will also explore facilitators and barriers to outcomes being achieved for children and young people.

2.1 Change in emotional and behavioural problems

2.1.1 Parents' and children's perspectives: SDQ

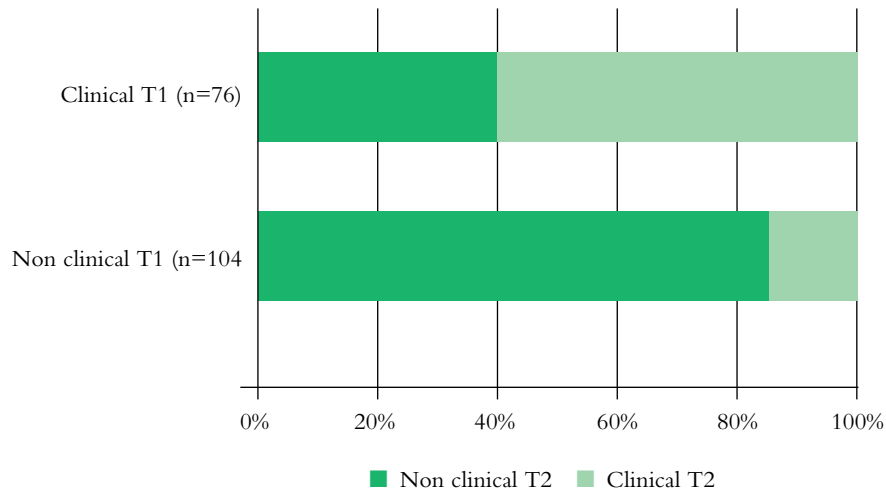
There was a small decrease in the mean total score between the beginning and end of the programme, from 15.6 to 14.8. This change is statistically significant ($p=0.03$), indicating a small reduction in children's emotional and behavioural problems.

Change in level of difficulties experienced by children

Forty-two per cent of children started FED UP with a clinical level of difficulty. Of this group of children, 40 per cent crossed the clinical threshold and ended the programme at a non-clinical level. A clinical level of difficulty was deemed to be any score falling within the 'high' or 'very high' scoring bands. This shift in the proportion of children experiencing a clinical level of difficulty was statistically significant ($p=0.04$). There is, therefore, also a clinically meaningful improvement in children's behavioural and emotional difficulties at the end of FED UP. Figure 3 shows the proportional shift from clinical to non-clinical levels of difficulty (and vice versa) at the end of the programme.

It is worth noting that most children started FED UP with a non-clinical level of need (58 per cent), so there was no scope for these children to experience a clinically significant improvement (of moving from the highest levels to lower levels of need), although they may have still experienced a reduction in emotional and behavioural difficulties from the point at which they started. There was also a large proportion of children (34 per cent) who ended the programme with a clinical level of need. This raises questions about who was accessing the service as well as the scope for a 10-week programme to bring about clinical change for children with the highest levels of need. These questions are explored in Chapter 5 of this report.

Figure 3: Proportional shift in clinical need at the end of FED UP



Changes in SDQ scores for the comparison group

Data from the comparison group (n=27) indicates a small improvement in mean scores in the SDQ, from 16.1 at Time 0 (pre-assessment) to 15.4 at Time 1 (pre-group work). However, this change is only small and remained within the ‘slightly raised’ score band; the change was not statistically significant (p=0.24) and, therefore, this does not represent a trend in scores improving for the comparison group.

The proportion of children who had a score that improved was slightly higher in the comparison group than in the intervention group. An improved score was deemed to be the movement from any higher scoring band to a lower one. In the comparison group, 56 per cent of children’s scores improved, while for the intervention group this was slightly lower, with 52 per cent of children’s scores improving.

However, when looking at clinical change, there was greater improvement for those children who went through the full programme. Only 29 per cent of children in the comparison group saw a clinical level of improvement, compared with 40 per cent of children in the intervention group. This suggests that while there may have been improvement for children who waited for the service and received the assessment, there was more clinically meaningful change for children who went through the programme, as a higher proportion of them moved from the highest to lower levels of need.

Change in SDQ subscales: pre- and post-FED UP and for the comparison group

Exploring the shift in the proportion of children falling within a clinical and non-clinical level of difficulty in each of the SDQ subscales provides an insight into where improvement, deterioration or no change at all took place for children who completed FED UP and for children who were part of the comparison group.

For children who completed FED UP, there was a statistically significant improvement ($p=0.008$) in their emotional difficulties and a clinically significant improvement ($p=0.03$) in the proportion of children with a clinical level of emotional difficulty at the end of the programme. There was also a statistically significant improvement ($p=0.04$) in children's peer problems.

There was, however, a small increase in clinical need for children's conduct and prosocial problems. It is not clear why these subscales may have seen an increase in clinical difficulty; however, it is worth noting that the extent of clinical scoring in the prosocial subscale remained at a very low level (less than 15 per cent) at the end of the programme. Figure 4 shows the proportional change in the number of children with a clinical level of need for each of the subscales.

Figure 4: Proportional change in clinical need by SDQ subscale pre- and post-FED UP

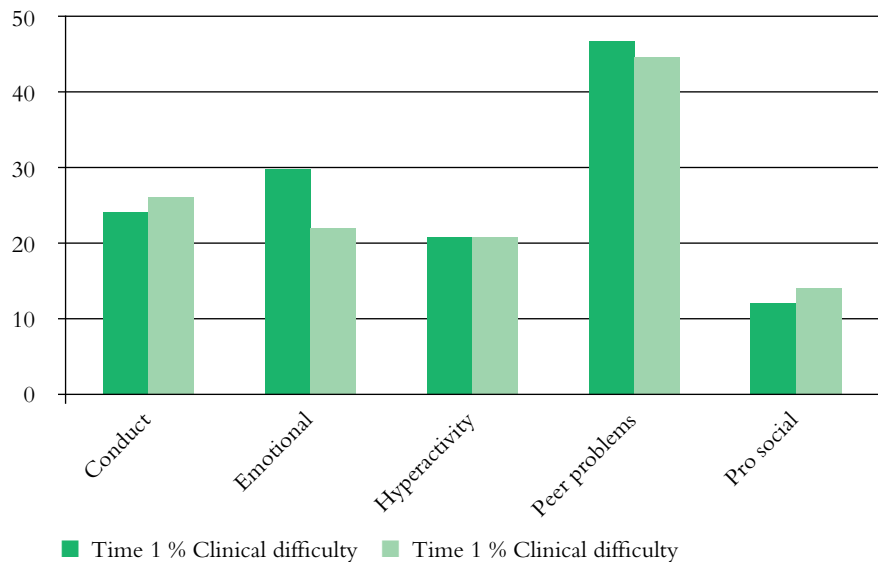
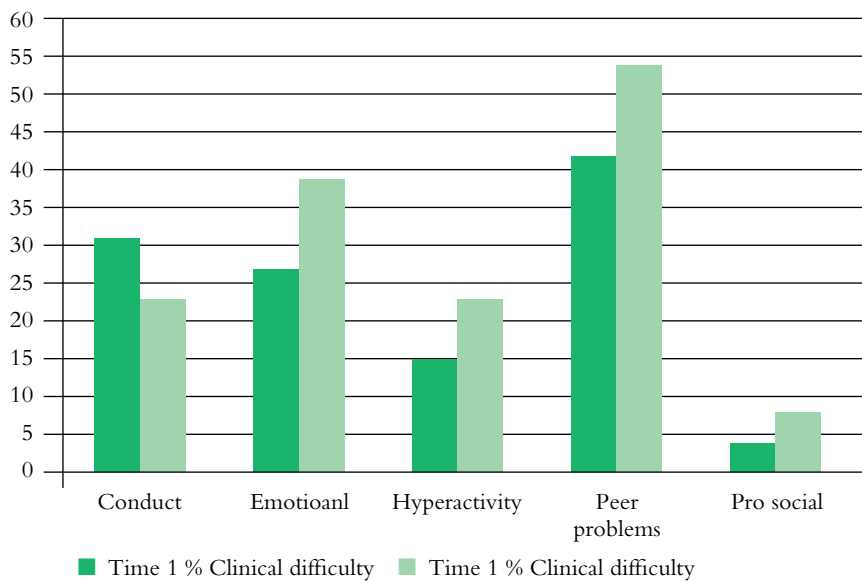


Figure 5 below shows the change in clinical need by subscale for children who were part of the comparison group. Unlike the pre-and post- data for the intervention group, it indicates clinical deterioration in all areas with the exception of conduct problems. It is unclear as to why there was a clinical improvement in children's conduct. This may be linked to a change in perception of children's behaviour through the assessment process. It is possible that through engagement in the assessment, parents and children began to reassess the extent of the child's behaviour problems and had a more positive perspective on this once the assessment was completed.

Figure 5: Proportional change in clinical need by SDQ subscale for the comparison group



The subscales data indicates the following:

- For the comparison group, the proportion of children falling within the clinical category for peer problems was greater than the proportion of children in the non-clinical category at Time 1. This is particularly notable since there was a significant improvement in this subscale for children who completed the programme.
- Emotional problems and peer problems emerge as the key difficulties for children waiting to receive the service, with the highest proportions of children falling within the clinical categories for these subscales at Time 1 for the comparison group. These two subscales improved significantly for children who completed the full programme.

Parental engagement and SDQ scores

Analysis of SDQ scores in relation to parental engagement in the programme highlights the importance of parental involvement in FED UP for achieving outcomes for children. From the sample of 180 children, 134 had parents who took part in the programme and 46 had parents who either did not engage fully (for example, took part in a few parenting sessions or only one joint session and none of the parenting sessions) or did not engage at all, either out of their choice or due to a decision taken by the practitioner (for example, the substance misuse being too erratic). Those children whose parents had taken part in FED UP experienced a statistically significant improvement ($p=0.01$) to their emotional and behavioural needs, while those children whose parents did not engage started the programme with a higher level of need that deteriorated slightly by the end (see Figures 6 and 7 for comparison).

Figure 6: Mean SDQ scores for children whose parents engaged in FED UP

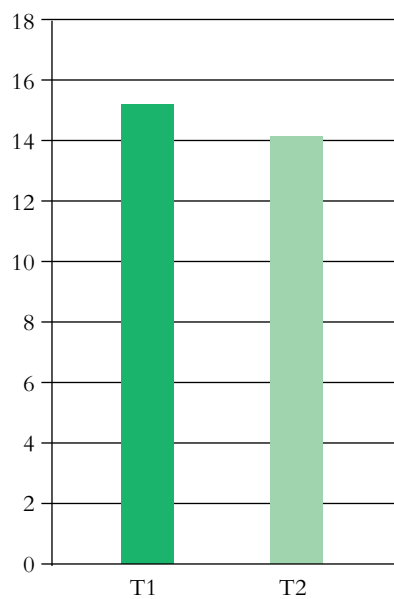
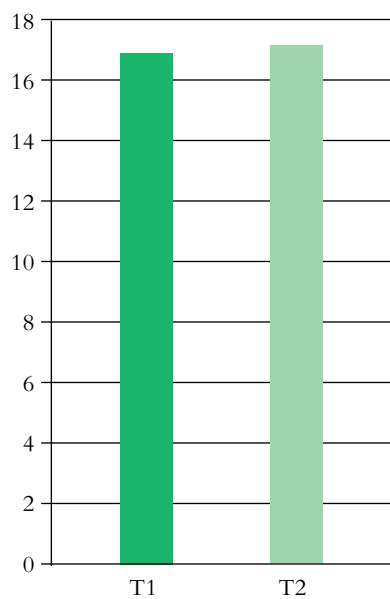


Figure 7: Mean SDQ scores for children whose parents did not engage in FED UP



This finding highlights the value of the FED UP model of parental engagement in the parenting work, not just in terms of outcomes for parents but also for children. It also draws attention to the high level of need of children who have parents who are not able to engage in a programme like FED UP and who may require further support in order to have their needs met.

Outcomes for children were not affected by the type of substance misuse (drugs or alcohol) of their parents.

2.1.3 Practitioners' perspective

The mean score for the HoNOSCA (n=180) at the beginning of the work was 6.6, which decreased to 5.7 at Time 2. This small change was also statistically significant ($p=0.004$), reflecting a trend in decreasing difficulties among children from practitioners' perspectives. Due to the absence of any cut off points for the HoNOSCA, it is not possible to determine the clinical significance of this change.

2.1.4 Examples of change in children's emotional and behavioural problems

Interviewees described children getting into fewer physical fights and their behaviour at home and at school also improving, as in these examples:

"Well before I went to the FED UP group I was like really stressed out all the time. Really like angry at everyone all the time, but now I've done that group I'm not as angry."

Boy, 13 years

"[My son] thinks about what he says a lot more. And he's not so angry. He'll just go up to his bedroom, take five, and then come and talk; not always, but most of the time."

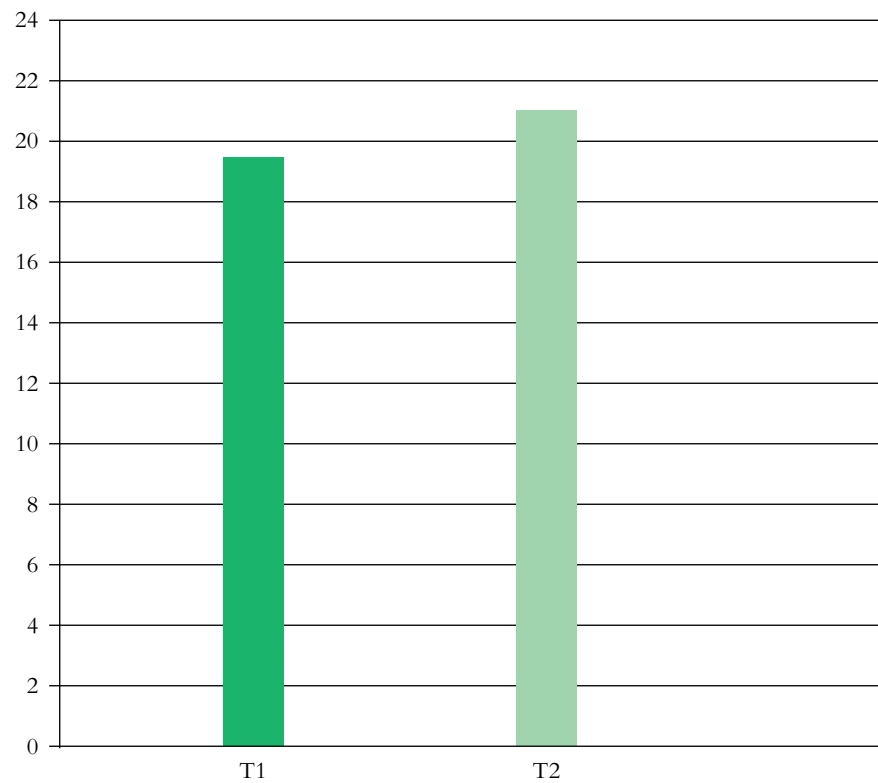
Parent, drug user

Children who had previously been anxious about their parent or felt guilty about their substance misuse felt relieved as they understood that they were not responsible for the situation. They were able to describe how they felt calmer and less stressed after attending the programme.

2.2 Change in children and young people's self-esteem

The Adapted Rosenberg Self-Esteem Scale (n=216) has been used to measure changes in children's self-esteem over the course of the FED UP programme. This data shows the mean score increasing from 19.55 at the start of the work to 21.10 at the end (see Figure 8). This increase is statistically significant ($p=0.0001$), indicating a trend in the self-esteem of children and young people increasing.

Figure 8: Adapted Rosenberg Self-Esteem Scale scores pre- and post-FED UP



Since this measure has been adapted, there are no cut off points defining clinical levels of high or low self-esteem. It is, therefore, not possible to deduce from the data whether the scores reflect a clinically high or low level of self-esteem.

2.2.1 Examples of change in self-esteem

Children reflected on how their feelings about themselves and what they were capable of achieving had changed during interviews. Some were able to describe the way in which they viewed themselves had improved and that they were more able to recognise positive achievements than they had previously been able to:

“I used to pretty much not like myself. I thought I was stupid, I thought I was dumb. But since [coming to FED UP], I was actually proud of what I did in my SATS.”

Boy, 11 years

Referrers also acknowledged how children’s increased self-esteem had been noted by schools, who had described children as being more able to participate in class and take part in school assemblies, and a general improvement in children ‘coming out of themselves’. Parents identified positive changes in the way in which their children were

feeling about themselves, for example, by being able to participate in performing arts activities that they had not previously felt able to be part of:

“[My son] was always depressed, it was like he was always down and he weren't getting in with a circle of friends and I was actually looking for an outlet for him...I've tried the GP, I've tried CAHMS counselling, I've tried the lot and then he come to NSPCC and it's built his confidence from zero to like he's going to performing art school and stuff so it's really, really good.”

Parent, drug user (cannabis)

2.3 Changes in children's ability to process their thoughts and feelings

The children's evaluation wheels were used to measure change in children's ability to process their thoughts and feelings. In total, 253 children's evaluation wheels were completed at the beginning and end of FED UP, with children rating each criterion on the wheel on a scale of 1–5.

Table 7: Data from children's evaluation wheels (n=253)

| Dimension | Pre-programme | Post-programme | Statistically significant |
|---|---------------|----------------|---------------------------|
| I can talk to someone if I'm worried about my parent's health | 3.69 | 4.12 | Yes |
| I can talk to my parent about how their drug/alcohol use affects me | 3.09 | 3.48 | Yes |
| I can easily make friends | 4.04 | 4.22 | Yes |
| I could talk to someone if I was being bullied | 4.09 | 4.32 | Yes |
| I am able to have fun when I want to | 4.23 | 4.35 | No |
| I feel supported by others around me | 4.1 | 4.13 | No |

The children's evaluation wheel data indicates that:

- There was an increase in mean scores across all six items on the wheel, which is statistically significant for all except two of the items. This suggests a trend, for those four items, in an improved ability to process thoughts and feelings.
- There is not a statistically significant improvement for being able to have fun and feeling supported by others. However, these remain at a high level, pre- and post-programme (these are the highest scores at T1), suggesting that these may not be areas of concern.

- The lowest mean scores at T1 were for items describing confidence in communicating concerns about parental health and substance use. This highlights particular areas of need for children on the programme.

2.3.1 Changes in children's ability to express their thoughts and feelings

Children described not only being more able to process their thoughts and feelings but also being more able to articulate them. Some children reflected on how they felt more able to talk to their parents about their thoughts and feelings than they had done prior to joining the FED UP group:

"It made me feel relieved because I've been holding it in and I needed to talk."

Girl, 10 years

"I just thought that I couldn't talk to her (mother) about a lot of things, but now I know I can talk to her about loads."

Boy, 13 years

Parents also recognised how their children were more able to assert their thoughts and feelings, where previously they would have allowed them to go ignored and unacknowledged:

"If he starts saying something and I try to interrupt, he says, 'No mum, listen to me', and he couldn't do that before."

Parent, alcohol dependent

A new-found ability to articulate thoughts and feelings also enabled some children to make disclosures about their parent's substance misuse to practitioners and to voice their concerns about issues like contact:

"Around the time that she was on the course the parents were in court with regards to contact, but she felt that she couldn't say that she didn't want to have contact to her social worker previously. So, while she was on the group she gained the confidence to be able to say 'No, I don't want to have contact, and I don't have to'. So she was empowered to be able to put her views across."

FED UP practitioner

Children described a sense of being more able to manage their feelings about their parents and to find ways to communicate these feelings rather than keeping them to themselves.

In summary, the key findings around outcomes for children and young people indicated that:

- Emotional and behavioural problems decreased among children by the end of FED UP.
- A slightly larger proportion of children waiting to receive FED UP saw improvement than those who went through the programme. There was, however, greater clinical change for children who completed the programme, as a higher proportion of those who had received the service moved from the highest level to lower levels of concern compared with the comparison group. This highlights the clinical impact of the programme on children.
- Children's emotional problems, peer problems, hyperactivity and prosocial scoring got worse while waiting to start the FED UP programme. There was a significant improvement in children's emotional and peer problems after completing the programme.
- There was greater improvement for children whose parents engaged in FED UP compared with those whose parents did not engage.
- There was a trend in children's self-esteem improving at the end of FED UP.
- There was an overall increase in children's confidence for talking about their worries related to the impact of parental drug/alcohol use and their ability to access support.

2.4 Factors affecting outcomes for children and young people

The qualitative interviews highlighted key barriers and facilitators to these outcomes for children being achieved.

2.4.1 Facilitators

Learning strategies to improve emotional wellbeing

Children and young people reported that the FED UP group sessions had equipped them with a range of skills to deal with complex emotions they might be experiencing at home, in school and with their peers. These skills included: focusing on strengths, being more assertive in communication and expressing feelings positively:

“It made me feel absolutely great because I’ve never expressed my emotions that way before.”

Girl, 11 years, describing an activity to help manage angry feelings

Children learnt strategies for dealing with anger, which they were able to put to use within the home environment. These included taking some time out to be alone and calm down, and shouting into a pillow to help manage feelings of anger and aggression.

Meeting other children and young people facing the same difficulties

The programme provided children with the opportunity to meet peers experiencing the same difficulties as themselves. Children often felt isolated and alone in their situation and, until joining FED UP, had not been aware of other children, similar to themselves, who were also coping with parental substance misuse.

The peer group provided children with a space where they could listen to others and exchange experiences with other children, not only about substance misuse but also the impact that it can have on their lives, for example in relation to house moves and losses of people and possessions. Some NSPCC practitioners suggested that the shared experience of the FED UP group work was pivotal for enabling children to understand that they were not alone. This was a view that was also expressed by children and parents alike:

“I always felt like I was the only one who had problems; but since I’ve met other people I don’t think that anymore. Since I go to my group [FED UP], it feels nice not being the only person... thinking you’re the only person with problems.”

Girl, 10 years

Sharing their experiences with others helped children realise that this was not something that they had to cope with by themselves or a reason for them to under-value themselves.

The peer group also provided a space for children to build new friendships, which enhanced their enjoyment of the group experience and enabled them to get the most out of participating in the programme:

“Due to his parents’ [substance] misuse he had become very isolated in school, so he doesn’t have many friends. He doesn’t get invited to parties. And he made friends on [FED UP] because he belonged with the other children. Because they had an understanding of what life was like for him.”

Referrer, Adult Drug and Alcohol Services

“The boy...we got put in the same car to go and be brought back [from FED UP group]...We got along even though he was younger, we got along and [NSPCC practitioner] always said we were like brothers and sisters.”

Girl, 13 years

Children could develop close bonds with their peers during the group work, and some older children described how they were able to maintain these new friendships beyond the end of the group. The social element to the programme was valued by children who may have previously struggled socially or felt isolated in the problems that they were facing.

Having a confidential space separate from parents

The peer group provided an environment for children and young people away from the stresses of their home lives. That children and young people were able to speak freely in the group in the knowledge that parents would not hear their discussions was key to children feeling able to share their feelings and contribute their ideas during sessions:

“She was able to talk about her feelings and everything that maybe she didn’t want to tell me because she didn’t want to upset me. So it gave her that, just a little bit away from...you know sometimes mums are a bit too close.”

Parent, drug user (heroin)

Siblings were also allocated to separate groups; this was generally perceived as a strength of the group work, by both service users and practitioners, for the same reason.

Knowing that parents were also engaged

While children valued having a confidential space away from their parents, they also placed importance on knowing that their parents were receiving support from FED UP practitioners. Knowing that their parents were also gaining an insight into how they were feeling was important to children who had not previously been able to express their feelings at home:

“I got to know that she was understanding how I felt about what she was doing and she got to feel what I felt when I was in the position I was in.”

Girl, 12 years

Children also felt that their parent’s participation in the parenting work demonstrated that they were taking the programme seriously, acknowledging the problems they faced as a family and giving them permission to actively participate in the group work. It helped to reduce children’s feelings of guilt for their parent’s substance misuse since they perceived their parent taking responsibility for the problem by participating in the programme. Further, it removed feelings of responsibility for changing the parent’s behaviour or monitoring the impact of substance misuse from lying on the shoulders of the child.

“He didn’t then feel that it was pressure on him to look after mum, he then realised that it was actually something that mum has to handle not me: I can’t check up on mum all the time.”

Referrer, local authority social worker

Supportive practitioners

Children appreciated the way in which practitioners who delivered FED UP enabled them to share their thoughts and feelings over the course of the programme:

“They helped us with stuff, helped us express ourselves, helped us with our feelings; didn’t make it too hard for us.”

Girl, 12 years

The facilitative approach taken by practitioners in supporting children to share their thoughts without making them feel that they had to speak if they did not feel comfortable to do so made it easier for children to enjoy and contribute to group discussions. The way in which practitioners made sessions fun and engaging was also important to children. They valued the wide range of methods and activities

used by practitioners to engage them in FED UP. In particular, children described their enjoyment of using arts and crafts, interactive storytelling, and creative experiments to explore ways of managing their emotions.

Practitioners emphasised the importance of creating an environment where children felt comfortable and listened to. Many were involved in transporting children to and from the sessions and described how this provided valuable opportunities for putting children at ease before the meetings and debriefing afterwards, although this could also put an additional strain on the team's time and capacity.

2.5.1 Barriers

Children's knowledge of substance misuse not matching other group members

Where children and young people felt that the sessions were not pitched according to their existing knowledge of substance misuse, they complained that attending the group had not provided them with any new knowledge and they were likely to disengage from the programme. In particular, where practitioners had to spend longer explaining a particular issue to some children in the group, there was potential for the other children to lose interest since they already had a good grasp of the subject being discussed. This was particularly a problem where the mix of ages within the group was too wide to meet the needs of all of the children within it:

"Like, it was getting kind of boring because we would sometimes go over the same things, again and again. And then we would, like all four of us, would just go off track and we'd just start speaking about different things."

Girl, 13 years

"They [practitioners] did go over and explain but at first they [younger children] were a bit confused. Then it took more time while they were explaining it and then most of us had already finished the activity so we were just standing there waiting."

Girl, 12 years

Having appropriate activities and ensuring there was variety in content that filled gaps in children's knowledge around substance misuse and keeping safe were important to children. Where children did not feel that this was happening, they were less likely to describe positive outcomes from being part of the programme.

Children's sense of loyalty to parents

Where parents were not able to acknowledge their own substance misuse problems or were anxious about their children making disclosures in the group, there was potential for this to discourage children from fully engaging in the work as their sense of loyalty to their parent took precedence:

"He was very aware not to speak about anything and I think his parents reinforced that at home...you know, it was very much a secret subject at home...On one occasion in the group it slipped out that his mum had been to the police station...a colleague said to him, 'Why did your mum go to the police station?' And he said, 'I'm not allowed to say'."

FED UP practitioner

"He was keen to come and he came to the first FED UP group and there was one other boy his age in the group who had already been removed from his mother, who was an alcoholic, and who was very outspoken in his resentment for his mother and condemning of his mother, and I think this child, who was incredibly loyal to his family, he's almost like a parent to his parent, just found it far too difficult and he refused to come back"

FED UP Practitioner

Without a sense of permission from parents or carers to participate in FED UP, some children were hesitant about taking part and were not able to benefit in the same way as their peers who were being supported and encouraged to attend. While practitioners emphasised the issue of family secrets in group sessions, for some children their loyalty to their parents prevented them from feeling able to talk about their home environment and benefiting to the greatest extent from the work.

Changes in staff delivering the programme

As previously explored, practitioners played a key role in facilitating the group and supporting children to achieve positive outcomes from participating in FED UP. Standard practice was for the same practitioner/s to deliver all group work sessions; however, if practitioners were no longer available due to long-term sickness or having left their positions with the NSPCC, it was unavoidable for this to affect the staffing of FED UP groups. Where the lead practitioners changed and sessions were delivered by a different practitioner from week to week, children struggled to build trusting relationships and to warm to them during the course of the work:

“Because there was four different women that did it [ran the sessions] and they would all have their own different way of doing it. So whichever one was doing it on that week you had to get used to their way...”

Girl, 13 years

Consistency in the key practitioner running the sessions was important to children for establishing positive relationships and getting the most out of attending the programme.

Ongoing difficulties at home beyond the end of the programme

Managing the way in which the programme ended was important where it appeared that children had ongoing needs. For some children, it appeared to be difficult to ‘let go’ of the group work; they wanted to continue attending the group and were left feeling disappointed that it had finished, even where practitioners had helped to prepare children for the group ending:

“Yeah when it ended, [my daughter] got quite needy again...[she] felt that everybody that she got close to she lost; so everybody that she cared about, they wasn't true...and she very much said ‘but mummy she only cared because she was doing her job’ and I said ‘no that's not true, she really does care about you’...I think there could be something put in place that they could keep in touch.”

Parent, drug user (heroin)

Children commented how they would have liked to continue coming to the FED UP group. Some practitioners also described their discomfort in the work ending when they felt that children still had a need for continued support:

“With the children who have experienced high levels of trauma, and have to live in that environment as well, continue to live in that environment, yes, there's a gap; the programme doesn't seem long enough.”

FED UP practitioner

This links closely to practitioners' concerns about children returning to homes where substance misuse continues and their needs remain ongoing:

“For a lot of families, it’s not something that just ends when the group ends. The families are still going to go up and down; people are going to relapse; people might still be drinking secretly, thinking their children don’t know.”

FED UP practitioner

In some areas, it was possible for practitioners to refer participants onto other local programmes, appropriate NSPCC programmes or to the NSPCC’s participation group as a way of ensuring that support continued for children with ongoing needs.

Summary

In summary, the key findings around facilitators and barriers to positive change for children are as follows:

- Facilitators of change for children include: learning new strategies to improve emotional wellbeing; meeting others facing similar difficulties; having a confidential space separate from parents; knowing that their parents were also engaged; and being helped by supportive practitioners.
- Barriers to change for children include: children’s knowledge of substance misuse not matching that of other group members; children’s sense of loyalty to their parents; changes in staff delivering the programme; and ongoing difficulties in the home environment.

Chapter 3: Outcomes for parents

In addition to the group work with children, an integral part of the FED UP model is the individual work with the parent who misuses drugs or alcohol. The aim for this work is to reduce parenting behaviours that contribute to the child’s vulnerability and risk, and to enhance the parent–child relationship.

This chapter evaluates the changes for parents/carers related to their protective parenting. It seeks to outline the changes reported by parents through the parent evaluation wheels and the Child Abuse Potential Inventory (CAPI).

3.1 Parents’ perceptions about their parenting and impact of substance misuse

Parents were asked to complete a parent evaluation wheel at the beginning of the work and then again at the end. Table 8 highlights the changes reported by parents.

Table 8: Average scores reported by parents who completed the parent evaluation wheel before and after the programme (n=95)

| Dimension | Pre-programme score | Post-programme score | Statistical significance |
|---|---------------------|----------------------|--------------------------|
| How much I think my child is affected by my behaviour | 3.6 | 4.2 | Yes (p<0.001) |
| How confident I feel that I am doing the best I can for my child | 3.8 | 4.4 | Yes (p<0.001) |
| How supported I feel in taking care of my child | 4.0 | 4.4 | Yes (p<0.01) |
| How confident I feel in asking for help when I need it | 3.7 | 4.4 | Yes (p<0.001) |
| How much knowledge I have about children’s needs at different stages of their development | 3.9 | 4.4 | Yes (p<0.001) |

Parents reported an increase in confidence and understanding across all of the criteria on the parents evaluation wheel, indicating greater insight into the impact of their substance use on their children.

Parents used the evaluation wheel to reflect on how they liked knowing that their children were benefitting from the programme, having the opportunity to talk about their problems and learning techniques to improve things at home. In terms of the aspects of the programme that they did not enjoy, parents described finding it hard

to confront difficult experiences from their past, to deal with their feelings of guilt and to take the time to focus on self-reflection.

In relation to what they felt they had learnt from the programme, one parent commented how they now understood that “*the actions of adults have a tremendous effect on children’s emotions and behaviours*”. These comments highlight some of the insight into the effects of their substance use that the programme helped to bring about.

Comparison group data

The parent evaluation wheel was also completed by parents (n=24) in the comparison group to provide an insight into the impact of FED UP on parents. The differences in mean scores for the comparison group and for the intervention group are displayed in Table 9.

Table 9: Differences in mean scores on the parent evaluation wheel for the comparison group and intervention group

| Evaluation wheel statement | Difference in mean scores between T0 & T1 (Comparison Group, n=24) | Difference in mean scores between T1 & T2 (Intervention Group, n=95) | Change greater for intervention group? |
|---|---|---|---|
| How much I think my child is affected by my behaviour | + 0.41 | + 0.54 | Yes |
| How confident I feel that I am doing the best I can for my child | - 0.08 | + 0.59 | Yes |
| How supported I feel in taking care of my child | - 0.21 | + 0.38 | Yes |
| How confident I feel in asking for help when I need it | + 0.04 | + 0.60 | Yes |
| How much knowledge I have about children’s needs at different stages of their development | + 0.09 | + 0.45 | Yes |

The data indicates greater change for parents who went through the programme compared with the level of change experienced by parents in the comparison group. This suggests greater improvement for parents who received the service compared with those who received the assessment only and highlights the impact of the FED UP programme on parents. However, due to the small size of the comparison group, and the absence of standardisation of the evaluation wheel, this data should be interpreted with some caution.

3.2 Change in behaviours that contribute to risk

The previous section explored whether parents experienced any change in their knowledge and confidence. This section now examines whether those changes translated into changes in their protective parenting behaviour, perceived by the parents themselves. The key standardised measure that was used to assess this change was the CAPI.

The Child Abuse Potential Inventory (CAPI)

Ninety-two parents completed a CAPI at both Time 1 and Time 2, but only 59 of these (64 per cent) were valid for analysis purposes. Table 10 outlines the changes reported by parents who completed the CAPI at both T1 and T2, and indicates if this difference is statistically significant or not.

Table 10: Average scores reported by parents who completed the CAPI before and after the programme (n=59)

| Subscale | Pre-programme | Post-programme | Statistically significant |
|--|----------------------|-----------------------|----------------------------------|
| Distress (cut off point of 152) | 153.3 | 132.5 | Yes (p<0.001) |
| Rigidity (cut off point of 30) | 10.2 | 10.4 | No |
| Unhappiness (cut off point of 23) | 29.9 | 25.6 | Yes (p=0.02) |
| Problems with child and self (cut off point of 11) | 6.8 | 5.1 | Yes (p=0.02) |
| Problems with family (cut off point of 18) | 13.5 | 14.6 | No |
| Problems with others (cut off point of 20) | 15.4 | 15.4 | No |
| Total score (cut off point of 215) | 229.2 | 203.6 | Yes (p<0.001) |
| Ego strength scale | 15.6 | 18.5 | Yes (p<0.001) |
| Loneliness scale | 9.5 | 8.7 | Yes (p=0.03) |

The average total score for parents on the CAPI decreased by the end of the programme. This change is statistically significant and crossed the threshold from a level of clinical concern of 215, indicating an overall improvement in parents' protective behaviours at the end of the programme that is clinically significant.

The CAPI subscales also provide a helpful insight into where changes took place:

- The statistically and clinically significant improvement in parents' level of distress suggests parents felt less frustrated, more in control and had a greater sense of self-worth by the end of FED UP.
- The statistically significant improvement in problems with the child and the self remained below the cut-off point, suggesting that this was not an area of concern for parents.

- The improvement in unhappiness levels was statistically significant but remained at a clinical level, suggesting that, while things had improved for parents, they may have continued to experience some difficulties in relationships, feeling generally unhappy in life or perhaps having a sense of inferiority to others.
- Parents' rigidity did not change over the course of the programme, but did remain within the normal threshold, suggesting that they do not have a particularly authoritarian parenting style.
- Problems with family and others also remained within the normal threshold, indicating that parents were getting on with their families and did not appear to perceive social relationships as the cause of their personal difficulties.
- There is a statistically significant improvement in the subscales of parents' ego strength and their level of loneliness. There are no cut off points for these subscales, but they indicate that parents may be feeling more emotionally stable at the end of FED UP and less isolated and alone.

3.2.1 Change in risk according to type of substance misuse

Of those parents who completed the CAPI at both time points (n=59), 24 per cent were drug users, 53 per cent were alcohol users, 15 per cent used both drugs and alcohol, and the type of substance misuse was not recorded for the remaining 8 per cent. The change in total CAPI scores, broken down by type of parental substance misuse, can be found in Table 11.

Table 11: Total CAPI results broken down by type of substance misuse

| Type of substance misuse | Pre-programme | Post-programme | Statistically significant |
|--------------------------|---------------|----------------|---------------------------|
| Alcohol (n=31) | 236.0 | 200.8 | Yes (p=0.007) |
| Drugs (n=14) | 240.9 | 239.5 | No |
| Drugs and alcohol (n=9) | 175.9 | 157.3 | No |

Breaking down this small sample into sub categories produces very small groups of data that need to be interpreted with caution. The key observations from this analysis are as follows:

- There is a statistically significant and clinically significant improvement in parents' protective parenting behaviours among those with alcohol misuse problems. The programme, therefore, appears to be particularly effective in bringing about changes for parents with alcohol problems.

- Only 14 parents with drug misuse problems completed the CAPI both at the beginning and end of the programme. There was no improvement for these parents, whose needs remained at a clinical level by the end of the programme. However, since this group is very small it is not possible to describe this change as a trend for all drug using parents on FED UP.
- The smallest subgroup of parents were those using both drugs and alcohol. This cohort of parents appears to present the lowest level of risk as they start and end the programme within the non-clinical range. While their scores improve, this change is not statistically significant. Again, due to the very small size of this group, it is not possible to generalise this finding for all parents using the service with both drug and alcohol problems.

3.3 Examples of changes for parents

So far, this chapter has explored the main outcomes for parents who took part in FED UP; this second part will provide more of an insight into these changes in parenting skills and protective behaviours, with some examples from the qualitative interviews.

Improved communication and more time for children

A key change that parents described at the end of the work was how they felt more able to set time aside for their children. They also reflected on how they were more able to listen to their children and their concerns, and to talk to them calmly, in a way that they may not have been able to previously:

“I think they probably feel that they can talk to me now instead of talking to each other and you just get a calmer vibe, I can make time for them more than I did.”

Parent, alcohol dependent

“Yeah we would spend quite a little bit more time together and stuff and it has worked, we’re getting on a lot better and there’s a lot more smiling and less shouting and yeah things are getting better, a lot better; I’m happy for a change”.

Parent, drug dependent

Children also acknowledged how their parents had changed and become calmer in their communication. They described feeling more able to talk to their parents in a way that they had not been able to prior to the programme. Parents were able to make their children feel comfortable and listened to. Further to this improvement in

communication, parents were also more proactive in organising time together as a family:

“I think what’s been different is dad is being a lot quieter and he’s doing a lot more different things for us. Last week, he took us to the chip shop and then into the arcade.”

Girl, 11 years

Parents recognised that they may not have been previously available for their children and were able to provide their children with more opportunities to talk to them and for the family to spend time together.

Improved household organisation

Children recognised changes that their parents had made to improve the home environment. These included: less shouting; creating a calmer atmosphere; improving routines around bedtime; and setting clearer boundaries about expectations at home and outside of the home:

“They’re good changes in my family, it’s a bit quieter, there’s not a lot of shouting and I can just chill out when I want...I think because I can go to bed early, because when my mum was around she always shouted and I couldn’t get to sleep quick because there was shouting”

Girl, 11 years

“Well my mum’s more calmer as I’ve said. Stepdad is working a lot more than he normally does and my sisters, like, they’re more happy. Yeah. I’m more happy.”

Boy, 11 years

The changes that parents made at home were acknowledged by parents themselves and also by their children. Improvements at home contributed to the whole family feeling happier and more relaxed.

In summary, the key findings around outcomes for parents were as follows:

- The quantitative data collected from parents indicates that parents perceived a greater confidence in their parenting skills at the end of the programme as well as an improvement in their protective behaviours.

- Improvement in parents' understanding of the impact of their substance misuse was greater for those who had completed the programme than for those in the comparison group, reflecting the impact of the programme on outcomes for parents.
- Qualitative data highlighted examples of change in parenting skills and protective behaviours, including improved communication with their children and household organisation.

3.4 Factors affecting outcomes for parents

3.4.1 Facilitators

Time to reflect on the impact of substance misuse

The programme provided parents with an important, and often emotionally challenging, space to reflect on their past behaviours relating to their substance misuse, their relationships with others and their overall parenting approach. For many of them, it was their first opportunity to think about how their actions might be affecting their children:

“Hard but it’s happened and I can’t get away from it. No it’s not very nice talking about it but it’s done me good because it’s made me think and maybe even come to terms with and to start forgiving myself a bit.”

Parent, alcohol dependent

“For her it was about acknowledging that she hadn’t really been emotionally available to him [child], and I think she found that really painful, so that brought up a lot of feelings about guilt and pain for her; that she’d not been there when he’d needed her, she’d not been able to respond to his needs for hugs. She’d also been in a domestic abuse relationship with the boy’s dad and he’d also pushed the child away as well, so lots of issues came up about that for her.”

FED UP practitioner

For many parents, realising the emotional impact of their behaviour on their children was the prompt for them to want to bring about change in terms of listening more to their children, and acted as a motivation to address their drug/alcohol use.

Opportunity to get an insight into children's perspective

Having a greater understanding about the impact of their own behaviour was often linked to parents reporting that the programme had helped them to see situations more from the perspective of their child:

"I hadn't thought before about how things had affected [my son] – in particular of him feeling insecure and as if people didn't want him and things like that...I hadn't before thought that he must have felt these things."

Parent, alcohol dependent

Practitioners described how sharing children's activities from the group work with their parents was a particularly powerful way of giving parents an insight into their children's perspectives:

"Dad had to acknowledge what was there in front of him, it was like 'He [child] was asked to draw his family and he drew you with a load of beer bottles around you, that's his view of you'. And so he was forced really to look at his behaviour and see that was affecting his children. And he did that; we had a big change around that family."

Referrer, primary school

"I took him [the dad] the Minging Man...he looked at that and he said, 'Oh, well I've got all of them, haven't I?' So it is an effective tool and it can be used in lots of different ways, but just in terms of acknowledging and recognising, 'If this is how I look or feel, my children see that all the time'."

FED UP practitioner

The Minging Man activity, usually used in the children's group to explore the effect of drugs and alcohol on the body, was also effectively used in encouraging parents to actively reflect on how they must appear to their children. The joint sessions at the end of the programme played a key role in providing an opportunity to hear directly from their children about how they had been feeling:

“Children felt able to talk freely in front of the parents and express to them their concerns and the parents spoke to them... sometimes it was with a bit of a remorse really, how they didn't realise what they'd put their children through.”

Referrer, local authority social worker

Learning new approaches to parenting

Parents said that the programme had given them new ways of managing challenging behaviour through advice on setting boundaries. Parents observed that FED UP had helped them realise the importance of talking rather than shouting and the tone of voice they used as a strategy to minimise conflict:

“When [son] is kicking off usually I'd end up kicking off and we'd have an argument – now, not so much. I actually speak to him rather than shout at him. I didn't realise how much I shouted and stuff, especially when we were outside.”

Parent, alcohol dependent

The safety planning exercise, which was part of the joint work at the end of the programme, enabled parents to commit to certain changes in their parenting to ensure that children were kept safe and for children to acknowledge this change:

“Although the parents weren't actually together, they'd agreed to do that [safety planning] together and to do it with the child, and that was about not allowing the child to go out unsupervised – he was seven – and would go off and play and he would cross two busy roads to go and call on a friend who might or might not be in.”

FED UP practitioner

Safety planning, therefore, created a space for parents to discuss with their children what would be expected from them, for children to express what they needed and for parents to commit to providing support and to set clear boundaries with the support of an NSPCC practitioner.

Focusing on strengths and building confidence

Parents felt that the FED UP work had helped increase their confidence as it focused on their strengths, motivating them to bring about positive change:

“I never used to speak up [before FED UP], but then I did, I found my voice finally. And they’ve [NSPCC] given me the address of the refuge centre to go to them, do a weekly course with them as well; which I did. And I passed as well. So everything I was doing I was getting positive feedback, which drove me more.”

Parent, alcohol dependent

With an improved sense of confidence, parents described how they felt more positive about the future, their ability to improve their parenting skills and to tackle their substance misuse problems. The focus on strengths within the programme also helped parents to feel more positive about themselves. Practitioners and referrers described changes in parents’ self-esteem and the way in which they took care of themselves while attending the programme:

“She started to put weight on, her complexion got better. She started to take care of herself. She started to take pride in her appearance. She had a haircut, she smiled a lot more. She walked with her head up.”

Referrer, primary school

Approach of practitioners

The aspects of the approach taken by practitioners that parents valued included: the ability to provide weekly support that took into account the immediate needs of the family; flexibility to adapt the programme to the individual needs of the parent; and not being judgemental:

“Well I didn’t say that to [NSPCC worker] but it was...the way that she was with me that made me think that she didn’t think that I was some kind of monster; do you know what I mean? I mean at first I didn’t know whether I was looking forward to it or not because I thought whoever was coming here was going to sit here and judge me and think that I was this and that and the other but [the NSPCC worker] wasn’t like that at all.”

Parent, alcohol dependent

Some parents reflected that the positive engagement with the NSPCC worker enabled them to have a more realistic understanding of the dynamics in the family and hence they were better able to discuss ways of addressing issues affecting the family.

Practitioners described the importance of going at the pace of the parent and not moving forward to the next topic of discussion until they were certain that the previous issue had been fully explored. They also stressed the need to work with parents through difficult topics of conversation and not feel uncomfortable about encouraging parents to reflect on emotional issues:

“Not to try and say, ‘It’s okay, let’s move on’, to actually say ‘No, stay with that pain, how does that pain feel?’.”

FED UP practitioner

It was important that practitioners were flexible in their approach, understanding of how individuals preferred to engage and delivering the programme as appropriate. Further, parents felt reassured to know that practitioners were professionals who they could call on for advice when needed and that the support they provided was not confined to the weekly sessions:

“Even if I’ve got things on my mind, there was always somebody there I could pick up the phone and tell...it’s good to know that there’s somebody there, someone’s always there to pick up the phone to.”

Parent, drug user (cannabis)

3.4.2 Barriers

Struggling to reflect on the past

For some parents, reflecting on their past and thinking about painful memories was too difficult a process to engage in:

“She was able to say, ‘Actually I found that really painful’, and it was bringing up issues for her that she couldn’t deal with and it was about her own childhood and her own experiences with her dad and why did she start using drugs, and the fact her dad gave it to her when she was quite young, and lots and lots of issues that have just remained unresolved for her.”

FED UP practitioner

Where parents had painful life experiences, potentially including their own abuse as a child or within a relationship as an adult, which they were not yet ready to talk about, engaging in a process of reflection was particularly challenging. Parents were able to identify those exercises that they found difficult as a consequence of this:

“I think that was quite difficult to go on a timeline. She [NSPCC worker] was able to manage it, yeah, but I think then the following week she came she wanted to do the timeline again and I just was opting out the whole session. Yeah, didn't like the timeline.”

Parent, drug dependent

Not enough joint work and group work for parents

Some parents would have liked more work with the family unit as a whole, especially group work with teenagers and young adults who did not meet the FED UP age eligibility criteria. Parents felt that there were very few services for these young people and the absence of such services negatively impacted on the progress for the family.

Parents also felt that a greater involvement of extended family and the child in sessions would help develop more effective support plans for the family. This was particularly the case where other family members, such as grandparents, played a key role in providing care to the children, as well as where children were living with foster carers. Parents or carers who did not have the substance misuse problem also suggested it would be helpful to be included in more sessions in order to be better equipped to support future safeguarding.

In addition to having more family members involved in the programme, some parents also suggested that they would have found it helpful to attend a group with other parents to gain support, similar to that received by children in their group:

“It would have been better to bring the parents and the children together, because it was very separate, and it would have been nice to have done some work together, and also it would have been nice to meet the other parents and hear how other people were coping.”

Parent, alcohol dependent

Not being ready to acknowledge the impact of substance misuse

Practitioners and referrers tended to agree that those parents who were able to benefit the most from the programme were less frequent users, those who had already made a commitment to change and who were ready to make a change. It was often more difficult to engage parents who were not ready or prepared to acknowledge the impact of their substance misuse on their children. In particular, where children were on child protection plans, it seemed that parents felt they had to participate in the programme and were not necessarily ready to take part.

In circumstances where there was a lot of chaos at home and where parents presented practitioners with complex and pressing problems at each session, it was more challenging to engage them in the work and to focus on their substance misuse rather than other issues. In such situations, it could sometimes be a challenge for practitioners to bring the work with the parent and with the child to a close at the same time. This could have implications for when joint work between the parent and child could take place.

Parents' willingness and motivation to engage in the work were also perceived to change regularly, often in relation to other problems they were facing. Some concern was expressed, among practitioners and referrers, that parents who were waiting for their children to be allocated to a group might be demotivated to take part by the time that the parenting work began.

In other circumstances, parents went through the parenting work but did not appear to have gained any insight into the impact of their substance misuse on their children:

"In one particular situation where I was with a girl in the end session, her mother was very critical of her and, sort of saying, 'When you are being quiet I don't know what you are thinking' and 'You need to tell me what you are thinking' and, you know, sort of critical – putting the responsibility on the daughter."

FED UP practitioner

In instances where parents were unable to recognise how their behaviour was affecting their child, they continued to place the responsibility for improving their situation on their children.

Summary

In summary, the key findings around facilitators and barriers to positive change for parents are as follows:

- Facilitators for change included: time to reflect on the impact on the family; opportunity to gain an insight into the children's perspectives; learning new approaches to parenting; focusing on strengths and building confidence; and the approach of practitioners.
- Barriers to change included: struggling to reflect on the past; not enough joint and parent group work; and not being ready to acknowledge the impact of substance misuse on their child.

Chapter 4: Exploring sustained change

4.1 Sustained changes for children and young people

Children's emotional and behavioural difficulties at six-month follow-up: SDQ

Sixty-five SDQs were completed by children at all three time points: Time 1 (start of the programme), Time 2 (end of programme) and Time 3 (six months after the programme was completed). The data indicates a decrease in mean scores between Time 1 (14.8) and Time 2 (13.9) and then a rise again at Time 3 (14.7). The changes are not statistically significant, indicating that improvements in children's emotional and behavioural problems are not sustained beyond the end of the programme.

Understanding change across clinical and non-clinical bands: Clinical change has also been explored for this cohort of children. The distribution of the data at Time 1, Time 2 and Time 3 is presented in Table 12.

Table 12: Distribution of clinical and non-clinical SDQ data from Time 1 to Time 3

| | T1 | T2 | T3 |
|--------------|----|----|----|
| Non-clinical | 44 | 49 | 46 |
| Clinical | 21 | 16 | 19 |

The table indicates that most cases started and ended in the non-clinical range and, again, fell within the non-clinical range at Time 3. There was a small increase in the number of non-clinical cases by the end of the programme, which then reduced a small amount at Time 3.

The movement into the non-clinical or clinical bands at Time 3 from the pre- and post-programme scores is displayed in Table 13.

Table 13: Clinical change at Time 3 for the SDQ

| Bandings at T1 and T2 | Non-clinical T3 (n=46) | Clinical T3 (n=19) |
|------------------------------------|-------------------------------|---------------------------|
| Non-clinical T1 and T2 (n=41) | 34 | 7 |
| Non-clinical T1, Clinical T2 (n=3) | 1 | 2 |
| Clinical T1 and T2 (n=13) | 6 | 7 |
| Clinical T1, Non-clinical T2 (n=8) | 5 | 3 |

The data from Table 13 indicates that:

- Most children who were part of this sample started and ended FED UP within the non-clinical level of difficulty (n=41).
- Of these children, the majority also remained at a non-clinical level at Time 3, indicating little change for this group of children beyond the end of the programme.
- Twenty-one children in this sample started FED UP with a clinical level of difficulty. Over half of these cases (n=13) also ended the programme with a clinical level of need, but nearly half of these children (n=6) had improved to a non-clinical level at Time 3. This suggests that improvement is possible for some children beyond the end of FED UP.
- Of those children who started FED UP with a clinical level of need, and improved to a non-clinical level at Time 2 (n=8), most remained within the non-clinical threshold at Time 3 (n=5).
Clinical change was, therefore, sustained for most of these children.

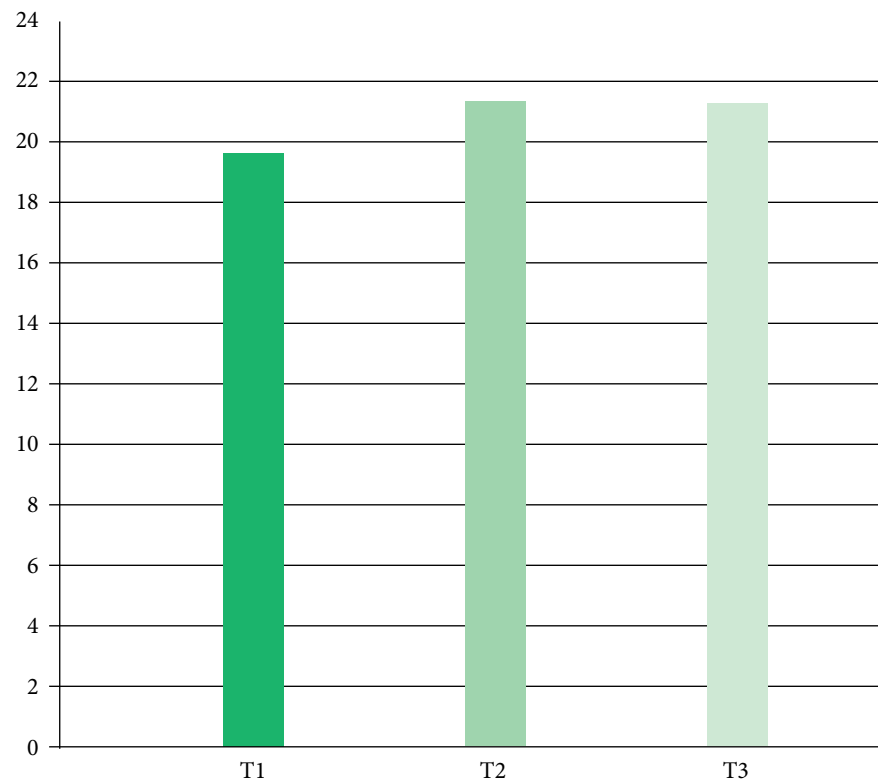
Although these numbers are very small, they do suggest that children who start in the clinical range of the SDQ may still achieve and maintain a non-clinical level of emotional and behavioural need beyond the end of FED UP.

The fact that so few cases in this sample start within the clinical range means that it is difficult to draw firmer conclusions about whether clinical change is sustained. A larger sample of cases that started at a clinical level and were followed up at Time 3 may allow for more in-depth analysis.

Children's self-esteem: Adapted Rosenberg Self-Esteem Scale

Eighty-eight children completed the Adapted Rosenberg Self-Esteem Scale before and after FED UP and again at six-month follow-up. Figure 9 shows the average scores at each time point.

Figure 9: Adapted Rosenberg Self-Esteem Scale scores pre- and post-FED UP and at six-month follow-up



The mean scores suggest a pattern of children’s self-esteem increasing by the end of FED UP and remaining at a higher level six months later. Mean scores were as follows: 19.7 at Time 1, 21.4 at Time 2 and 21.3 at Time 3; the increase in score between Time 1 and Time 3 is statistically significant. It is worth noting that the main improvement occurs by the end of the programme and there is no further change between the end of the programme and the point of six-month follow-up. This suggests that positive change in children’s self-esteem is sustained beyond the end of the programme but does not appear to improve further beyond the programme ending.

4.2 Sustained changes for parents

Thirty-two CAPIs were collected from parents at all three time points. Of the 32 sets, only 19 of these (59 per cent) were valid at all time-points.

Sustained change in behaviours that contribute to risk: CAPI

Due to the small sample, it was not possible to run any statistical analysis; rather, descriptive analysis has been used to explore changes for this cohort of parents. The mean scores for each CAPI subscale at Time 1, Time 2 and Time 3 are outlined in Table 14.

Table 14: Average scores reported by parents who completed the CAPI pre- and post-programme and at six-month follow-up (n=19)

| | Pre-programme | Post-programme | Six-month follow-up |
|---|---------------|----------------|---------------------|
| Total score (cut off point of 215) | 243.26 | 230.79 | 239.74 |
| Distress score (cut off point of 152) | 162.77 | 157.11 | 162.55 |
| Rigidity score (cut off point of 30) | 10.39 | 11.5 | 10.66 |
| Unhappiness score (cut off point of 23) | 32.17 | 30.72 | 31.17 |
| Problems with family (cut off point of 18) | 13.83 | 14.17 | 12.11 |
| Problems with child (cut off point of 11) | 8.39 | 5.72 | 7.44 |
| Problems with others (cut off point of 20) | 16.67 | 15.17 | 16.94 |
| Ego strength | 14.39 | 14.78 | 14.10 |
| Loneliness scores | 9.94 | 10.61 | 10.72 |

The data indicates that:

- The level of improvement in the total mean score is not sustained six months after the programme; however, it remains at a lower level than at the start of FED UP. This suggests that, while improvements are not sustained for this group of parents, neither do they deteriorate to the point they were at when they started the programme.
- Total scores at all three time points remain above the clinical threshold, indicating parents' level of need remains high throughout the programme and after its completion.
- The Distress and Unhappiness subscales also remain at clinical levels at Time 1, Time 2 and Time 3, suggesting they remain as issues of concern.
- Problems with child and Problems with others also deteriorated once the programme had ended but remained below the clinical threshold. While change may not have been sustained in these areas, they do not appear to be issues of concern to these parents.
- Ego strength and Loneliness also deteriorate at Time 3. These are notable because they are worse than at Time 1.

The sample of parents who completed the CAPI at all three time points is very small. It does not reflect the larger pre- and post-programme sample, who showed a greater level of clinical improvement by the end of FED UP (although the characteristics of these two samples were very similar – see Appendix 5). A larger

sample of parents at Time 3 would enable more reliable conclusions to be reached regarding sustained change for parents.

Summary

In summary, the key findings from this chapter on sustained change are as follows:

- Changes in children's emotional and behavioural problems, according to mean scores of the SDQ, are not sustained after the programme.
- There is some clinical improvement at Time 3 for children who started FED UP at a clinical level of need. However, the sample of children who started the programme within the clinical threshold, on the SDQ, is too small to draw firm conclusions about sustained clinical change.
- Improvements in children's self-esteem at the end of FED UP are sustained beyond the end of the programme.
- The sample of parents who completed the CAPI at Time 3 is too small to draw firm conclusions around sustained change for parents. However, for that cohort of parents who were part of the Time 3 sample, there does not appear to be sustained improvement in protective parenting.

Chapter 5: Conclusion and discussion

Pre- and post-programme data has provided a positive picture of improvement for parents and children at the end of FED UP. Improvements in children's outcomes appear to be fairly small but they do indicate a change for children in the correct direction, as hypothesised in the theory of change. The evaluation has highlighted a statistically significant improvement in all of the anticipated outcomes for children and parents at the end of the programme: children's emotional and behavioural problems; self-esteem; and ability to process their thoughts and feelings; and an improvement in parents' protective parenting as well as greater insight into the impact of their substance misuse on their children. The change for parents at the end of FED UP is larger than the comparison group and is clinically significant, with mean CAPI scores crossing the threshold to a non-clinical level at the end of the programme.

The outcomes data has been supported by the small comparison group. Families who were part of the comparison group had been assessed for FED UP, attending up to four assessment sessions with an NSPCC practitioner, but were waiting to be allocated to an appropriate FED UP group. Comparison group data indicated a greater change for parents following FED UP, compared with those waiting to start the programme. Data from children provided a slightly more mixed picture, with greater clinical change for those who completed the group work but a slightly higher level of improvement (reduced scoring on the SDQ – but not crossing the clinical threshold) for those children in the comparison group. A clinically significant change was defined as one that moved from the clinical to non-clinical range on the SDQ. These findings suggest the possibility that the assessment period supports a process of change for children, which begins before the FED UP programme itself commences. It also highlights the importance of the programme in bringing about a clinical level of change.

Children and parents who participated in FED UP and took part in qualitative interviews described feeling a greater confidence in speaking about the impact of drugs and alcohol within the family. This suggests the importance of the programme in supporting families to talk about drugs and alcohol in a more honest way, developing a positive environment for families to discuss their worries, feel valued and seek support.

At follow-up, six months after completion of the programme, there was a sustained improvement to children's self-esteem; however, it appears that improvements to their emotional and behavioural difficulties were not sustained. The small sample of parents at follow-up also makes it difficult to draw any firm conclusions regarding the extent to which improvements to protective behaviours are sustained beyond the end of FED UP.

5.1 Suggestions for improvement

There were a number of suggestions from children and parents, as well as practitioners and referrers, regarding ways in which the programme could be improved. Parents emphasised the importance of involving all family members, including extended family members in the joint work to ensure that the family felt supported in achieving change that was sustained after the end of the programme. Both children and parents spoke about how they would have valued the provision of longer-term or drop-in support once the programme had finished, or signposting to other services that could provide such support on a more ongoing basis.

Findings regarding the importance of parental engagement for ensuring outcomes for children may suggest that using a tool for determining parental capacity to change during the assessment could be helpful for identifying parents who would be able to engage effectively in the programme. It was also suggested by practitioners that being able to offer individual, one-to-one work with some children who struggled with being part of a group would be beneficial.

5.2 Discussion

5.2.1 Learning from the comparison group: importance of the first point of contact

The SDQ data from the comparison group has highlighted that there is a small amount of improvement for children from the assessment process and waiting period before beginning on the FED UP programme. This improvement suggests that the assessment period is an important starting point for establishing supportive relationships with practitioners. It is also likely to be the beginning of the process for children of gaining an insight into substance misuse and its effects.

It highlights the importance of families' first point of contact with FED UP, since this appears to mark the beginning of the process of change for children, before the programme itself has started. Seeing parents being supported by practitioners during the assessment process may have reassured children that they were being helped by

professionals who had respect for them and their families. Families may also feel more hopeful about the service as a result of practitioners seeing through their commitment to revisit them to carry out an assessment, several weeks after their initial referral. This presents a question around the extent to which the assessment is actually perceived as part of the intervention itself, since these were seen as distinctive pieces of work in the evaluation design.

However, that there is greater clinical change for children and greater overall improvement for parents who were part of the intervention group does indicate that improved outcomes for parents and children could not be achieved without involvement in the full FED UP programme.

5.2.2 The needs of children accessing the service

The SDQ data has also provided a valuable insight into the clinical needs of children at the start and end of the programme. It was noted that there was a statistically significant shift in the proportion of children who started FED UP with a clinical level of need and who ended with a non-clinical level of need. However, it also emerged that over 50 per cent of children started and ended the programme within the non-clinical threshold and that around a third of children were left within the clinical threshold at the end of the programme.

That a large proportion of children appeared to join the programme below the clinical threshold may raise questions regarding who FED UP is for. Providing a programme like FED UP to children who may not yet have been harmed to a great degree is important from a prevention perspective. Ensuring that children receive support before they are displaying clinically concerning difficulties helps to keep them safe from harm should things deteriorate at home. It should also be noted that a key element of the inclusion criteria was that the level and complexity of children's needs should not lead them to cause disruption and prevent them – or others – from participating in the programme. That children's needs may not have fallen within the clinical range when they joined FED UP does not necessarily mean that they did not benefit from participating in the programme. Indeed, a child does not have to be in clinical need to benefit from the FED UP work.

It is also important to acknowledge the various challenges of accurate measure completion at the start of an intervention where respondents may not always feel able to respond honestly or accurately to the questions they are being asked. This may mean that some level of clinical need among children was not picked up on at the start of the evaluation.

At the other end of the spectrum were those children who started and ended FED UP with a clinical level of need. This raises questions around the length of the programme and the potential that it has to address entrenched issues affecting families. For some families where substance misuse persisted or a range of other factors (such as the presence of domestic abuse, mental health problems, contact with the criminal justice system or frequent house moves) continued, there may have been a need for support to exist beyond the 10 weeks of group work.

The mix of clinical and non-clinical need among children at the start of the programme may reflect the mixed make-up of the children's groups, which enabled them to run successfully. The range of need and ability within the group may have encouraged children to support one another and participate comfortably within the group context. However, it was also highlighted that this range in knowledge and understanding within a group should not be so broad as to prevent the group from moving through the activities at the same pace. This further indicates the importance of the assessment period for enabling the appropriate allocation of children to groups where their needs can be effectively met.

5.2.3 The effectiveness of FED UP for parents

The positive outcomes highlighted by the CAPI data reflect the effectiveness of FED UP for parents who were able to complete the programme. That there is both statistical and clinical significance in this improvement in the CAPI data underlines the effectiveness of the programme in achieving outcomes for parents. However, it is not clear whether this change is sustained for parents.

This finding also raises questions about how the programme could enable those parents who dropped out from FED UP early to complete the programme and realise these positive outcomes too. This is a particularly pertinent issue when considering rates of service attrition among parents, with only 56 per cent of those who started in the programme completing FED UP in full, representing a third of parents who were referred to the service.

The exploration of facilitators and barriers to outcomes being achieved for parents reflects the importance of parents being able to confront the impact of their substance misuse, to reflect on their past and to acknowledge the effect of their behaviour on their children. This is an important finding for considering who may benefit the most from the parenting work and for understanding some of the reasons behind service drop-out.

5.2.4 Programme design as a key factor for achieving outcomes

The qualitative element of the evaluation has highlighted the importance of the structure of FED UP. Children valued the opportunity to have space away from their parents, of knowing that their parents were also committed to their part of the programme and to having the opportunity to share their learning and listen to their parents in the joint work. Similarly, parents placed importance on their children receiving support from the group, participating in individual work with a practitioner and developing a safety plan with their child. These separate components of FED UP were valued for facilitating outcomes for families.

It is also a key finding that outcomes for children appear to be closely linked to parental engagement in the programme. This highlights the importance of the FED UP model, which includes work for both the child and the parent. It also raises questions about why parents might not engage in the parenting work and the specific needs of those children whose parents opt out of, or are unable to, participate. This may also relate to a barrier highlighted in this report of children feeling that they need their parents' encouragement to take part in FED UP. Where parents are reluctant to engage themselves, it is possible that they may also be discouraging of their children's involvement.

This finding draws attention to the value of each of the components of the programme as well as raising questions about how the needs of children whose parents or carers are not able to engage could also be supported.

5.2.5 Making change sustainable: reviewing the theory of change and future developments

Programmes like FED UP have a potential significance in bridging the gap between adults' and children's services and this could be significant for improving safeguarding of children. There was limited evidence, however, for the sustainability of outcomes achieved. This was partly a methodological limitation and further evaluation could address that. It does also suggest, however, that the theory of change for the programme should be reviewed. A fuller articulation of families' multiple and enduring needs has to be presented and the theory of change should then specify how the programme would address the practice challenges arising from these. For example, this study found the potential of the assessment phase for engaging with parents and this needs to be situated within a more nuanced understanding of the challenges of engaging with parents in these circumstances.

The outcomes outlined in the programme's theory of change are primarily for children. It is obviously the hope that the programme will benefit children, but a more sophisticated series of intermediate outcomes around changes in parental awareness, parenting behaviour and parent-child relationships are required. This is particularly significant given the finding that children's outcomes were often determined at least to some extent by the level of their parent's engagement with the programme. There have been challenges in keeping parents engaged with the programme and this has undermined the "whole family" ethos of the programme, which needs to be reinforced.

The programme is very limited in duration and this raises a question about dosage: is it reasonable to expect a 10-week programme to generate change that is sustained in the context of multiple and enduring needs and disadvantage? The theory of change and practice guidance needs to address more explicitly the position of FED UP within the wider systems and networks for families. In addition, more attention needs to be paid to societal and structural factors that contribute to the families' disadvantage and which act as barriers to change. This will be addressed through a new initiative the NSPCC is promoting in selected areas: Together for Childhood. There will be three projects for families experiencing multiple adversities, including drug and alcohol misuse, mental health difficulties and domestic abuse. A public health approach will be adopted, promoting prevention at different levels and the ethos of the projects will be collaborative, to work in partnership with local communities and agencies. It is hoped that these projects will be transformative in their local areas by generating systems and cultural change through workforce development, campaigns and empowering local communities and service users to set priorities and oversee progress.

Bibliography

- Adamson, J. and Templeton, L. (2012) *Silent Voices, supporting children and young people affected by parental alcohol misuse*. London: Children's Commissioner
- Advisory Council on the Misuse of Drugs (ACMD) (2003) *Hidden harm: responding to the needs of children of problem drug users: the report of an Inquiry by the Advisory Council on the Misuse of Drugs*. London: Home Office
- Barlow, J. and Schrader McMillan, A. (2010) *Safeguarding Children from Emotional Maltreatment: What Works Well*. London: Jessica Kingsley Publishers
- Barnard, M. and Bain, C. (2015) Resisting your good intentions: substance-misusing parents and early intervention to support and monitor children in need. *Child and Family Social Work*, 20(2): 171–180
- Barnard, M and McKeganey, N (2004) The impact of parental problem drug use on children: What is the problem and what can be done to help? *Addiction*, 99:552–559
- Brandon, M., Bailey, S. and Belderson, P. (2010) *Building on the learning from serious case reviews: a two-year analysis of child protection database notifications 2007–2009*. London: Department for Education (DfE)
- Brooks, C. and Rice, K. (1997) *Families in Recovery: Coming Full Circle*. Baltimore: Paul H. Brookes Publishing Co.
- Child Welfare Information Gateway (2004) *Risk and Protective Factors for Child Abuse and Neglect*. Washington DC: Child Welfare Information Gateway
- Cleaver, H., Unell, I. and Aldgate, J. (2011) *Children's Needs – Parenting Capacity. Child Abuse: Parental mental illness, learning disability, substance abuse and domestic violence*. London: TSO
- Dawe, S. and Harnett, P. (2007) Reducing potential for child abuse among methadone- maintained parents: results from a randomized controlled trial. *Journal of Substance Abuse Treatment*, 32(4): 381–90
- Department of Health (DH), Department for Education and Employment (DfEE) and Home Office (2000) *Framework for the assessment of children in need and their families*. London: The Stationery Office (TSO).

- Devaney, J., Bunting, L., Hayes, D. and Lazenbatt, A. (2013) Translating Learning into Action: An overview of learning arising from Case Management Reviews in Northern Ireland 2003–2008. London: NSPCC
- Forrester, D. and Harwin, J. (2006) Parental substance misuse and child care social work: findings from the first stage of a study of 100 families. *Child and Family Social Work*, 11(4): pp325–335
- Forrester, D. and Harwin, J. (2011) Parents who misuse drugs and alcohol: effective interventions in social work and child protection. Chichester: Wiley-Blackwell
- Goodman, R. (1997) The strengths and difficulties questionnaire: a research note. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 38(5) 581–586
- Hogan, D. and Higgins, L. (2001) When Parents Use Drugs: Key Findings from a Study of Children in the Care of Drug-Using Parents. Dublin: The Children’s Research Centre
- Holland, S., Forrester, D., Williams, A. and Copello, A. (2014) Parenting and substance misuse: understanding accounts and realities in child protection contexts. *British Journal of Social Work*, 44: 1,491–1,507
- Houmoller, K., Bernays, S., Wilson, S. and Rhodes, T. (2011) Juggling Harms: Coping with Parental Substance Misuse. London: London School of Hygiene and Tropical Medicine
- Kroll, B (2004) ‘Living with an elephant: Growing up with parental substance misuse’. *Child and family social work*, 9(2): 129–140
- Manning, V., Best, D., Faulkner, N. and Titherington, E. (2009) New estimates of the number of children living with substance misusing parents: results from UK national household surveys. *BMC Public Health* 9: 377
- Milner, J.S. (1986) The child abuse potential inventory manual. 2nd edn. Dekalb, Illinois: Psytec
- Morris, R. (1981) Society and the Adolescent Self-Image. Revised edition. Middleton, CT: Wesleyan University Press
- O’Connor, L., Forrester, D., Holland, S. and Williams, A. (2014) Perspectives on children’s experiences in families with parental substance misuse and child protection interventions. *Children and Youth Services Review*, 38: 66–74

- Ritchie, J. and Lewis, J. (2003) *Qualitative Research Practice: A guide for social science students and researchers*. Sage Publications: London
- Sawyer, E. and Burton, (2012) *Building resilience in families under stress: supporting families affected by parental substance misuse and/or mental health problems*. 2nd edition. London: National Children's Bureau (NCB)
- Scottish Executive (2003) *Getting our priorities right: Good practice guidance for working with children and families affected by parental substance misuse*. Edinburgh: Scottish Executive
- Templeton, L (2012) Supporting families living with parental substance misuse: The M-PACT (Moving Parents and Children Together) programme. *Child and Family Social Work*, 19: 76–88
- The Coram Family (2002) *Intervening Early: A 'snapshot' of approaches primary schools can use to help children get the best from school*. Nottingham: Department for Education and Skills
- Velleman, R. and Templeton, L. (2007) Understanding and modifying the impact of parents' substance misuse on children. *Advances in Psychiatric Treatment*, 13: 79–89
- Wing, J.K., Curtis, R.H. and Beever, A.S. (1996) *HoNOS: Health of the Nation Outcome Scales: Report on Research and Development July 1993–December 1995*. London: Royal College of Psychiatrists

APPENDICES

Appendix 1: Programme details

Overview of sessions

Overview of sessions for children:

Session 1: Can you break the FED UP code?

This introductory session begins the process of forming the group and allowing children to get to know each other and the facilitators. It is also to enable the group to agree rules that will form the written agreement.

Session 2: Getting to know you

This session explores where the child sees themselves in relation to their family and the roles taken on by the child and other family members. The session aims to support children in understanding that families are all different, have different support systems and may have different rules, but that they all share a common bond of living or having lived in a substance using environment.

Session 3: Safety in the home and community

This session is focused on both educating and raising awareness of how children can keep themselves safe at home and in the community through development of basic strategies and who they can turn to as a trusted adult if they have worries or concerns.

Session 4: Living with chaos

This session aims to help the children process some of their memories connected to house moves and acknowledge the impacts.

Session 5: Good and bad habits and the ripple effect on families

The session aims to help the child begin to understand the problems and begin to share feelings about the impact their parent's behaviour has upon them.

Session 6: Friends and bullies; healthy relationships

This session is aimed at helping children to explore their experiences of bullying and to consider the impact of being a bully themselves. Towards the end, the session introduces the concept of ‘when adults bully’. This is aimed at leading the group into the next session to talk about relationships at home where control, bullying and violence may be a feature.

Session 7: Angry Adults: Family Secrets

Many of the children who attend the FED UP group will also have experienced the impact of domestic abuse. This session has often enabled children to tell their own stories, although they will usually do so in the third person.

Session 8: My feelings

This session links to the last session in continuing to support children to talk about their experiences in a safe and confidential environment, except where clear child protection issues emerge.

Session 9: First aid: presented by a qualified first aider

Substance using parents are often suspicious of emergency services and external agencies. This session aims to demystify the emergency services and help the children see them as a place they can turn to for help.

Session 10: Goodbyes

A key outcome for our work is to ensure that children are cared for safely, that their needs are being met and identifiable risks are reduced. A key message is that children should not be responsible for managing their own safety. However, it is intended that this group work programme will have raised the child’s understanding and awareness of what they can do to help keep themselves safe.

Overview of sessions for parents:

Session 1: My Child’s Story

This session focuses on the child’s needs and safety in order to understand the child’s experience of family life so far, and for the parent to highlight key strengths and areas of difficulty that they identify from their child’s story.

Session 2: My Child's Story (continued)

As described in Session 1. The child's story may be complex and there may have been a lot of changes taking place, such as periods of alternative care, exposure to domestic abuse and violence, and involvement of statutory agencies.

Session 3: The Caring Circle

This session identifies current support systems and key relationships, and focuses on assessing how these impact on parenting and the child's world.

Session 4: Every Child has Needs

This session focuses on making the parent clear about their responsibility and role as a parent. It aims to give them an improved understanding and knowledge of their child's needs that is developmentally appropriate and begins to consider ways in which these are met, partially met or not met.

Session 5: Living with the Elephant

This session enables the parent to see their substance misuse as another family member. It supports them in understanding the impact of their substance use upon the child, and challenges the myth that their child does not see what is occurring in their family.

Session 6: The Parent's Cycle

This session explores with the parent their substance using history and links this to the cycle of change. It aims to help the parent identify where they are now on the cycle of change, and to identify possible goals that can achieve change.

Session 7: The Rollercoaster of Change

This session helps the parent to understand the emotional impact their substance use has upon their child. It explores the child's vulnerability and resilience, and the parent's motivation to make or sustain change in their parenting behaviour.

Session 8: Keeping my Child Safe

This session aims to develop a safety plan that looks at all aspects of safeguarding the child from harm.

Overview of joint sessions for parents and children:

Session 1

This session brings together the parent and child to recap on the work they have both done through group work and one-to-one sessions. The aim is to enable the parent and child to share their experiences and learning from the programme and to open up the communication between them about family life – for the child to have their feelings acknowledged by the parent and for the parent to seek to release the child from taking responsibility for their behaviours.

Session 2

This is a joint session with the parent and child to develop a safety plan that both can own and share ownership of.

Programme inclusion and exclusion criteria

Threshold: Children can be referred across the spectrum of need but, as this is a targeted service, the minimum expectation is that children will be subject to Common Assessment if not a Child in Need plan, Child Protection registration or a Child Protection plan.

If the parent does not engage or drops out of the programme:

The inclusion criteria makes clear that no child should be penalised for their parent not engaging or disengaging in this programme. It is vital that all children have the opportunity to receive a service unless their own needs are a barrier. Children who also live with alternative carers but who continue to be exposed to their parent's lifestyle through contact will also be included. See below.

Exclusion criteria – children: Children who have severe behavioural difficulties will be too disruptive to manage within a group work setting and are likely to impact negatively upon others in the group. It is also not appropriate for children who are known to be experimenting with substances to be included as their needs require a different service and a referral should then be made.

Experience has told us that some children have parents who are highly resistant and are not supportive of their child attending the group; nor do they wish to engage themselves. Such situations are likely to have a negative impact upon the child as they will not be supported emotionally to attend and sabotage is likely.

Siblings: Experience has also shown us that it is not possible to work with more than one sibling in a group work setting. The child lacks the freedom to be themselves. They may have the role of carer within the family or have taken on a level of emotional responsibility for their parent or sibling, which would then impact on their level

of engagement if another sibling is present. It is possible to include the sibling in a later group programme. The parent would engage in the work again with another sibling to support them through the programme.

Treatment: The parent does not have to be in treatment in order to access this service. However, it will be important to establish through the initial assessment process that the parent is sufficiently stable and that there are no known identifiable factors that would disrupt the programme of work. This is an important factor, as experience has shown that if the parent is too chaotic in their use, they are unable to sustain a programme of work and the child often then drops out of the group programme too. It will be important to instigate child protection procedures if the impacts upon the child are assessed as being harmful.

We hope that there will be some parents at the end of the programme that feel sufficiently motivated to seek treatment and support.

Non-substance-using parent: We are hoping to establish whether the level of engagement from parents may be a factor in improved outcomes for the child. The focus of the parenting programme will, therefore, be on the primary care giver, whether or not they are the substance user.

We consider that it is important to involve where possible all of the adults involved in caring for the child.

Non-using parents have a crucial role to play in ensuring the child's needs are met by understanding the impact upon the child of the other parent's/carer's misuse and in establishing an effective safety plan for the child.

Role of fathers/cohabitee: Other consistent/constant adults in the child's life should be assessed and offered the programme of work. Men who are on the periphery need to be known about, particularly when assessing risk, and appropriate steps should be taken to share information with relevant agencies if concerns arise.

Alternative carers: The parenting programme is also designed to include carers who provide alternative care to children.

Appendix 2: Interview schedules

Interview schedule for children

1. **Genogram:** to understand more about you and your family
2. **About the programme:** how many, how long ago, what you liked – why, what did you not quite like – why; exercises; what you remember about the group (spider diagram).
3. **Specifically about the group experience**
 - How did you feel about working with the other children in your group?
Did you enjoy this most of the time or not? (explore: group dynamics)
(If yes) What did you like about this?
(If no) What didn't you like about this?
 - How did you feel about talking about things which have happened to you and your parent?
If yes, did you find it any easier to talk about things after you had been at the groups a bit longer?
Did you feel any better or worse after talking about these things?
4. **Changes before and after:**
 - 4.1 **How you feel life is going for you overall**
 - Did they make you feel differently about yourself?
 - 4.2 **Change in understanding about your parent's drug or alcohol misuse**
 - Do you feel you learnt anything about your parent's situation?
 - 4.3 **Change in talking about your parent's behaviour with others**
 - Did they make you feel differently about your parent?
 - 4.4 **Change in your own behaviour**
 - Have you noticed any changes in yourself at home, with friends or in school?
 - 4.5 **Change in your parent's behaviour**
 - Do you think they feel better after this work or not?
 - 4.6 **Change in your relationships**
 - Have you noticed any changes in how you get on with others and your parents?

5. Comments on how the safety plan worked

- How did you feel about doing the joint work with your parent?
- Did you enjoy this most of the time or not?
- (If yes) What did you like about this?
(If no) What didn't you like about it?
- Is there anything that could be done to make the FED UP programme better?
If yes, please explain

Interview schedule for parents

- 1) On the whole, how would you describe your experience on this programme?
For example, has it been a mostly positive or negative experience?
- 2) Was there anything you particularly liked or disliked about the individual work?
(Prompts used if necessary) For example, any particular sessions, anything in general about the sessions.
- 3) Do you think this experience has helped you in any way, or not?
(Prompts used if necessary) For example, coping with your past experiences, relating to your child, understanding your child better, feeling better about yourself.
 - 3a) (If yes) Please give details.
 - 3b) (If no) Are there any reasons you feel this work has not helped you?
- 4) Do you think the groups/work have helped your child in any way, or not?
(Prompts used if necessary) For example, coping with their past experiences, affecting their behaviour in any ways, dealing with their emotions differently.
 - 4a) (If yes) Please give details
 - 4b) (If no) Are there any reasons you think they have not helped?
- 5) Do you feel that your relationship with your child has been affected in any way by the FED UP program?
 - 5a) If yes, how has it been affected?
(Prompts used if necessary) For example, positively or negatively?
- 6) How have you felt about talking about things that may have happened in your past to the worker?
(Prompts used if necessary) For example, have you found it hard/easy? What has been hard/easy?

- 7) How have you felt about talking about your experiences with your child in the joint work?
(Prompts used if necessary) *For example, have you found it hard/easy? What has been hard/easy?*
- 8) Has this programme made you think differently about anything that has been discussed?
8a) (If yes) What do you think you have learnt?
(Prompts used if necessary) *For example, where do you think you would go to get this support?*
- 9) What did you think of the worker on the programme?
(Prompts used if necessary) *For example, in terms of how well you related to them, how easy it was to talk to them, how they dealt with the group, how they dealt with sensitive issues.*
- 10) Do you have any suggestions of how this service could be improved?

Interview schedule for FED UP practitioners

| Theme | Need to explore |
|---|---|
| 1. Introduction and sharing of specific cases (before the interview, practitioners will be asked to think of a case where they perceived a high level of change for the family and one where there was no change for the family. This will be used as the starting point for discussion.) | <ul style="list-style-type: none"> • Changes that took place for the case where a positive outcome was perceived: <ul style="list-style-type: none"> – What did these changes look like and when did they take place? Was there change for everyone in the family or just the parent? Child? Those family members receiving the FED UP service? – Can the success of this case be attributed to any specific aspects of the programme? – Can the success of this case be attributed to any aspects of the family's circumstances at the point of starting the programme (for example, parent not having misused substances for a number of months)? • Do you still have contact with the family? <ul style="list-style-type: none"> – Have these changes been sustained? • The case where no changes/negative changes occurred: <ul style="list-style-type: none"> – Who took part in the programme? Any significant issues at home? – What do you think were the barriers to change coming about for the child/parent? – Do you think any changes to the programme structure/content could have changed outcomes for that family at all? • Do you still have contact with the family? Do you know if there have been any changes to their situation since completing FED UP? • How do these cases compare to other children/parents you have seen come through the programme? |

| Theme | Need to explore |
|---|--|
| 2. Programme structure: Exploring the experience and value of each component of the programme – group work, parent work and joint work | <ul style="list-style-type: none"> • Experience of delivering each component of the programme? For example, parent work, group work, joint work. • Views on the strengths and challenges of each component of the programme? • Any particular group work sessions/activities that were helpful for bringing about outcomes for children? Any sessions that stand out as being less helpful? • Any particular parent work sessions that were especially helpful for improving protective parenting? Any that were less helpful? • Usefulness of the manual for carrying out sessions with parents and children? • Anything that would have helped to better deliver this programme? • Views on key skills needed to be able to deliver FED UP effectively? |
| 3. Implementation issues | <ul style="list-style-type: none"> • Process of work – creating groups of children with similar ages, managing demand over geographical area, managing endings, referring on. • Support structures needed to deliver the service |
| 4. Access to the service | <ul style="list-style-type: none"> • What helped referrals come in or not? • What were the views of referrers? |
| 5. Drop-out from the programme and long-term changes | <ul style="list-style-type: none"> • Most common reasons for children/parents to drop out from the programme • Types of approaches to preventing programme drop out • Any changes that could be made to the programme to help retain parents/children • Knowledge of changes for children/parents who completed the programme • Where do families tend to be six months later? Views on longer term impact of FED UP on children/parents |
| 6. Evaluation – measures | <ul style="list-style-type: none"> • Experience of using the measures – benefits and challenges |

Interview schedule for FED UP referrers

Background

- Did they make the referral to FED UP themselves?
- Did they work with the family throughout their period of involvement in FED UP?
- Is the case still open?
- How many other cases referred to FED UP in the past?

Reason for referral to the NSPCC

- Why did they think it would be a useful programme for the family to have access to?
- What did they hope that the family would get out of participating in the programme?
 - Improved protective parenting
 - Confidence of the child
 - Improved ability of the child to keep themselves safe
 - Change in child protection status

Views on the programme

- Did it address the issues that they expected it to address?
- Thoughts on the structure and content of the programme – group work, parent work, joint work
- Whether the programme filled any gaps in their own work
- Whether there is anything missing from the programme that would support their work with the family more

Contact with the NSPCC

- Level of contact with the NSPCC over the course of the families' involvement with the FED UP programme:
 - Updates on changes for the family in relation to: level of participation in the programme; passing on any concerns that arose during the course of the work; communicating positive changes during the course of the programme.
 - Level of contact felt right
- Time it took to allocate children to a group

Longer-term changes

- Check if still involved in the case
- Change for the child/children since taking part in the programme
 - Ability to stay safe, understanding of parent's condition, change in confidence/self-esteem
- Change for parent/s since taking part in the programme
 - Protective parenting knowledge; understanding impact of substance misuse on the child
- Change in relationships within the family since taking part
- Change in risk levels for parent/s since taking part in the programme
- Change in relationship between the family and children's services since taking part
 - *Probe for whether any changes might be attributed to the programme*
- Check if they ever refer to any other similar services in the local area – how does FED UP compare?
- Are there any improvements that could be made to the programme?
- Any other comments or suggestions

Appendix 3: Ethics overview

All NSPCC practitioners delivering FED UP attended evaluation training in order to gain an understanding of how the evaluation worked and the key ethical considerations in carrying out the evaluation. The ethical issues central to this evaluation are listed below:

- **Gaining informed consent from service users** – practitioners explained the purpose of the evaluation to service users, their role within the evaluation and the way in which information they shared with the evaluation team would be used. Service users consented to the evaluation with a clear understanding of these issues. Consent forms were signed at pre- and post-programme by parents who were happy for themselves and their child to take part in the evaluation. Verbal consent was obtained from children regarding their participation in the evaluation. The same process is also being used for those parents and children who are part of the comparison group.
- **Data protection, security and confidentiality** – it was explained to service users that all information that they shared with the evaluation team would be treated in the strictest confidence unless they shared something with the team that raised concerns about a child's safety. The information sheet explained that the data would be held securely and how it would be used to inform analysis and reporting.
- **Option to withdraw from study** – service users understood at the time that they consented to be part of the evaluation that they could change their mind at any time and withdraw their involvement or contribution to the evaluation before the final report is produced.
- **Protection of participants** – practitioners were requested to use their judgement when asking service users to take part in the evaluation, particularly regarding their capacity to cope with completing certain measures to ensure that doing so did not cause them any harm. This was especially crucial when administering the CAPI, which is a lengthy measure containing some difficult and personal questions that may cause parents to reflect on their lives in such a way that causes them a level of distress. Practitioners were able to use their judgement regarding where the CAPI should not be completed; this was particularly important when working with parents with mental illness or drug/alcohol misuse

problems. Similarly, practitioners were able to use their judgement to ensure that service users who may have felt vulnerable in an interview situation were not included in the sample for qualitative interviewing. In this way, participants were protected from any potential harm. All interviews were gently wound down at the end to ensure that participants were left feeling as upbeat as possible.

- **Advice/support for participants** – should any evaluation participant be left feeling in need of extra support following an interview, researchers were able to suggest services that might be able to help them. While practitioners administered measures with service users, they were able to discuss any feelings that completing the measures had brought up and obtain advice and support directly from their NSPCC worker.
- **Debriefing** – all interviews and completion of measures ended with a discussion regarding how the service user found taking part in the evaluation to ensure that they felt comfortable with what they have just done and to provide them with the opportunity to ask any questions that they may have had.

Appendix 4: Standardised measures

The Strengths and Difficulty Questionnaire (SDQ)

- The SDQ measures the emotional and behavioural problems of children and young people; measuring strengths as well as difficulties.
- It has been used in the Framework for the Assessment of Children in Need and their Families (Department of Health et al, 2000) and by CAMHS Outcome Research Consortium (CORC).
- Young people aged 11 years or over, and younger children who practitioners felt were able to complete the SDQ alone, were offered the self-complete version of the questionnaire. The SDQ was completed by the parent/carer if the child was younger than 11 or unable to complete it themselves.
- It contains four difficulty subscales: hyperactivity; conduct problems; emotional symptoms; and peer problems – plus a strength subscale of prosocial items.
- The higher the total score, the higher the level of difficulty.
- There are four scoring thresholds for the total scores and subscale scores: very high, high, slightly raised and close to average.
- For the purposes of understanding clinical change, the two lower bands and two higher bands have been grouped together and have been defined as non-clinical or clinical difficulty respectively.

HoNOSCA (Health of the Nation Outcome Scales Child and Adolescent Mental Health)

- The HoNOSCA captures practitioners' perspective on children's behavioural and emotional difficulties.
- It measures the range of physical, personal and social problems associated with mental health.
- Practitioners provide a score between 0 and 4 for each of 13 criteria set out in the HoNOSCA covering four broad categories: behavioural problems; impairment; symptomatic problems; and social problems.
- There are no clinical cut off points for HoNOSCA; rather, it allows for a change in average scoring to be identified over the course of the programme.

Adapted Rosenberg Self-Esteem Scale

- The self-esteem questionnaire is based on the Rosenberg Self-Esteem Scale and was adapted by the NSPCC for use with children.
- Since it has been adapted, it is not standardised and, therefore, no clinical thresholds are available.
- It is relatively short (10 statements); includes reversed scoring.
- Total scores range from 0–30 with a higher score indicating a higher level of self-esteem

Child Abuse Potential Inventory

- Developed in the 1970s by Joel Milner to assist social services in the US to screen parents who ‘potentially’ may be at risk of physically abusing their child. Subsequently, it has been used as an assessment tool and for evaluation purposes.
- Used for FED UP as an evaluation tool only and not for predicting abuse. It is a reliable tool for measuring change in protective parenting.
- Validated to determine six key aspects:
 - Attitude: Rigidity, Distress, Unhappiness
 - Interpersonal: Problems with child and self, problems with family, problems from others
- Also includes scales to measure ego strength and loneliness.
- Inbuilt validity scales to filter out parents who may be faking good responses or being inconsistent or random in their responses.
- More than 1,000 journal articles, chapters, books, dissertations, theses, convention papers, and unpublished reports describing the psychometric characteristics and/or applications and/or limitations of the CAPI.
- 160-item questionnaire. Cut off score of 215 indicates that parents with scores above this threshold have poor protective parenting behaviours.

Evaluation wheels

- Evaluation wheels are completed by parents and children and are not standardised measures.
- Respondents rate themselves between 1 and 5 (1 being low, 5 being high) against 5 criteria (parents) and 6 criteria (children), such as confidence in being able to do the best for their children (Parents’ wheel) and being able to talk to parents about their drug or alcohol misuse (Children’s Wheel).

Appendix 5: Characteristics of children and parents at each point of the referral journey and the evaluation

Characteristics of parents

| Stage of case | Characteristics of parents/carers | |
|--|-----------------------------------|--|
| Point of referral (n=612) | Type of substance use | 44% alcohol , 37% drugs, 16% both, 3% not recorded |
| | Parent/carer engaged | 61% mothers, 19% fathers, 19% non-substance-using parent/carers (68% female, 27% male, 5% not recorded), 1% not recorded |
| Start of assessment (n=481) | Type of substance use | 47% alcohol, 35% drugs, 14% both, 4% not recorded |
| | Parent/carer engaged | 58% mothers, 20% fathers, 21% non-substance-using parent/carers (70% female, 26% male, 4% not recorded), 1% not recorded |
| Start of the intervention (n=347) | Type of substance use | 50% alcohol, 33% drugs, 14% both, 3% not recorded |
| | Parent/carer engaged | 58% mothers, 18% fathers, 24% non-substance-using parent/carers (69% female, 26% male, 5% not recorded) |
| End of FED UP (not full programme) (n=59) | Type of substance use | 48% alcohol, 32% drugs, 15% both, 5% not recorded |
| | Parent/carer engaged | 53% mothers, 15% fathers, 32% non-substance-using parent/carers (79% female, 16% male, 5% not recorded) |
| End of FED UP (full programme) (n=196) | Type of substance use | 52% alcohol, 31% drugs, 12% both, 5% not recorded |
| | Parent/carer engaged | 55% mothers, 17% fathers, 28% non-substance-using parent/carers (71% female, 29% male) |

| Stage of evaluation | Characteristics of parents/carers | |
|--|--|--|
| All at T1 (n=226) Of which valid for analysis (n=166) | Type of substance use for all | 39% alcohol, 26% drugs, 13% both, 22% not known |
| | Type of substance use for valid completions only | 42% alcohol, 22% drugs, 13% both, 23% not known |
| | Parent/carer | 49% mothers, 14% fathers, 15% non-substance-using parent/carers (76% female, 24% male), 22% not known |
| | Parent/carer for valid completions only | 52% mothers, 14% fathers, 11% non-substance-using parent/carers (74% female, 26% male), 23% not known |
| Pre- and post-programme (n=92) Of which valid for analysis (n=59) | Type of substance use for all | 42% alcohol, 22% drugs, 13% both, 23% not known |
| | Type of substance use for valid completions only | 53% alcohol, 24% drugs, 15% both, 8% not known |
| | Parent/carer | 57% mothers, 20% fathers, 10% non-substance-using parent/carers (70% female, 30% male), 13% not recorded |
| | Parent/carer for valid completions only | 61% mothers, 19% fathers, 10% non-substance-using parent/carers (83% female, 17% male), 10% not recorded |
| Pre, post and 6-month follow-up after programme (n=32) Of which valid for analysis (n=19) | Type of substance use for all | 50% alcohol, 28% drugs, 13% both, 9% not known |
| | Type of substance use for valid completions only | 53% alcohol, 21% drugs, 16% both, 10% not known |
| | Parent/carer | 56% mothers, 28% fathers, 9% non-substance-using parent/carers (100% female), 7% not known |
| | Parent/carer for valid completions only | 63% mothers, 32% fathers, 5% not recorded |

Characteristics of children

| Stage of case | Characteristics of children | |
|--|-----------------------------|--|
| Point of referral (n=583) | Gender | 45% girls, 51% boys, 4% not recorded |
| | Age | 1% under 5; 28% 5 to 7 years; 45% 8 to 10 years; 26% 11 years and over |
| Start of assessment (n=522) | Gender | 47% girls, 51% boys, 2% not recorded |
| | Age | 29% 5 to 7 years; 47% 8 to 10 years; 24% 11 years and over |
| Start of the intervention (n=419) | Gender | 48% girls, 51% boys, 1% not recorded |
| | Age | 26% 5 to 7 years; 49% 8 to 10 years; 24% 11 years and over; 1% not recorded |
| End of FED UP (not full programme) (n=47) | Gender | 49% girls, 51% boys |
| | Age | 26% aged 5 to 7 years; 40% aged 8 to 10 years; 34% aged 11 years and over |
| End of FED UP (full programme) (n=341) | Gender | 48% girls, 50% boys, 2% not recorded |
| | Age | 28% aged 5 to 7 years; 50% aged 8 to 10 years; 21% aged 11 years and over; 1% not recorded |

| Stage of case | Characteristics of children | |
|-------------------------|-----------------------------|---|
| T0 only (n=56) | Gender | 34% girls, 45% male, 21% unknown |
| | Age | 18% 5 to 7 years; 43% 8 to 10 years; 18% 11 years and over; 21% unknown |
| T0 and T1 (n=27) | Gender | 41% girls, 59% boys |
| | Age | 19% 5 to 7 years; 62% 8 to 10 years; 19% 11 years and over |
| T1 only (n=350) | Gender | 36% girls, 39% boys, 25% unknown |
| | Age | 16% 5 to 7 years; 42% 8 to 10 years; 18% 11 years and over; 24% unknown |
| T1 and T2 (n=180) | Gender | 47% girls, 53% boys |
| | Age | 14% 5 to 7 years; 48% 8 to 10 years; 18% 11 years and over; 20% unknown |
| T1, T2 and T3 (n=65) | Gender | 42% girls, 40% boys, 18% unknown |
| | Age | 14% 5 to 7 years; 45% 8 to 10 years; 23% 11 years and over; 18% unknown |

N.B. The reason for the high level of unknown data for both parents and children (around 20 per cent) is a result of evaluation data being connected to the case of a child for the CAPI or the parent for the SDQ, which made it difficult to link this to the characteristics of the appropriate individual.

Appendix 6: Statistical analysis and qualitative data management

Excel was used to carry out one-tailed T-Tests to look at the change in mean scores between the beginning and end of FED UP. The McNemar test on SPSS allowed for proportional movement between the clinical and non-clinical threshold to be tested for and the Repeated Measures ANOVA and Friedman’s 2-way ANOVA were also used in SPSS to test the changes in mean scores across three time points – pre- and post-programme and at six-month follow-up.

I. Strengths and Difficulties Questionnaire data: Change in mean score, pre- and post-FED UP based on the one-tailed T-Test (n=180)

| SDQ subscale | Mean at T1 | Standard Dev. at T1 | Mean at T2 | Standard Dev. at T2 | P Value |
|------------------------|-------------------|----------------------------|-------------------|----------------------------|----------------|
| Emotional difficulties | 3.96 | 2.22 | 3.56 | 2.10 | 0.008* |
| Conduct problems | 3.22 | 2.12 | 3.11 | 2.08 | 0.24 |
| Hyperactivity | 4.98 | 2.42 | 4.91 | 2.37 | 0.33 |
| Peer problems | 3.44 | 2.39 | 3.21 | 2.34 | 0.04* |
| Prosocial | 8.05 | 1.96 | 8.03 | 2.06 | 0.44 |
| Total score | 15.59 | 6.55 | 14.82 | 6.2 | 0.03* |

* Statistically significant

II. (a) Strengths and Difficulties Questionnaire data: Proportional shift in children from a clinical level of difficulty (High and Very High) to a non-clinical level (Close to Average and Slightly Raised) between the beginning and end of FED UP. Based on an Exact McNemar’s Test (n=180)

| Level of difficulties | Pre-programme (per cent) | Post-programme (per cent) | P Value |
|---|---------------------------------|----------------------------------|----------------|
| Non-clinical range (Close to Average and Slightly Raised bands) | 57.22% | 65.56% | 0.04* |
| Clinical range (High and Very High bands) | 42.78% | 34.44% | |

* Statistically significant

II. (b) Strengths and Difficulties Questionnaire data: Movement of children from a level of clinical need to non-clinical need (and vice versa) at the end of FED UP (n=180)

| | Clinical level of need post-FED UP | Non-clinical level of need post-FED UP |
|---------------------------------------|---|---|
| Clinical level of need pre-FED UP | 47 | 30 |
| Non-clinical level of need pre-FED UP | 15 | 88 |

III. Adapted Rosenberg Self-Esteem Scale Questionnaire for Children: Change in mean score, pre- and post-FED UP. Analysis based on the one-tailed T-Test (n=216)

| | Mean at T1 | Standard Dev. at T1 | Mean at T2 | Standard Dev. at T2 | P Value |
|-------------|-------------------|----------------------------|-------------------|----------------------------|----------------|
| Total score | 19.56 | 5.26 | 21.10 | 5.16 | 0.000* |

*Statistically significant

IV. HoNOSCA: Change in mean score, pre- and post-FED UP. Analysis based on the one-tailed T-Test (n=180)

| | Mean at T1 | Standard Dev. at T1 | Mean at T2 | Standard Dev. at T2 | P Value |
|-------------|-------------------|----------------------------|-------------------|----------------------------|----------------|
| Total score | 6.55 | 5.21 | 5.67 | 5.13 | 0.004* |

*Statistically significant

V. CAPI: Change in mean scores, pre- and post-FED UP. Analysis based on the one-tailed T-Test (n=95)

| | Mean at T1 | Standard Dev. at T1 | Mean at T2 | Standard Dev. at T2 | P Value |
|----------------------|-------------------|----------------------------|-------------------|----------------------------|----------------|
| Distress | 153.29 | 70.45 | 132.51 | 74.12 | 0.001* |
| Rigidity | 10.24 | 10.74 | 10.41 | 11.10 | 0.45 |
| Unhappiness | 29.88 | 20.51 | 25.59 | 18.71 | 0.02* |
| Problems with child | 6.85 | 7.82 | 5.12 | 6.34 | 0.02* |
| Problems with family | 13.54 | 12.30 | 14.59 | 13.72 | 0.21 |
| Problems with others | 15.42 | 6.86 | 15.41 | 7.71 | 0.49 |
| Total score | 229.22 | 101.45 | 203.63 | 101.19 | 0.001* |
| Ego strength | 15.66 | 10.57 | 18.49 | 10.98 | 0.001* |
| Loneliness | 9.46 | 4.12 | 8.73 | 4.58 | 0.03* |

* Statistically significant

VI. Parents' evaluation wheel score, pre- and post-FED UP.
Analysis based on the one- tailed T-Test (n=94)

| | Mean at T1 | Standard Dev. at T1 | Mean at T2 | Standard Dev. at T2 | P Value |
|---|-----------------------|------------------------------------|-----------------------|------------------------------------|----------------|
| How much I think my child is affected by my behaviour | 3.62 | 1.25 | 4.16 | 1.10 | 0.000* |
| How confident I feel that I am doing the best I can for my child | 3.84 | 1.02 | 4.43 | 0.69 | 0.000* |
| How supported I feel in taking care of my child | 4.03 | 1.11 | 4.41 | 0.84 | 0.001* |
| How confident I feel in asking for help when I need it | 3.75 | 1.29 | 4.35 | 0.91 | 0.000* |
| How much knowledge I have about children's needs at different stages of their development | 3.92 | 0.94 | 4.37 | 0.65 | 0.000* |

* Statistically significant

VII. Children's evaluation wheel score, pre- and post-FED UP.
Analysis based on the one-tailed T-Test (n=253)

| | Mean at T1 | Standard Dev. at T1 | Mean at T2 | Standard Dev. at T2 | P Value |
|--|-----------------------|------------------------------------|-----------------------|------------------------------------|----------------|
| I can talk to someone if I'm worried about my parent's health | 3.69 | 1.41 | 4.12 | 1.18 | 0.000* |
| I can talk to my parent about how their drug/ alcohol use affects me | 3.09 | 1.62 | 3.48 | 1.59 | 0.001* |
| I can easily make friends | 4.04 | 1.28 | 4.22 | 1.20 | 0.02* |
| I could talk to someone if I was being bullied | 4.09 | 1.33 | 4.32 | 1.10 | 0.003* |
| I am able to have fun when I want to | 4.23 | 1.19 | 4.35 | 1.15 | 0.07 |
| I feel supported by others around me | 4.1 | 1.10 | 4.13 | 1.25 | 0.38 |

*Statistically significant

VIII. Adapted Rosenberg Self-Esteem Scale Questionnaire for Children: Change in mean score, pre-, post- and six-months following FED UP. Analysis based on the repeated measures ANOVA (n=88)

As the data violated the assumption of sphericity, we used the values in the “Greenhouse-Geisser” row. Using an ANOVA with repeated measures with a Greenhouse-Geisser correction, the mean scores increased significantly over time ($F(1.854, 161.282) = 5.462, p < 0.006$).

| Descriptive Statistics | Mean | Std. Deviation | N |
|---------------------------------|-------------|-----------------------|----------|
| Rosenberg T1 Total score FED UP | 19.70 | 5.494 | 88 |
| Rosenberg T2 Total score FED UP | 21.40 | 4.945 | 88 |
| Rosenberg T3 Total score FED UP | 21.27 | 5.422 | 88 |

| Source | | Type III Sum of Squares | df | Mean Square | F | Sig. |
|-----------------|--------------------|--------------------------------|-----------|--------------------|----------|-------------|
| Rosenberg FedUp | Sphericity Assumed | 156.689 | 2 | 78.345 | 5.462 | .005 |
| | Greenhouse-Geisser | 156.689 | 1.854 | 84.523 | 5.462 | .006 |
| | Huynh-Feldt | 156.689 | 1.892 | 82.797 | 5.462 | .006 |
| | Lower-bound | 156.689 | 1.000 | 156.689 | 5.462 | .022 |
| Rosenberg FedUp | Sphericity Assumed | 2495.977 | 174 | 14.345 | | |
| | Greenhouse-Geisser | 2495.977 | 161.282 | 15.476 | | |
| | Huynh-Feldt | 2495.977 | 164.644 | 15.160 | | |
| | Lower-bound | 2495.977 | 87.000 | 28.689 | | |

IX. Strengths and Difficulties Questionnaire data: Change in mean score, pre-, post- and six-months following FED UP. Based on the Friedman’s 2-way ANOVA by ranks (k samples) test

The SDQ data was skewed; therefore, a Friedman’s 2-way ANOVA by ranks (k samples) test was used to look at change across the three timeframes.

| | Mean | Std. Deviation | N |
|---------------------------|-------------|-----------------------|----------|
| SDQT1 Total score FED UP | 14.80 | 6.645 | 65 |
| SDQ T2 Total score FED UP | 13.98 | 6.321 | 65 |
| SDQ T3 Total score FED UP | 14.75 | 7.192 | 65 |

Hypothesis Test Summary

| | Null Hypothesis | Test | Sig. | Decision |
|---|--|--|------|----------------------------|
| 1 | The distributions of SDQT1, SDQT2 and SDQT3 are the same | Related Samples Freidman's Two-Way Analysis of Variance by Ranks | .369 | Retain the null hypothesis |

Asymptotic significances are displayed. The significance level is .05

Framework themes and sub-themes for FED UP interviews

Framework in NVivo was used to analyse interview transcripts. Data was classified and organised in the analytical frameworks according to key themes, concepts and categories.

Framework for children and parent interviews

- 1.0 Analysis of standardised measure
- 2.0 Practitioner case closure summary
- 3.0 Family environment
- 4.0 Changes after or during programme
 - 4.1 Talking about the issue and impact
 - 4.2 Knowledge or confidence in dealing with crisis
 - 4.3 Change in own behaviour and impact
 - 4.4 Change in other behaviour and impact
 - 4.5 Change in relationship and impact
 - 4.6 Change in family situation and impact
 - 4.7 Change in aspiration, motivation, hopefulness
 - 4.8 Change in understanding about issues
 - 4.9 Change in using other service
- 5.0 Role of the programme
 - 5.1 Activities that helped or not
 - 5.2 Practitioner support
 - 5.3 Peer support (for children)
 - 5.4 Safety plan
- 5.5 External factors
 - 5.6 Expectations met or not
- 6.0 Suggestions
- 7.0 Learning
- 8.0 Other

Framework for FED UP practitioner interviews

- 1.0 Nature of positive change observed
 - 1.1 Change for the child
 - 1.2 Change for the parent
 - 1.3 Change for the family
- 2.0 Reasons for the positive change
 - 2.1 Programme-related elements
 - 2.2 Non-programme-related elements
- 3.0 Nature of negative change
 - 3.1 For the child
 - 3.2 For the parent
 - 3.3 For the family
- 4.0 Reasons for negative, little or no change
 - 4.1 Programme-related elements
 - 4.2 Non-programme-related elements
- 5.0 Aspects that worked well
 - 5.1 Assessment
 - 5.2 Group work
 - 5.3 Parent work
 - 5.4 Safety plan
- 6.0 Aspects that did not work so well
 - 6.1 Assessment
 - 6.2 Group work
 - 6.3 Individual work with parent
 - 6.4 Safety plan
- 7.0 Problems implementing the model
- 8.0 Skills needed to deliver programme
- 9.0 Experience of using standardised measures
- 10.0 Sustained change

Framework for referrer interviews

- 1.0 Referral experience
 - 1.1 Referral process
 - 1.2 Reasons for referral
 - 1.3 Fit with referrers workload
 - 1.4 Availability of similar services
- 2.0 Positive changed observed
 - 2.1 For children
 - 2.2 For parents
 - 2.3 For family
- 3.0 Reasons for positive change
 - 3.1 Programme-related
 - 3.2 Non-programme-related
- 4.0 No change or negative observed
 - 4.1 For children
 - 4.2 For parents
 - 4.3 For family
- 5.0 Reasons for no change in negative cases
 - 5.1 Programme-related
 - 5.2 Non-programme-related
- 6.0 Aspects that worked well
 - 6.1 Children's group work
 - 6.2 Individual parent work
 - 6.3 Joint work
- 7.1 Aspects that did not work so well
 - 7.1 Children's group work
 - 7.2 Individual parent work
 - 7.3 Joint work
- 8.0 Engagement with the NSPCC
 - 8.1 Contact during programme
 - 8.2 Overall relationship
 - 8.3 Involvement in external or child protection discussions
- 9.0 Suggestions

www.nspcc.org.uk

Registered charity numbers 216401 and SC037717.