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**Centre for Educational Development,  
Appraisal and Research**

**Evaluation of Addaction's 'First Steps' Children's Centre Project  
Final Report  
April 2013**

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# Evaluation of Addaction's 'First Steps' Children's Centre Project Final Report

## EXECUTIVE SUMMARY

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This report presents the findings from the evaluation the First Steps children's centres project, building on the earlier report of the first year of the pilot project (Cullen, Cullen, Lindsay, Barlow, 2012).

### Introduction

Addaction (<http://www.addaction.org.uk>) is a UK specialist drug and alcohol treatment charity, founded in 1967. Its mission is reducing the use of, and the harm caused by, drugs and alcohol. It offers holistic support to adults, teenagers, young adults and older people who have a problem with drink or drugs. Given that the majority of those seeking help from Addaction also have children, and that substance misuse affects not only the user but also other family members, Addaction views providing support to the families of service users as fundamental to its role.

First Steps was funded by a Department of Education (DfE) grant over 2011-2013 as part of the department's key strategic objective to improve outcomes for families with multiple problems. The DfE set a number of key performance indicator (KPI) targets for delivery. For Addaction, the First Steps pilot was part of a wider sector partnership alliance with Adfam and Alcohol Concern. Together, that partnership was tasked with developing the skills of a broad range of professionals who support children and families affected by substance misuse.

The **objective** of First Steps was to improve outcomes for families affected by substance misuse through delivering staff development for children's centre staff across England at three levels:

- a one day awareness raising training course open to any/all staff working in or from a children's centre (KPI target of 2400 participants by March 2013), including 'train the trainer' sessions and paid for training from Year 2 (KPI of £40000 income generation from sale of the training by end of March 2013).
- intensive partnership work over 15 months in 15 selected children's centres to embed the training in everyday working practices.
- development of e-learning resources and working protocols for effective work with substance misusers and their families, including: best practice guidance, a framework for service audits, and core standards for identifying and working with families affected by substance misuse.

The **aims** of First Steps were to work with children's centres:

- to improve staff skills, knowledge and working practices around identifying and supporting families affected by substance misuse (KPI target of 80% satisfaction with the training).
- to improve, by 10%, the engagement and retention of substance misusing parents at the 15 partner site children's centres (KPI target).

## Methods

The evaluation comprised a combined methods approach using pre-training, post-training and follow-up questionnaires to evaluate the one-day training. The partnership work in the 15 children's centres was evaluated mainly through qualitative interviews in the early stages of the work and again towards the end. Numerical data on parents identified as misusing substances was also collected, along with anonymised case work summaries for a sample of families affected by parental substance misuse but only a minority of the children's centres provided these data.

This is the final evaluation report for the First Steps project, and builds upon the interim report which focused on the first year of First Steps. The data that underpin this final report are:

- Pre and post First Steps one day training questionnaires (N = 2039 pre, and 2014 post)
- Follow up questionnaires completed 6-8 months following completion of one day training (N = 363)
- Recorded, semi-structured interviews with staff from 12 of the 15 First Steps partner site children's centres, including centre managers (N = 12), and centre workers (N = 27; 18 family support or outreach workers; eight early years or play and learning or children's workers; one office administrator) (Three centres did not participate in the final phase of the evaluation because of work pressures.)
- Interviews with seven parents from three First Steps partner site children's centres
- Analysis of working documents associated with the 15 partner children's centres
  - From the three Family Development Managers: logs of work with each centre; action plans for each centre co-created with each centre; exit summaries for each centre.
  - From the centres: anonymised summaries of children's centre case work with a sample of families where at least one parent was a substance misuse (two centres); and data from initially eight and finally two of the partner site children's centres on numbers of families identified as having parental substance misuse.

## Key Findings

### *1. The one-day training course for children's centre workers and colleagues*

- The one-day training course had **2351 participants**, about 50 short of the target KPI of 2400. The number who booked on the training day **exceeded** the target; the small shortfall was due to people cancelling, or not being able to turn up on the day, due to unforeseen circumstances.
- Analysis of pre-post questionnaires consistently showed **statistically highly significant ( $p < .001$ ) improvements in knowledge, skills and confidence** in supporting parents where substance misuse was an issue in the family (N = 2041 pre and 2014 post; a response rate of 87% pre- and 86% post-training).
- Analysis of follow-up questionnaires completed 6-8 months later (N = 363) showed that the mean total score for knowledge, skills and confidence **remained significantly higher** than the pre-training score ( $p < .001$ ). The

follow-up response rate of 18% was low but not unexpected given the time lag and the demands on children's centre staff. Comparison of those who returned a follow-up questionnaire with those who did not, found no significant differences on either mean pre-training score or mean post-training score, suggesting that the 18% who returned a follow-up questionnaire were reasonably representative of the participants as a whole.

- This statistically highly significant rise from pre-training, and which was maintained 6-8 months later, indicates that the training is **effective in creating a lasting impact** on knowledge, skills and confidence.
- 6-8 months after the training, **94%** 'agreed'/'strongly agreed' that the training had improved their **knowledge** of how to support families affected by substance misuse; **91%** their **skills** to do so; and **90%** their **confidence** to engage such families.
- Most of those who received a **Participant's Handbook** after the training found each section '**useful**' or '**very useful**' (66%-91%).

In Year 2 of the pilot, the training was offered as a commercial product, priced at £35 per head, with reductions for bookings of 20 or more.

- Despite great efforts on the part of the First Steps team, the income generation KPI target of £40000 was not reached within the timescale of the pilot.
- There was evidence that, given a longer timescale, this could have been achieved. For example, opportunities to train large numbers of staff were negotiated but could not be finalised and timetabled until after the pilot.
- Without the security of proven income generation, the First Steps team was viewed as unsustainable and disbanded. The demise of the team, despite the high quality and lasting effects of the training, illustrate the harsh reality of having to move from grant funding to commercial funding without the availability of transitional resources to bridge the gap between delivering on the grant and gearing up to achieve commercial income to scale.

*Legacy:* the First Steps training will continue to be offered by Addaction although the First Steps pilot team has been disbanded.

## **2 The partnership work in 15 children's centres**

The 15 partnership children's centres were distributed evenly across the three First Steps areas (five in each area). They were selected by Addaction's First Steps team through a process of open invitation to all children's centres, followed by local discussion and negotiation meetings and, finally, the signing of a Memorandum of Understanding. The main selection criteria were a desire to improve knowledge, skills and practice in identifying, engaging and retaining substance misusing parents; and a willingness to be part of the evaluation.

Analysis of interviews with the First Steps Family Development Managers, and of their summary logs of work with the 15 centres, showed that the creation of an effective partnership between Addaction, the children's centre, and local treatment agencies was a complex process, and involved dealing with:

- the complexity of each local area's structures and environment within which each partner children's centre operated;
- multiple agencies in each local area, including health, social work, educational psychology, family support, adult treatment service/s, drug and alcohol action teams;

- numerous barriers to progress that required patience, persistence and creativity to overcome; for example, the impact of the wider economic situation on job security; of local restructuring or recommissioning of children's centre delivery; of competition among drug and alcohol service providers, and of normal operational issues such as turnover of managers.

Because of these barriers, progress in embedding the First Steps work progressed at different rates in each of the centres. By the end of the pilot, **positive changes were evident in practice in all 15 centres.**

Partner site work was, in general, highly valued, and managers and staff provided a wealth of positive feedback on partner working. In particular, partner working was valued because of:

- the in-centre visits, co-working and knowledge of the Addaction Family Development Managers giving children's centre managers and staff access to support and specialist knowledge surrounding substance misuse.
- the development of integrated working with other local agencies and services. In a minority of cases, partner children's centres already had an active referral network, but for the majority of partner children's centres, the opportunity to build local networks and referral pathways was a new, and highly valued experience.
- shadowing opportunities were seen to be important and valued, both in terms of children's' centre workers shadowing colleagues in adult treatment services, and these colleagues shadowing children's' centre workers.
- the opportunity that partner working provided for children's centres to showcase to a range of relevant local support services the range of provision that they offered universally to parents and families.

The **Practice Guidance**, and the **Core Standards Action Plan** were welcomed by children's centre managers as providing informed guidance for work in relation to substance misuse. In addition:

- managers welcomed the opportunity, often shared with other centre staff, to input into the development of the Practice Guidance and the Core Standards Action Plan.
- For the majority of the partner sites (at the time of final interviews) the implementation of some points on the Action Plan was still a work in progress but many positive changes in practice were evidenced and commitment was strong to continue to work on making other changes beyond the life of the pilot project.

It was not possible to assess the number of centres which achieved the KPI target of improving by 10% the engagement and retention of substance misusing parents. The data proforma designed to evidence this were not returned by every site (8 of 15 did so at the baseline point; two at the final point). Feedback from some partner sites suggested that being asked to collate figures on this topic was not viable within the lifetime of the pilot project (at least one centre manager had set up systems to do this for the future and others had this on their action plans). **In the two centres that returned baseline and final data on this measure, identification of parental substance misuse rose significantly** (for example, from 12 to 17 families; from 0 to 23 families), with **evidence** from case work files and activity registers **of successful long-term engagement of these families.**

In the three least successful partner sites (one per area), there were barriers to full engagement in the pilot not related to the initiative. For example, local children's centre reorganisation, staffing problems (long term sickness, understaffing), staff cuts resulting in over-stretched centres finding it difficult to take on a new initiative, local managers not ensuring a voluntary buy-in to the initiative. To enable engagement, these situations required the First Steps team to show sensitivity to the good work of, and pressures faced by, such partner sites and to work with them at the speed and in the ways that best fitted their situation.

*Legacy of the partner work:* In addition to the Core Standards, Practice Guidance and online learning, typically, partner centre managers and staff hoped that the First Steps initiative would mean continued engagement with the issue of supporting families affected by substance misuse. In particular it was hoped that:

- links with local agencies and services would be maintained and extended.
- more referrals from adult treatment services of substance misusing parents/partners in to children's centres would result from greater integrated working, in addition to referrals by children's centres of such parents to local treatment and support agencies and services.
- refresher training would be available for children's centre staff around substance misuse.
- the learning from the project would be shared locally to extend good practice as part of area strategy. For example, at least eight exit strategies documented local strategic commitment, from children's centre leads and adult treatment service leads, to taking forward the First Steps agenda across the local area.

### **3 Conclusion**

Based on the evaluation data, although the 'First Steps' pilot did not achieve all its target KPIs in full, there is evidence to show that it has been a successful and beneficial project leaving a legacy on which further work can be built.

The **one-day training** has been of high quality with a lasting effect on staff knowledge, skills and confidence 6-8 months later. The KPI for 80% satisfaction with the training was exceeded (98%); and the KPI for 2400 trained was achieved (allowing for the fact that some who booked did not turn up on the day). Although the KPI for £40000 of income generation was not achieved within the lifetime of the pilot, there was evidence of large-scale interest post-pilot. The training continues to be available through Addaction, although the First Steps team has been disbanded.

The **partnership work** has been highly valued. The KPI of a 10% improvement in engagement and retention in *each* centre was not achieved (e.g. one centre manager saw no need for improvements in this regard) but qualitative data indicated improvements in identification, engagement and retention in the majority of centres and quantitative data provided examples where the KPI improvement target was far exceeded. Difficulties encountered in a minority of partner centres have led to improved understanding of the factors critical to success which is important for how Addaction takes this work forward. In a majority of the local authorities where the partner children's centres were based, there was strategic commitment to spread the First Steps work across all children's centres. The Core Standards, template Action Plans, and Best Practice Guidance provide a framework for such an expansion in these, and other, areas.

## **Recommendations**

'First Steps' was a pilot project from which much has been learned that is of continuing relevance to the Department for Education which provided the pilot funding; to Addaction, the organisation that designed and delivered the project, to children's centres, and local adult treatment services. The following recommendations are made:

### ***Recommendations to the Department for Education (DfE)***

- To consider how the development of the First Steps training, the Core Standards, and the Best Practice Guidance for children's centres can best be taken forward, alongside Addaction and others in the sector.
- To consider issuing guidance to children's centre and adult treatment service providers, emphasising the mutual benefits of working together to improve outcomes for families affected by parental substance misuse, and encouraging them to implement the First Steps Core Standards and Best Practice Guidance.

### ***Recommendations to Addaction***

- To consider how best the work of the First Steps pilot can be taken forward strategically, working with the Department for Education and sector partners.
- To work with *all* their local adult treatment services to ensure family-focused work is embedded in each area, and that all their treatment services are routinely linking in with universal services, including children's centres, to support recovery for users who are parents of young children, to support the developmental needs of those children, and as a gateway to holistic support for the whole family.
- To plan strategically to avoid the loss of expertise and experience built up during pilot projects, such as First Steps, when these come to an end, seeking to ensure a source of alternative funding to bridge the inevitable gap between grant-funded pilot projects, on the one hand, and fully commercial income streams on the other.
- To draw on the expertise of sales and marketing professionals, if appropriate, to support development of fully commercial income streams through direct selling of training, such as the First Steps training.
- To commit to marketing the First Steps training.
- To consider using the members of the First Steps team as consultants to train up trainers to deliver it across the country.

### ***Recommendations to children's centres leaders***

- To adopt and implement the Core Standards (including a local version of the Action Plan template) and Best Practice Guidance developed through the First Steps pilot project.
- To work together strategically with drug and alcohol treatment service leads to improve the operational delivery of holistic support for families affected by substance misuse.

### ***Recommendations to local drug and alcohol treatment services***

- To engage with local children's services to develop an understanding of the role universal services, such as children's centres, can play in the recovery process.
- To support local children's services to implement the aspects of the Core Standards and Best Practice Guidance that require collaborative and integrated working.

### **References**

- Addaction, with Wendy Robinson, 2012. *Addaction: First Steps. For Children's Centres working with Parental Substance Misuse. Best Practice Guidance.* London: Addaction.
- Cullen, S., Cullen, M.A. Lindsay, G., Barlow, J., 2012. *Evaluation of Addaction's 'First Steps' Children's Centre Project; End of Year 1 report.* Coventry: CEDAR, University of Warwick.

# 1 INTRODUCTION

## 1.1 Addaction and 'First Steps'

Addaction (<http://www.addaction.org.uk>) is a UK specialist drug and alcohol treatment charity, founded in 1967. Its mission is to reduce the use of, and the harm caused by, drugs and alcohol. It offers holistic support to adults, teenagers, young adults and older people who have a problem with drink or drugs. Given that the majority of those seeking help from Addaction also have children, and that substance misuse affects not only the user but also other family members, Addaction views providing support to the families of service users as fundamental to its role.

Support for family members affected by substance misuse (Addaction Family) includes Young Addaction Plus (support for young users and their families), Breaking the Cycle (support for parents with drug and alcohol problems and their families) and Skills 4 Change (support for secondary school pupils affected by substance misuse in the family). Although all Addaction workers are trained to be family focussed, at the start of the project, family support was available in a limited number of areas (Addaction website, accessed 2.11.11). The First Steps children's centre project built on, and extended, Addaction's family-focussed work.

First Steps was funded by a Department of Education (DfE) grant over 2011-2013, as part of the department's key strategic objective to improve outcomes for families with multiple problems. For Addaction, it was part of a wider sector partnership alliance with Adfam and Alcohol Concern. Together, that partnership was tasked with developing the skills of a broad range of professionals who support children and families affected by substance misuse.

The **objective** of First Steps was to improve outcomes for families affected by substance misuse through the delivery of staff development for children's centre staff across England at three levels:

- a one day awareness raising training course open to any/all staff working in or from a children's centre (target of 2400 participants by March 2013), including 'train the trainer' sessions and paid for training from Year 2
- intensive partnership work over 15 months in 15 selected children's centres to embed the training in everyday working practices
- development of e-learning resources and working protocols for effective work with substance misusers and their families, including: best practice guidance, a framework for service audits, and core standards for identifying and working with families affected by substance misuse.

The **aims** of First Steps were to work with children's centres:

- to improve staff skills, knowledge and working practices in terms of the identification and support of families affected by substance misuse
- to improve, by 10%, the engagement and retention of substance misusing parents at the 15 partner site children's centres

The First Steps project was managed by a National Family Development Manager and delivered across England by three regional Family Development Managers (FDMs): one for the North & West; one for the North & East; and one for the South. The expectation was that the work would become sustainable after the period of grant funding, through income from the roll out of paid for training from Year 2 onwards.

The focus on children's centre staff was aligned with the government's vision for supporting families in the Foundation years (DfE & DH, 2011) and the proposed core purpose of children's centres:

'to improve outcomes for young children and their families, with a particular focus on the most disadvantaged, so that children are equipped for life and ready for school, no matter what their background or family circumstances' (p55).

## **1.2 About this report**

### **1.2.1 Data**

This final evaluation report for the First Steps project builds upon the interim report which focused on the first year of First Steps. The data that underpin this final report consist of the following:

- Pre and post First Steps one day training questionnaires (N = 2039 pre, and 2014 post)
- Follow-up questionnaires completed 6-8 months after completion of a one day training (N = 363)
- Recorded, semi-structured interviews with staff from 12 of the 15 First Steps partner site children's centres, including centre managers (N = 12), and centre workers (N = 27; 18 family support or outreach workers; eight early years or play and learning or children's workers; one office administrator) (Three centres did not participate in the final phase of the evaluation because of work pressures.)
- Interviews with seven parents from three First Steps partner site children's centres
- Analysis of working documents associated with the 15 partner children's centres
  - From the three Family Development Managers: logs of work with each centre; action plans for each centre co-created with each centre; exit summaries for each centre
  - From the centres: anonymised summaries of children's centre case work with a sample of families where at least one parent was a substance misuse (two centres); and data from initially eight and finally two of the partner site children's centres on numbers of families identified as having parental substance misuse.

### **1.2.2 Structure of the report**

The evidence relating to the experience and longer term impact of the First Steps training day is summarised in Chapter 2. Chapter 3 provides reflections of the experience and impact of partner site working, including and the development of Core Standards, best practice guidance, action plans and working protocols. In Chapter 4, the two over-arching aims of the project – improving children's centre staff skills, knowledge and working practices in relation to families affected by substance misuse, and the goal of a 10% increase in the engagement and retention of substance misusing parents/carers at the 15 partner sites are examined in relation to the qualitative and quantitative data gathered. Chapter 5 provides a summary of our conclusions and in Chapter 6 our recommendations are set out.

## 2 THE ONE-DAY AWARENESS TRAINING

### 2.1 Introduction

#### 2.1.1 *The learning needs analysis*

The First Steps team developed a one-day training course, '*Families and substance misuse: opportunities to intervene*', based on a commissioned analysis of children's centre staff learning needs around supporting parents/families affected by substance misuse. The learning needs analysis (Cullen & Cullen, 2011) was conducted in summer 2011 and was informed by:

- 6 focus groups of parents with a history of substance misuse (20 parents in total)
- 5 focus groups with a wide range of relevant professionals and 1 focus group of national stakeholders (41 professionals in total)
- questionnaire responses from 449 staff working in or from over 200 different children's centres (from a random, stratified sample of centres).

The focus groups generated wide ranging information regarding the perceptions, needs and views of parents/carers with substance misuse issues and those of children's centre staff, and other interested stakeholder professionals. Of particular interest is the fact that the separate focus groups for parents/carers and professionals provided a high degree of agreement in terms of what was seen as important with reference to ensuring that children's centres are welcoming to families with substance misuse issues. Mutually identified factors included:

- effective outreach characterised by good information and personal support into the children's centre
- clear statements of children's centres' policy, function, and relationship with other agencies, particularly social services
- trusting relationships between parents/carers and children centre workers
- good substance misuse training for all children's centre staff
- a substance misuse champion in each children's centre with specialist knowledge
- effective sign-posting by the children's centre to other services and support
- willingness on the part of children's centre staff to challenge misconceptions and remove barriers to engaging in children's centres for families with substance misuse issues.

Analysis of the questionnaire responses showed that, whilst some children's centre managers and workers felt knowledgeable, skilled and confident in their work with families affected by substance misuse, **a substantial section of children's centre staff did not**. The recommendation was that the 'First Steps' training needed to target that proportion who did not feel knowledgeable, skilled and confident to work with families affected by substance misuse.

The questionnaire included an open question asking respondents what they thought the main learning objectives for the proposed First Steps training should be. Sixty three (71%) of the managers, and 121 (79%) of the centre workers, responded to this open question. The range of answers covered ten themes, listed below in order of frequency, with the first six being much more frequent than the last four themes.

1. Increased knowledge/confidence/skills/practical strategies to **support affected adults and children appropriately** (n = 91)
2. Increased knowledge to be able to **signpost** appropriately/know **local pathways of support/** know how to and to whom to **refer locally** (n = 62)
3. Increased knowledge/awareness/understanding of **impacts of substance misuse** on the family *or* specifically on children *or* adults (n = 52)
4. Increased knowledge/awareness/understanding of **substance misuse** (n = 44)
5. Increased knowledge/confidence/skills to **identify signs of possible substance misuse** (n = 37)
6. Increased knowledge/confidence/skills to **broach this subject and engage affected parents** (n = 34)
7. To be able to set up **clear protocols** (n = 8)
8. Increased knowledge and awareness of how to **ensure staff safety** (n = 5)
9. Increased knowledge and confidence around **safeguarding and child protection related to substance misuse** (n = 5)
10. Increased knowledge/awareness/understanding of the **legal framework and government policies and guidance** (n = 3)

The findings from the learning needs analysis informed the development of the First Steps training day.

### **2.1.2 Aims and objectives of the training**

The Participants' Handbook (Addaction, 2011) gave the **aim** of the training day as:

'to improve the knowledge, skills and working practices of early years' staff, to better identify and support families affected by substance misuse.'

The **objectives** were:

1. To discuss the impact of substance misuse on families and parenting from the perspective of both children and adults;
2. To review the signs associated with substance misuse in parents and their extended families;
3. To consider ways to initiate a conversation around substance misuse and related problems; and
4. To establish the means to effectively engage and support families affected by substance misuse.

The intended **learning outcomes** of the training day were that, by the end of the day, participants would be able to:

1. Describe the impact of substance misuse on families and parenting from the perspective of both children and adults
2. Identify the signs associated with substance misuse in parents and extended family
3. Demonstrate ways to initiate a conversation around substance misuse and related problems
4. Identify strategies to effectively engage and support families affected by substance misuse

## 2.2 Findings

### 2.2.1 The questionnaires and response rates

To evaluate the impact of this training, questionnaires were designed to reflect relevant First Steps Key Performance Indicators (KPIs), the findings of the learning needs analysis, and the aims and objectives of the training day. These were completed by trainees before any input on the training day and again at the end of the day. About six months later (range was 6-8 months), a follow-up questionnaire was either sent or e-mailed according to participant preference to all those who gave permission for this.

The total number of participants was **2351**. The number of completed questionnaires were:

- pre-training 2039 (87% response rate)
- post-training 2014 (86% response rate)
- follow-up 361 (18% response rate)

The follow-up response represents 18% of the post-training responses. This is low but not unexpected, given demands on staff time and staff turnover in the intervening months.

### 2.2.2 The respondents

The First Steps training reached staff working in a **wide variety of relevant roles** (see Table 2.1).

**Table 2.1 Roles of First Steps training participants**

<b>Roles (coded <i>post hoc</i> into broad categories)</b>	<b>Frequency (Percentages)</b>
Family support work	27
Outreach work	13
Children's centre worker (not specified further)	10
Early Years work/Education/Educare/Early Learning	9
Health professional/worker	6
Children's centre manager/lead/coordinator	5
Variety of local professionals (e.g. education welfare)	4
Administration/business/kitchen/laundry work	4
Project work (mostly unspecified)	3
Parenting support work	3
Volunteers (of various types)	3
Childcare staff	3
Play workers (and play plus other work)	3
Nursery staff	2
Community workers	2
Student professionals (e.g. social workers, health visitors)	2
Community workers	2
Drug and alcohol workers	1
Other (combination of role categories less than 1%)	4

N = 2039. Source: Pre-training day participant questionnaire.

About half of the participants, however, held one of four roles:

- family support workers, the most frequent category, made up just over a quarter of participants (27%)
- outreach workers (13%) in a variety of roles (e.g. family outreach worker; children’s outreach worker; chlamydia outreach worker)
- children’s centre workers (not specified further) (10%)
- Early Years/education workers (9%).

## 2.3 The findings to date

### 2.3.1 Comparison of knowledge, skills and confidence pre- and post-training day

On their pre- and post-training questionnaires, trainees were asked to indicate their level of agreement ,on a four-point Likert scale (strongly disagree, disagree, agree, strongly agree), with the statements set out in Figure 2.1.

**Figure 2.1 Statements on the pre- and post-questionnaires**

1. I feel confident that I have a good understanding of the impact of substance misuse:
a) on parent/carer users.
b) on parenting capacity.
c) on children’s development.
2. I am confident I can <i>identify</i> possible substance misuse in parent/carers I work with.
3. I am confident I can <i>address</i> possible substance misuse in parent/carers I work with.
4. I know a range of appropriate ways in which I could ask a parent/carer about substance misuse in their family.
5. I am confident I have the skills to ask ‘difficult questions’ related to substance misuse.
6. I understand the fears that someone affected by substance misuse has in relation to disclosing that misuse to professionals.
7. I have a good knowledge of practical approaches to <i>engaging</i> families affected by substance misuse.
8. I have a good knowledge of practical approaches to <i>supporting</i> families affected by substance misuse.
9. I am confident that I could offer appropriate support (within the remit of my role) to families I work with that are affected by substance misuse.
10. I could explain to a substance misusing parent/carer the referral pathway to access appropriate additional support.

There were **2003 matched pairs** of pre- and post-training questionnaires. We compared the mean responses to each statement, before and after the training, using a paired t-test.

- **There were statistically highly significant positive changes ( $p < .001$ ) for every statement.**

To give an example, the statement pre-training with the lowest mean response ( $M = 2.12$ ;  $SD^1 = .60$ ) on a Likert scale of 1 (strongly disagree) to 4 (strongly agree) was, ‘*I know a range of appropriate ways in which I could ask a parent/carer about substance misuse in their family*’. After the training, the mean response rose to  $M = 3.38$  ( $SD = .51$ ).

We also calculated a pre- and post-training Total Score for each participant who responded to at least 10 of the 12 statements (prorated for those who had completed fewer than 12) and compared the means.

- **There was a highly significant ( $p < .001$ ) positive change in mean total score from  $M = 28.37$  ( $SD = 5.32$ ) before the training to  $M = 38.80$  ( $SD = 4.47$ ) afterwards<sup>2</sup>.**

#### *Analysis by previous training around substance misuse*

To see if the statistically significant rise in mean Total Score was true for those with *different levels of previous training around substance misuse*, we created three groups:

- those with no previous training
- those with Basic level previous training
- those with Level 3 or above previous training.

In each case, the statistically significant rise in mean Total Score held true (Table 2.2).

We also checked this finding separately for a) those with previous training at university level and b) for those who had had training as part of their being a registered professional. The rise in mean Total Score remained statistically significant for each grouping.

- The results (Table 2.2) indicate that the First Steps training made a **statistically significant mean positive difference for participants**, irrespective of their previous level of training on substance misuse.

**Table 2.2 Previous training on substance misuse and mean Total Score**

<b>Previous training (Number)</b>	<b>Questionnaire</b>	<b>Mean Total Score</b>	<b>Standard Deviation</b>	<b>Statistical significance (comparing pre to post mean Total Scores)</b>
None (924)	Pre	26.38	5.10	$p < .001$
	Post	38.07	4.31	
Basic (901)	Pre	29.53	4.54	$p < .001$
	Post	39.14	4.36	
Level 3 or above (202)	Pre	32.32	5.51	$p < .001$
	Post	40.47	4.94	

<sup>1</sup> SD = standard deviation, a measure of the range of response around the mean.

<sup>2</sup> The standard indicator used for ‘statistical significance’ is  $p < .05$  which means that the likelihood of the result happening by chance is less than 5%. A next indicator used is  $p < .01$  which means the chance is less than 1%. Therefore,  $p < .001$  is an indicator of very high statistical significance, i.e., that the likelihood of obtaining the result by chance is less than 0.1%.

### Analysis by First Steps area

The First Steps project was delivered across England through Family Development Managers each responsible for one of three areas – coded as 12, 13, 14 (Table 2.3).

**Table 2.3 Matched cases (pre- and post-returns) by area**

Area	Number	Percent
12	765	38
13	651	33
14	587	29

N = 2003

Analysis by First Steps area indicates that the First Steps training made a **statistically significant mean positive difference** for participants in **each** of the three First Steps areas.

Area comparisons of mean Total Scores<sup>3</sup> pre- to post-training for the statements in Figure 2.1 showed that gains were significantly higher in Area 12 compared to Area 13 ( $p < .05$ ). There were no other area differences.

### 2.3.2 Views of the training day

On the post-training questionnaire, the trainees were asked to indicate their level of agreement on a four-point Likert scale (strongly disagree, disagree, agree, strongly agree) with the statements set out in Figure 2.2.

**Figure 2.2 Statements on the post-training questionnaire only**

- 
11. Today's training improved my:
    - a) *knowledge* of how to support families affected by substance misuse.
    - b) *skills* in supporting families affected by substance misuse.
    - c) *confidence* around engaging with families affected by substance misuse.
  12. Today's training was worthwhile.
- 

- *Knowledge* – Almost all (**97%**) either '**agreed**' (**53%**) or '**strongly agreed**' (**44%**) that the training had improved their **knowledge** of how to support families affected by substance misuse.
- *Skills* – Almost all (**96%**) either '**agreed**' (**55%**) or '**strongly agreed**' (**41%**) that the training had improved their **skills** in supporting families affected by substance misuse.
- *Confidence* – Almost all (**97%**) either '**agreed**' (**55%**) or '**strongly agreed**' (**42%**) that the training had improved their **confidence** around engaging with families affected by substance misuse.

Responses to Statement 12 (Figure 2.3), 'Today's training was worthwhile.', showed a very high (98%) agreement rate:

- *Worthwhile training* - Almost all (**98%**) either '**strongly agreed**' (**64%**) or '**agreed**' (**34%**) that the training had been worthwhile.

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<sup>3</sup> Area differences were explored through one-way analysis of variance (ANOVA). Sheffe post hoc tests were then used to explore where differences, if any, lay i.e. between which areas.

There was a statistically significant difference (at the  $p < .001$  level) in views about the training between Area 13 (less positive) and Areas 12 and 14. However, analysis by training event indicated that the majority (23/40; 58%) of those who did *not* agree that the training was 'worthwhile' had attended one of three specific training days held at the start of the delivery of the training. In each case, the *majority* of people attending these events indicated that, in their view, the training was worthwhile. All the other cases of people ticking that the training had not been worthwhile (17/40) consisted of only one person (13 training events) or only two people (two training events) among all participants at a training day.

- The very high (**98%**) level of participants indicating that the First Steps one day training was worthwhile **exceeds the KPI target of 80% satisfaction**.

### **2.3.3 Open Comments on the post-training questionnaires**

Respondents were invited to write an open comment on the post-training questionnaire about what, if anything, they had gained from the day. Just over half (52%) wrote no comment. Of those that did comment ( $n = 974$ ), **the majority (86%) were wholly positive in their comments**. Of the remainder, a small minority (4%) wrote entirely negative comments, while the rest (10%) wrote mixed comments.

Qualitative analysis of a sample of comments made during Year 2 of the project (from April 2012, after the Interim Report) confirmed the findings reported in the Interim Report. That is, that the themes covered were:

- experience of the training
- impact of the training
  - on knowledge
  - on thinking and understanding
  - on confidence
  - on practice
- other benefits of the training
- suggestions for additional content.

Rather than repeat the extensive analysis of comments provided in the Interim Report, here we provide **a flavour of the range of feedback** by including all comments from *one randomly selected training event in each of the three areas that took place during Year 2* (Figure 2.3).

**Figure 2.3 Comments from 3 randomly selected training events – 1 per area**

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***Experience of the training***

*Area 12, Group 1826 (chosen randomly)*

Enjoyed the day. (9863)<sup>4</sup>  
Found today very helpful. Found exercises interesting/helpful. (9870)  
Very insightful, interesting and useful. (9873)

*Area 13, Group 1780 (chosen randomly)*

Very good informative day – thank you. (9709)  
Time management was an issue, consequently some parts were rushed and not covered wholly. (9709)  
A very long day with a lot packed in but very worthwhile. Excellent delivery from a confident, knowledgeable trainer. (9716)  
The training was very good, very worthwhile and I enjoyed it. My only feedback point would be the timekeeping of the day. (13/1780/9717)  
Really interesting. Thank you. (9718)  
Bit rushed at end. Time management. (9722)  
Thank you. (9724)

*Area 14, Group 1851 (chosen randomly)*

Really nice not to have a PowerPoint. Felt much more personal and engaging. (10263)  
I really enjoyed today's format. It was refreshing to look in depth at the experience from a parent's viewpoint. [Trainer] was brilliant!' (10265)  
I really enjoyed [the] training. [...see under Impact ...] Great course. Thank you. Great looking at children's centre point of view. (10266)  
Thank you. I have enjoyed the day. (10267)  
Really pleased to have training specifically targeted at children's centres. (Never known this to happen to date!) (10273)  
Excellent presentation/listening skills. (10275)  
Children centre specific training – a first! Many thanks. (10278)

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***Impact of the training***

*Area 12, Group 1826 (chosen randomly)*

It has developed my confidence as a worker. (9863)  
Really useful, interesting and having an understanding of what parents must feel like when being approached or asking for support and how difficult this must be. (9865)  
[I now understand] the need to ask the question in the first place. (9867)  
Very informative. (9869)  
A very empowering course. Raised my confidence in areas, and confirmed a number of things I am doing right. (99871)

*Area 13, Group 1780 (chosen randomly)*

Better understanding. Useful to expand my knowledge to use with my role in school setting. (9719)

*Area 14, Group 1851 (chosen randomly)*

Learnt a lot about viewing experience from user's point of view. (10266)  
Gain[ed] knowledge and information to pass to parents and use in my centre. (10267)  
  
[Gained] more knowledge of why people misuse substances and how to support them [and] how people can sometimes still parent when heroin addicted. (10270)  
Very informative and useful. Thank you very much! (10274)

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***Suggestions for additional content***

*Area 13, Group 1780 (chosen randomly)*

Was useful but I would like to look more in to if the child is making a disclosure (I work with 15-19 year olds). (9713)

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<sup>4</sup> The number in parentheses is the respondent ID.

Throughout Year 2, the majority view of the respondents continued to be, as reported in the Interim Report, that the training day had been **worthwhile** and **enjoyable**, and that there had been **a range of benefits accruing** from having taken part in the training. Overall, qualitative analysis indicated there were no differences in the types or range of open comments by area. The themes, as outlined above, were consistent.

### **2.3.4 Knowledge, skills and confidence six to eight months later**

All participants in the one-day training who completed a pre-training questionnaire (N = 2039) were asked to provide either a postal or an e-mail address if they were willing to receive a follow-up questionnaire about six months later. Almost all (98%) provided this information. We sent out 685 postal questionnaires and 1314 e-mails with a link to the same questionnaire online.

The response rates show that those who received a paper questionnaire were more likely to respond:

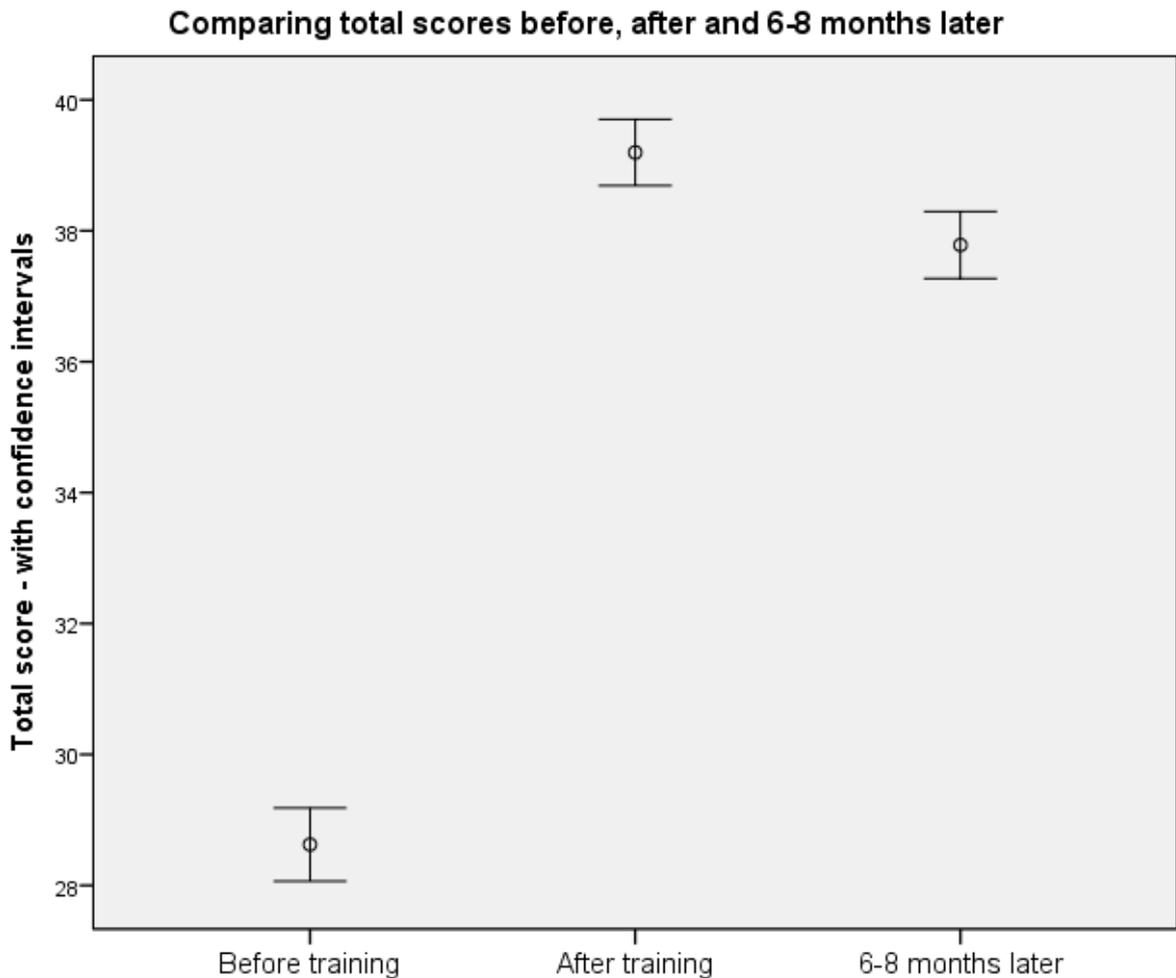
- paper questionnaires – 208 (30% response rate)
- online questionnaires – 153 (12% response rate)
- Total follow-up questionnaires – **361 (18% response rate overall)**.

Comparing those who returned follow-up questionnaire with those who did not, there were no significant differences on either mean pre-training total score or mean post-training total score. This suggests that the 18% who returned a follow-up questionnaire are reasonably representative of the participants as a whole.

The online and paper responses were analysed separately but there were no significant differences, and they were therefore combined and analysed together.

Figure 2.4 shows that, 6-8 months later, there was a statistically significant drop ( $p < .01$ ) in the mean total score for knowledge, skills and confidence relative to immediately after the training, but there **remained a statistically highly significant improvement ( $p < .001$ ) compared to pre-training**.

Figure 2.4



A drop in scores over time is to be expected. Figure 2.4 illustrates the **lasting impact of the training** in significantly increasing the knowledge, skills and confidence of the children’s centre staff and other professionals who participated.

Regarding impact on practice, in response to the statement, *‘I believe the training informed positive changes in my day-to-day practice with parents and/or children affected by substance misuse’*, **87% ‘agreed’ (62%) or ‘strongly agreed’ (26%)**.

#### *Open comments*

The open comments written on the follow-up questionnaires provided examples reflective of the findings of the closed questions reported above. Of the 124 open comments on the follow-up questionnaires, the majority (71%) were totally positive. These focused on **improved knowledge, understanding, awareness, skills and confidence among the staff**. Figure 2.5 captures the flavour of these.

**Figure 2.5 Benefits of the training: Illustrative comments from the follow-up questionnaire 6-8 months after the training day**

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*Improved awareness and empathy*

'More aware of the signs to look out for. Following the training, has made me more empathic in my approach with these struggling families.'

'More understanding of the impact substance misuse has on the children and how the parent may feel.'

'Real difference made was by remembering they are people with needs, feelings and circumstances they may not have had control in previously.'

*Improved identification, support and signposting*

'Has made me more aware of what to look for in identifying substance misusers and where to signpost them when needed.'

'Have signposted to Addaction as a result of the training. Feel a lot more confident when talking about these issues.'

'I always ask the question [about substance use] especially when I have concerns there may be substance misuse.'

'I am now aware and have gained knowledge in the area of substance misuse. Feel I can address any concerns confidentially.'

'It gave me a better understanding of drug misuse in parents. This course enabled me to signpost parents to the help they needed.'

'It has allowed me to approach the subject without feeling intimidated.'

'Now I can ask difficult questions to my clients and I can advise them or refer them to support.'

'Now I am aware of the referral process. I am able to identify if a parent/carer has misused a substance and I am able to address this with them, offer support in referring on to Addaction.'

'A better understanding of referral pathway and agencies to refer families to for support. I feel more confident to support parents and families affected by substance misuse.'

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Source: Follow-up questionnaire

The remaining open comments were mainly mixed; for example, people making positive comments about the training but also adding a suggestion for additional content (which depended on their individual needs and interests) or explaining that it had not yet impacted on their practice or noting that they had not received a copy of the Participant Handbook. (This was later addressed by copies being e-mailed out.) There were seven negative comments; for example, *'I felt the training did not teach me anything I didn't know already'*.

Of the 323 participants who answered the follow-up question as to whether or not they had received the Participant Handbook, under half (42%) had done so. For those who had received the Handbook (or had shared a copy given to someone else), there were a series of subsequent questions asking how useful they had found each section. In each case, some people indicated that they hadn't read or didn't remember the particular section but a high percentage (66-91% or above) of those who had used the handbook found each section 'useful' or 'very useful' (Table 2.4).

**Table 2.4 Views of the Participant Handbook**

<b>Handbook section</b>	<b>Number responding</b>	<b>Percentage who found it 'useful' or 'very useful'*</b>
a. The effects of substances	168	88
b. The children of substance misusers	163	91
c. The needs of children	160	88
d. The impact of parental substance misuse	162	89
e. Patterns of substance misuse	161	84
f. Sharon's story	162	86
g. The cycle of change	164	87
h. Talking about the hard stuff	160	81
i. Feel, Think, Do	162	78
j. Tips for talking to parents	161	86
k. Double bind – paradoxical communications	163	66
l. What next/	159	72
m. Further links and resources	158	78

Source: Follow -up questionnaire. \*Note: almost all who did not respond with 'useful' or 'very useful' responded with 'have not read/do not remember' rather than 'not very useful' or 'not useful at all', except for section k. where 5 people found it 'not at all useful' and 5 'not very useful'.

### **2.3.5 Impact of the training in the partner site children's centres**

During the final round of interviews with children's centre staff from the partner sites, the managers and staff were asked to reflect on how effective and worthwhile they felt the First Steps training day had been in the light of their work since the training. In addition, the interviewees were asked how the training, and working as a partner site in the First Steps project, had equipped them to work more effectively with families affected by substance misuse.

The dominant view about the training was that it had been effective and worthwhile, and an important stage in developing the First Steps project in the partner sites. A small minority of interviewees from children's centres which were the first to receive the training raised issues about weaknesses in the content and delivery of the training. However, all these interviewees were aware that the training had been revisited and amended after initial delivery and that problems had been addressed.

The training was seen to have raised awareness, and extended and reinforced knowledge; with, for example, a family support worker commenting:

'It [the training] was fabulous [...] it gave you more knowledge, it helped to reinforce things' (15/FSW1)

Further, the training was largely successful in providing trainees with the knowledge, confidence and ideas for asking their parents and carers questions related to substance misuse. This achievement related closely to the aim of improving children's centre workers' skills in relation to the identification and engagement of families affected by substance misuse. As one interviewee explained:

'The biggest thing for me was just knowing how now [after the training] to approach the parents [...] It was one of those things before [the training] where I was, "you're joking, aren't you? I'm not asking that!" But it's now "Actually, yes, I can ask it [about substance misuse] but I don't have to ask it straight away"'. (5/FSW1)

In addition, the training was widely perceived to have been an enjoyable and effective learning experience and to have been worthwhile. One early years worker commented:

'I think it was really effective, I really enjoyed the day, and I think it was definitely worthwhile because although I haven't personally come across families who are misusing drugs and alcohol (although I know the other workers have), it's made me feel confident, and I do look out for those signs and things; so it was effective and definitely worth doing.' (9/EYW1)

Finally, the whole-staff approach of the First Steps training day was greatly valued, with interviewees noting that it was rare for all children's centre staff to be included in training, and that such an approach ensured that all staff were 'reading from the same book'. Both children's centres and the First Steps team were aware, from the outset, that the aim of improving identification, engagement and retention of families affected by substance misuse required a whole centre approach. The manager of one centre explained that:

'From the very beginning for it [First Steps] to have worked we were very clear for us that if we were going to do it, it would have to be the whole centre, because it's just as important for that person on the front desk to acknowledge somebody coming in who's having a difficult morning or something to pick up any signs [of substance misuse] as it is for the Family Support Team to be able to do some intervention with them.' (20/M)

All the children's centre workers who participated in the one day training received a copy of the Participant's Handbook. The follow-up questionnaires, delivered 6-8 months after the training, showed that over 80% of respondents found each section of the handbook 'useful' or 'very useful'. However, among interviewees from the partner sites, the more typical response to the question, 'how, if at all, have you used the Participant's Handbook from the training day?', was that the handbook had not been widely used. An explanation of this apparent discrepancy may well be that the interviewees were from children's centres benefiting from close partnership working with the FDMs, and that, therefore, there was less need to draw upon information in the handbook.

In terms of content, delivery, and goals, the First Steps training day was still valued by the partner site interviewees long after delivery.

#### *Parents' views of children's centre staff receiving First Steps training*

We asked centre managers if there were any parents who had benefited from First Steps who would be willing to be interviewed. As a result, a small number of parents volunteered to be interviewed ( $n = 7$ ; from three centres). Their voices add another important element to the evaluation of the impact of the training. All of them strongly expressed the view that it was of benefit for staff to receive this training and that the difference after the training was noticeable. One example is given to illustrate this (Case Study 1).

## Case study 1 A young mother notices the impact of the training

I think it's great [that the staff got the First Steps training].

When I was with my baby's dad he was quite a violent alcoholic. *He* got the support *he* needed. I never got any support through that. We're not together anymore – but me and my son were left to deal with it. But since we've been at the children's centre and they've had their training, it's been just like another someone to talk to about things like that. They kind of understand a bit better now.

When we used to chat about it, it was just like chatting to a friend who doesn't really know what it's like, or understand what is going on. Now that they've had a little bit of training on it, it's like they understand a little bit better what I'm trying to say about things.

I split up with my ex-partner about 2 years ago but obviously when we first split up there wasn't the training at the children's centre that dealt with that, but obviously they've had some of their training in that now and you can just tell the difference. They can understand a bit more when you talk about things, about the situation. They seem to understand a bit more than they did.

They seem to know a bit better where you can get other support as well. Before, if I said, 'Is there anywhere I can go for support?', they'd hand you a leaflet and you'd be like, 'OK, I don't quite get what I'm supposed to be looking at here'. But now they can hand you a leaflet and say, 'Oh this is such and such. This would be good for you for this reason.' They're a bit more informed.

'Sandra', a young mother of one child under 5  
and ex-partner of a violent alcoholic

### **2.3.6 The trainers' views of why the training was so successful**

The three First Steps Family Development Managers delivered the training to over 2000 participants. Over that period of time, they gained insight into the reasons why the training was so successful on the day and in the longer term (as evidenced by the follow-up questionnaire and the views of staff and parents in the partner sites.)

They emphasised a small number of key reasons for this success (Figure 2.6).

**Figure 2.6 Reasons why the First Steps training was so successful: views of the First Steps trainers**

- It was developed on the basis of a previous learning needs analysis (see Section 2.1.1)
- It evolved in the light of delivery experience, participant feedback and, crucially, learning from staff in the partner children's centres: it was updated twice to reflect this (once to enhance the coverage of what children's centre staff could do to in response to parental substance misuse and secondly to enhance the coverage of the enhanced skills required to overcome fear of raising the topic and assumptions that it was not necessary to ask the questions of every new parent registering with the centre)
- It effectively engaged participants' emotions in terms of the impact of substance misuse from the parent and the child's perspectives in such a way that participants became prepared to make positive changes to their practice, especially to talk about substance misuse (where this was not previously the case)
- It gave people an opportunity to reflect on their own attitudes to substance misuse and used a specific exercise to help people understand this in a non-judgemental way that helped to change previously negative/judgemental attitudes
- It was interactive with activities designed to apply the new knowledge and to practise the skills being covered, as well as providing opportunities for participants to feedback their own experiences
- It highlighted the positive 3-stage role that children's centre staff could have in a) using open, neutral questions to enable substance misusing parents to talk about this in a stigma-free way; b) in offering brief advice and information; and c) in offering brief interventions (if trained to do so) and bridging the gap between the parent and adult treatment services
- It was relevant to practice - the tasks and activities used in the training were made available to participants as resources they could use with parents in their day to day work
- Participants were encouraged to create an action plan of three things from the training they could take away and begin to apply immediately to their work with families
- When offered as an open session in an area, it supported integrated working locally by attracting people from a range of related professions and providing the opportunity for networking
- When offered as a closed session for a particular children's centre, it supported a whole team approach and a sense of being a team working together for the benefit of local families

Source: Final interviews with the 3 First Steps Family Development Managers

### **2.3.7 The shift from a free offer to a commercial product**

The First Steps training was delivered free of charge during the first year of the DfE grant. In the second year, the aim was for the training to become sustainable through income generation of £40000. This meant charging at a rate of £35 per head, with some discounts available for block bookings of 20 or more. Ultimately, this aim was not achieved, despite great efforts on the part of the First Steps team, with some additional support from Addaction around marketing.

Summarising from the views of the First Steps team, there were three main reasons for the difficulty in turning the high quality training product into a commercial success: a) the lack of marketing expertise; b) a timing issue; and c) was the fact that the training was not accredited to link in with the Drug and Alcohol National Occupational Standards (DANOS).

The First Steps team were not, and could not be expected to become, marketing experts. Addaction as an organisation did not have its own marketing department to take on this brief but supported the team by providing access to a mass e-mailing system provided by an external organisation to use to send out information about the training. However, the First Steps team had to provide the contacts, a difficult job in itself. In addition, their experience was that a 'cold' e-mail was relatively ineffective in producing bookings (only 6-9% of these e-mails were ever opened and, of these, only a small percentage led to bookings); what worked best was the labour and time intensive route of telephone follow-up and face-to-face conversations with local strategic leaders. Although this produced results, the three-person delivery team was too small to be able to market the product effectively to the scale required to achieve £40000 of sales, in addition to delivering the training across each large First Steps area (the whole of England divided into three), and doing the intensive partnership site work in five centres per area.

The timing issue involved three components: first, it took time for Addaction to incorporate the First Steps training into its overall marketing strategy, delaying the point when the First Steps team could begin marketing the training. Second, most public sector budgets run from April to March, and are mainly pre-allocated. Thus additional buying, for example of new training such as First Steps, is often planned in for the *following* financial year, rather than bought within a given year. This was a problem for a short-term project such as First Steps. With an end date of 31 March 2013, the team could not commit to accepting bookings after this date, even though there was evidence of large-scale demand in several areas where positive relationships had been created. If more time had been allowed, this suggests that income generation would have increased. (Although First Steps has ended, Addaction intends to meet continuing demand by continuing to offer the training through Addaction's learning and development team.) The third aspect of the timing issue was that during 2012 many local areas were in the throes of restructuring their services which effectively prevented them from engaging with the offer of additional training; plus the wider political and economic context was one of cutbacks, with many areas cutting the numbers of staff in children's centres and associated services. This wider climate of change, uncertainty, job losses, and budget cuts made it a difficult time to try to sell new training however high the quality of the product.

Finally, the fact that the training was not officially accredited to tie in with DANOS meant that some potential customers were not willing to invest in the training. However, the First Steps team felt that linkage of the training to DANOS would

potentially have increased the cost and would also have changed the way in which it was delivered.

The three First Steps Family Development Managers also made a number of suggestions about how the training could, with more time, have been made commercially successful:

- Addaction as an organisation involving sales and marketing professionals to sell the training.
- marketing the 'unique selling points' of the training (see Figure 2.6) to differentiate it from other drug and alcohol awareness training available.
- publicising the positive evaluation results of the training so that commissioners and other buyers understand the value they will receive in return for their investment.
- promoting the training as a way of encouraging drug and alcohol organisations and services to become more family focused in their approaches.
- promoting the training not only to children's centre staff but also to universal health practitioners (e.g. health visitors) and substance misuse practitioners to encourage an integrated approach to providing effective support for substance misusing parents of young children – the need for this became very clear through the work in the 15 partner site areas.
- promoting the fact that the training content ties in with OfSTED framework 2013, the Troubled Families agenda, and the National Treatment Agency agenda (Public Health England, from 1 April 2013).

Without the security of proven income generation to the scale of £40000, the First Steps team (the three Family Development Managers and their national lead) was viewed as unsustainable. As a result, the team were notified of the intention to make them redundant. Although subsequently two of the team were offered other positions within Addaction, the dispersal of the team's knowledge, skills and experience as First Steps practitioners can only be seen as a loss to Addaction and the substance misuse treatment sector as a whole. The demise of the First Steps team, despite the success of the training, illustrates the harsh reality of how difficult it is to move from grant funding to commercial funding without a safety net of transitional resources to bridge the gap between delivering on the grant and gearing up to achieve commercial income to scale.

### 3 THE FIRST STEPS WORK IN 15 PARTNER CHILDREN'S CENTRES

#### 3.1 The aims and scope of the partner site work

The partner site aspect of the First Steps project involved the three Family Development Managers working intensively (e.g. one day a month) with 15 selected children's centres to embed improved working practices in the children's centre and between the children's centre and the local treatment provider (the local providers came from a range of agencies; sometimes being local Addaction teams, but other drug and alcohol agencies were also involved). The aims of the work were:

- to increase the identification of families affected by parental substance misuse;
- to increase the support available to families affected by substance misuse (referrals into local treatment providers and/or specialist services); and
- to improve the engagement and retention levels of substance misusing parents at the children's centre by a minimum of 10% by 31<sup>st</sup> March 2013.

In other words, the work was seeking to increase early identification of substance misusing parents with young children (to address 'hidden harm'), to engage them with the children's centre itself, and to retain that engagement so that parents would use the centre as a source of support for themselves and their child/ren and as a gateway to other services in the local area, including adult treatment services for substance misuse.

The 15 partnership sites/intensive sites were distributed equally across the three First Steps regions: five in each area. They were selected by the Addaction First Steps team through a process of open invitation to all children's centres, followed by local discussion and negotiation meetings and finally the signing of a Memorandum of Understanding. The main criteria were a desire to improve knowledge, skills and practice in identifying, engaging and retaining substance misusing parents; and a willingness to be part of the evaluation.

The partnership was designed to be two-way, with the Addaction team learning from the children's centres, as well as sharing their expertise in working with adult substance misusers. The work was intended to inform and support the development of a resources pack and the development of working protocols such as establishing joint local protocols and national standards. It was **successful in achieving this**:

- **Core Standards** (set out in Appendix 1) were developed around five themes:
  - Orientation
  - Workforce development
  - Integrated working
  - Engagement and retention
  - Safeguarding and child protection
- **Best Practice Guidance** (Addaction, with Wendy Robinson, 2012) was produced covering factual and theoretical information about parental substance misuse and the role of children's centres in responding effectively, including a template audit/action plan framework structured around the Core Standards and a summary of 12 best practice points, as well as a reading list and resource guide
- An **e-learning package** was developed and made available (for details, contact Velda Hudson – v.hudson@addaction.org.uk)

The First Steps Family Development Managers focused their work with the partner children's centres on supporting and enabling the centre managers and staff, especially the family support workers, to implement a local version of the template audit and associated action plan. Of necessity, this involved also engaging the local adult treatment service/s to work in partnership with the centre and *vice versa*.

### **3.2 Engaging the centres in the work**

Analysis of interviews with the First Steps Family Development Managers, and of their summary logs of work with the 15 centres, showed that the creation of an effective partnership between Addaction, the children's centre, and local treatment agencies was a complex process, and involved dealing with:

- the complexity of each local area's structures and environment within which each partner children's centre operated
- multiple agencies in each local area, including health, social work, educational psychology, family support, adult treatment service/s, drug and alcohol action teams
- numerous barriers to progress that required patience, persistence and creativity to overcome (see Figure 3.1)

**Figure 3.1 Barriers to progress in the First Steps partnership work requiring time and persistence to overcome**

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***Impact of the wider economic climate***

- cuts to staffing in children's centres and, for staff remaining in post, fear of losing their job in the next round of cuts – this affects capacity and willingness to take on board new learning and ways of working

***Impact of changes in local environment***

- local restructuring of children's centres or recommissioning of delivery to a new provider and/or local restructuring or recommissioning of local drug and alcohol services – these changes also affected staff willingness and ability to take on a new project and affected access to data on families
- where children's centre staff felt they have been asked to take on too many pilot projects – e.g. community budget pilot, payment by results pilot – and viewed these as competing for attention with First Steps rather than recognising the potential for synergy

***Impact of strained relationships in the local management hierarchy***

- where there are communication issues between local strategic managers of children's centres and the managers with operational responsibility – in some instances, this led the children's centre manager to feel that First Steps was a project imposed from above by a more senior manager; conversely, in other instances, more senior strategic managers or local commissioners felt threatened by the operational manager being keen to be involved in First Steps and blocked or delayed progress – in these situations, it took time for the First Steps regional manager to build a relationship of trust that allowed the different managers to understand that the success of First Steps would make their work easier, not more onerous, by improving service integration

***Impact of competition among drug and alcohol service providers***

- where the local drug and alcohol service was initially uncooperative, perceiving First Steps as a threat to its role – it took time to build relationships and create a shared purpose for the benefit of the sector as a whole

***Impact of normal operational issues***

- illness of a key member of children's centre staff – e.g. the manager
- turnover in children's centre management
- where the local drug and alcohol service was organised as area teams – it took longer to reach all the staff to increase their awareness of what children's centres offer families

***Impact of existing attitudes to substance misuse***

- where substance misuse was so 'hidden' or 'forgotten' or 'denied', children's centre staff presumed it was not an issue for any local family using the centre and so would not ask the questions that could uncover it
- where children's centre manager and staff thought they were doing this work already and did not view it as a priority to build on this and develop it further
- where there was already a named substance misuse lead person but that person did not have the knowledge, skills or experience required and had not been given any previous training or support to carry out that role
- where local drug and alcohol services are unaware of the role that children's centres could play in supporting clients and their families

Because of the barriers identified in Figure 3.1, progress in embracing and embedding the First Steps work in the 15 partnership children’s centres happened at very different rates. In each of the three First Steps regional areas, however, there was at least one of the five partner centres that became a flagship of what was possible to achieve if the local context was reasonably stable, the manager was committed, and brought the staff team along with her/him to share in the vision of improving support for local parents of young children where parental substance misuse was an issue.

Figure 3.2 summarises the overall picture of the types of **successes that were achieved** in developing good practice within the partner centres and also shows the added value that the First Steps project could create in making a positive difference that also impacted on other local children’s centres.

**Figure 3.2 Some examples of successes in changing practice**

<b>Strategic achievements</b>	<b>Operational impact</b>
putting children’s centres on the map for drug and alcohol treatment services	raising awareness of how children’s centres can support and complement recovery work by drug workers e.g. by shadowing each other’s work
improved interagency liaison	Network/participation days which led to better knowledge about, and use of local services for families
improved partnership working between treatment services and children’s centres	e.g. delivery treatment outreach from one or more children’s centres
	clarifying and publicising local referral pathway from children’s centres to treatment services and vice versa
	improved assessment of risk to children
	increased referrals from children’s centres to treatment services and vice versa
	development of joint working protocols e.g. regarding joint home visits; initial meetings with parents in the children’s centre
	joint delivery of an alcohol awareness day hosted in the First Steps partner centre
	recognition of the role of children’s centres as part of the ‘step-down’ process from treatment
	local treatment provider represented at children’s centre case coordination meetings
extending existing local good practice	e.g. spreading good practice in joint working between children’s centres and treatment services from one

	children's centre to others – such as treatment service workers coming along to children centre family fun days to be available for informal support
	e.g. recognising good practice in a local drug service and adapting it for use in the local alcohol service too
establishing new expectations of good practice	e.g. modelling good practice to family workers through e.g. joint home visits
	e.g. attending multi-agency meetings and being able to model the recognition of substance misuse as a potential hidden issue in a case presented as being about domestic violence and mental health issues
	modelling inclusion of the children's workers (early /play and learning workers) in a centre's response to identification of substance misuse
	identifying and meeting requirements for additional training around e.g. assessment, risk and recovery
	sharing knowledge of a range of approaches to responding to substance misuse as an issue within a family
establishing representation of children's centres on local drug and alcohol forums (e.g. Hidden Harm Forum)	e.g. made it easier for centres to access additional training from the local treatment provider
	substance misuse included in local referral form to children's centres for the first time
	First Steps partners site becoming an identified hub for taking referrals from local treatment providers and coordinating support with other children's centres in the area
	children's centres being in the knowledge loop regarding local developments e.g. adopting a specific parenting programme for substance misusing parents

The views of the First Steps Family Development Managers are the basis of the accounts given of the most successful partnership work within one centre per area. The perspectives of the centre staff follow.

In **Area 12**, the flagship partnership work benefited from strong managerial commitment to the project, in particular to the benefits that would arise from improved joint working with local treatment services. The 'twin-track' approach, that is, strategic and operational, adopted by this centre included:

*at strategic level:*

- the children's centre manager regularly attending the monthly planning meeting of all the drug and alcohol service managers as the parenting support partner (this was facilitated by the First Steps worker)
- a change made to the local protocol setting out the processes and pathways between adult treatment services and children's services to ensure that low to medium risk was covered by children's centres, while high risk remained with social services; the protocol also states what children's centres can offer to support low to medium risk substance misusing parents (i.e. how children's centres can play a part in the recovery process)

*at operational level:*

- the First Steps worker facilitated meetings between the partner children's centre manager, the partner children's centre family support coordinator and the local drug and alcohol manager to discuss joint working opportunities to ensure that families engaged with the treatment service would be informed about and introduced to the children's centre and vice versa
- the First Steps worker and the children's centre manager and/or the family support coordinator gave children's centre awareness sessions to each of the local drug and alcohol services to ensure they understood the family support and other work done by children's centres
- as a result, the children's centre workers began to view the drug and alcohol services as their partners, being able to pick up the phone and ask for advice when relevant situations occurred, such as parents turning up to groups appearing 'spaced out'
- the First Steps worker did practice reviews with the children's centre workers e.g. providing ideas about how to introduce substance misuse as a neutral topic within existing groups, providing additional resources as conversation starters
- the main outreach/engagement worker from the children's centre and her counterpart from the alcohol and drug service jointly support the new recovery gym and have formed a joint football team
- the substance misuse midwife began to hold her appointments at the children's centre
- to increase understanding of the different roles, children's centre workers and alcohol and drug workers have work shadowed each other

The success of this twin-track approach in enabling a truly family-focussed approach to treatment by bridging the previous gaps between treatment services and children's centres was endorsed as best practice by the National Treatment Agency Regional Director. Locally, the First Steps worker reported, there was acknowledgement that, without the First Steps project providing the leadership, this essential work would not have happened.

The best example of partnership work in any one children's centre in **Area 13** led to:

- the creation of a local strategic working group comprising representatives from two children's centres (including the partnership centre), the health visitor service, the alcohol service and the drug service. This group created a

local referral pathway and acted as a catalyst for spreading existing good practice between the drug service and one local children's centre to the partnership children's centre also, and generated a new relationship between the alcohol service and the partner children's centre which in turn was spread to other local children's centres

- the creation of a substance misuse lead role, with a clear role remit, in the partner children's centre (which previous to First Steps had had little awareness of the issue). This role was taken on by an existing staff member who intended to keep the profile high even after the end of the First Steps pilot

In **Area 14**, the most successful partnership work was achieved in a children's centre where local restructuring had already taken place and where the management team was keen to promote the First Steps work as a positive opportunity to harness external expertise to develop the service staff were able to offer to substance misusing parents and their children. Crucially, this management approach built on an existing positive culture of staff development, and a local authority culture that gave children's centre managers a degree of autonomy in terms of the project work that was undertaken. Successful work here included:

- the centre manager becoming part of the local Hidden Harm forum and, as a result, taking on a strategic role as contact person for referrals from local treatment services to any local children's centre.
- staff engaging individually with the First Steps worker about specific family cases.
- provision of bespoke training session workshops in response to expressed needs of staff e.g. around risk assessment and around how to use a local resource designed for supporting work with parents who were not yet ready to engage with treatment – staff implementing this afterwards led to new referrals to the adult treatment services.
- management team regularly reviewing their First Steps action plan (based around the Core Standards) and being proactive about implementing these.
- increased knowledge and confidence among the staff.
- staff working closely with adult treatment services which had not happened before.
- posters and leaflets about the availability of support around alcohol and drugs in the centre.
- a successful alcohol awareness day held for the community as a result of which at least one mother self-reported her concerns about her partners alcohol use and was able to receive support immediately from the local alcohol service worker who was in attendance.
- staff being proactive about checking out the more complex aspects of case work with substance misusing parents with the First Steps worker .
- staff finding additional substance misuse related training for themselves.
- the First Steps project included regularly on the agenda of the centre's Parents Forum – after a few months, one parent attending the Forum self-reported her partner's problematic cannabis use and was given information and advice about the support and treatment available, followed by a centre worker contacting a relevant treatment provider and accompanying the father to the first session.
- as a result of all the work, especially of the centre workers routinely asking neutral questions about substance misuse of every parent, over the period of the First Steps pilot there was a large increase from no substance misusing parents being identified to 23 families identified and supported.

These three case studies demonstrating successful implementation show the potential in terms of what can be achieved operationally and strategically when the expertise of substance misuse workers is combined with the expertise of children's centre workers.

### 3.3 Centre staff views of the partnership work

The partner site interviews showed that this aspect of the First Steps project was eagerly anticipated, highly valued, and was seen to create new opportunities for practice development. The experience of partner site working is examined here in relation to the five key areas of the Core Standards (see Appendix 1 for more details) that were developed by the First Steps team working with the partner site children's centres. The five key areas in relation to the identification, engagement and support of children and families affected by substance misuse are:

- **orientation**, i.e., easily accessible information provided by children's centres;
- **workforce development**, i.e., developing centre knowledge and skills;
- **integrated working**, i.e. effective working by and with children's centres;
- **engagement and retention** of families affected by substance misuse;
- **safeguarding and child protection**; i.e., ensuring that children of parents/carers who substance misuse are safely cared for.

#### 3.3.1 Partner site working and orientation

The situation with regard to children's centre 'orientation' in relation to substance misuse was, at the outset, varied. In this context, orientation refers to the existence of easily accessible visual and printed literature providing information about substance misuse, sources of help and support; and the children's centre's own services and policy with regards to parental misuse. Across the partner sites, there was no existing standard of orientation in relation to substance misuse. A few children's centres did have easily accessible information available in key centre areas, such as the reception area and the toilets. In one case (CC13) the manager and staff felt that even before the First Steps project, their centre was well orientated, and were unhappy when it was suggested that they were not. This led to initial misunderstandings between the First Steps Family Development Manager (FDM) and the centre, which took some time to be resolved. However, the majority experience among the partner sites was that work with the FDMs facilitated and extended the orientation of centres. For example, one manager said:

'The question was, how did we start telling families we're looking at this [support for those affected by substance misuse], and we thought if we have it out there, and it's something you see as soon as you walk in the door. There's leaflets in the toilet as well. And for us it was a way of putting this message out to parents that it's there, talk to us if you want to, but we're not going to push it on you [...] and we wanted to get a poster created, because we have lots of flyers in the centre, so for us the first call was creating the substance misuse poster.' (20/M)

In addition to ensuring widespread availability of information concerning substance misuse, and children's centres' services in relation to the issue, a further important step was incorporating questions relating to substance misuse in children's centre referral and registration forms. In a few cases, this was already standard practice, especially where centres were incorporated into local authority practices built on the Common Assessment Framework (CAF). However, where this was not the case,

partner sites made additions to their standard registration and referral forms to incorporate questions relating to substance misuse. The routine collection of these data was seen by children's centre staff as normalising questions about substance misuse, while at the same time being an additional way of helping staff to identify families affected by the issue. Further, such changes to data collection also impacted upon the children's centres' ability to engage and retain parents and carers affected by substance misuse. For example, one partner site manager explained:

'We've changed our systems so we've now got a flag on our database so that we identify families where we know there's substance misuse within that family or wider family. So now [...] we can pull off data about who we're working with [...] so we can see if people are engaging or not engaging. And I think from then that means [...] generally people are being much more up front about it [substance misuse]. We've got generally better at finding different opportunities to ask that question [about substance misuse], whereas we might not have asked about it before. So we are identifying more families.' (G/M)

This was a typical account from partner site interviewees, who talked about changed registration and referral forms, improved systems to flag up relevant cases, and, in consequence, improvements in identifying, engaging and retaining families.

### **3.3.2 Partner site working and workforce development**

Overall, interviewees were positive about the impact of partner site working on workforce development. The intensive work carried out by the FDMs was seen to be beneficial in a number of respects:

- (i) It offered the children's centres ready access to expertise relating to substance misuse.
- (ii) In conjunction with the FDMs, the children's centre managers were able to develop their centre policy and agreed practice around parental substance misuse.
- (iii) It enabled continued training in the area of substance misuse.
- (iv) The continued engagement of the FDMs with the partner site children's centres acted as a stimulus to maintaining the momentum regarding support for families affected by substance misuse.

#### *(i) Access to expertise*

Different partner sites were at different stages in the development of partner working with the FDMs, but with two exceptions, the managers of the sites were very positive about the working relations with the FDMs. In those sites that had progressed farthest in terms of partner working, the children's centre workers were also positive about the benefits arising from having access to the expertise of the FDMs. The FDMs were seen to be readily accessible – in person, by e-mail and by telephone – and this accessibility was valued. For example, a children's centre family support worker explained that the FDM and a drugs and alcohol outreach worker who had been linked into the children's centre by the FDM were frequently involved with partner working:

'I think that it [partner working] has helped the centre, because there's, like, regular updates with [the FDM] and we're working very closely with [name] one of the outreach team, and she comes into the group and she's getting familiar with the parents.' (1/FSW)

The importance of the role of the FDM was, in effect, stressed by the manager of another partner site children's centre, who explained how effective and active the FDM was:

'The [FDM] is very hands on, very available and very knowledgeable. You trust that when you ask a question and if [name] doesn't know the answer, [name] will come back with an answer – and that's brilliant. I phoned [name] up one day and asked about a family where a dad was getting an injection for something, and [name] didn't know what it was, but came back half an hour later and said this is for this. What are the needs of the family? Let's talk it through.' (20/M)

### *(ii) Policy development*

The managers of the partner site children's centres were also positive about the opportunity that working with the FDMs gave to develop, or introduce, centre policies in relation to supporting families affected by parental substance misuse. For example, one manager gave an account of her most recent working with the FDM:

'We had a meeting with the Commissioner for Drugs and Alcohol Services, and the strategic leads – that was useful to put faces to names, and sort out the roles of everyone and what services were involved. And then, in the afternoon, we went through the drug and alcohol policy; we looked at the Council's one, it's very broad because it's for right across the Council, so then we took that on board and tailored it more towards children's centres, and all the different aspects that as children's centres we would need to be clear on; the policies and procedures. That was really useful, and now it has been adopted by all children's centres in the borough now.' (9/M)

Here the impact of partner site working went beyond the partner site children's centre, affecting all children's centres in the local authority.

### *(iii) Further training*

The partner sites were also able to access and develop additional substance misuse related training for their workforce. FDMs provided direct training themselves, but they also assisted the partner sites in developing their own training, and helped the centres make links with other training providers. Typically, the additional training built upon the First Steps '*Opportunities to Intervene*' training days, and aimed to increase the skills and confidence of the children's centre staff, improve services for families affected by substance misuse and sustain the First Steps project within the centres. An example was given by a partner site manager who was unsure, initially, as to the reception that her staff would give to further training:

'We've had loads of training and the good thing is (because at first when we started I thought, "oh, the staff are going to love this – more training!"), but the staff have identified the training they wanted themselves, so, for instance, the staff identified that we had an issue around prescription drugs that probably wouldn't have been in your general drugs awareness type issue, so we've gone out [and found training], and they're going to come and do that for us. And we had somebody from Cocaine Anonymous come and talk to the staff, and the staff were really moved by that, which then led us on to other things [...]' (5/M)

One of the family support workers from the same children's centre gave her view of the additional training:

'Well, [the FDM] has actually put in a lot of training with our centre manager, who is my line manager. There's been lots of training with the outreach services that we can access. For me, it's given me more up to date [knowledge] because I was a total novice, basically, prior to any of this support. Yes, I knew about basic drugs and everything, but not where you could go with it, and certainly not how to approach a parent with this, so it's actually given me personally I would say confidence in that side of things.'  
(5/FSW1)

This children's centre worker had benefited from continued training, enabled by the partner site status of her centre, which led to improved knowledge and increased confidence to engage parents/carers affected by substance misuse. The majority of other partner site workers also commented in a similar fashion, and most noted that continued training was essential to maintaining focus, knowledge and confidence:

'initial training has led on to other training from other agencies – it's about keeping things fresh in your head' (11/FSW).

*(iv) Embedding the work for sustainability*

Continued training and 'keeping things fresh in your head' was seen by the partner site managers and workers as being an important key for ensuring the sustainability of the First Steps approach within the children's centres. The combination of the initial one day First Steps training, partnership working with the FDM, additional training, and the development of protocols and practice in relation to the identification, engagement and continued support of families affected by substance misuse helped to embed the initiative in the children's centres. For example, one manager explained how she had seen the First Steps approach embedded in her centre through the impact of the training and of all the work undertaken to implement the action plan based around the Core Standards:

'It's kind of, like, this is part of our practice here now, rather than it being forgotten, because I think my concern was, how do you maintain it, sustain it, keep it going. [Implementing our action plan] is one way that it actually keeps it on the agenda for the children's centre.' (20/M)

The importance of embedding the initiative was also stressed by other managers who highlighted the fact that not only are children's centres typically under-resourced and facing a wide range of family related issues, but they are also the target of competing demands and initiatives. Only by embedding the First Steps approach into normal practice and policy could it be expected to continue.

### **3.3.3 Partner site working and integrated working**

The FDMs sought to improve partner site integrated working by assisting the children's centres to make links with other key universal and specialist agencies, including local treatment agencies, with the aim of improving the holistic support for parents affected by substance misuse by boosting co-working and improving referral pathways both into and from the children's centres. In addition, integrated working aimed to extend the information and training resources available to children's centres. Integrated working was developed, under First Steps, between the partner sites and a range of agencies, including local treatment providers. Overall, the children's centres' experiences of First Steps support to enhance local integrated working was positive; however, interviewees in four centres expressed

disappointment about the quality of co-working with local Addaction teams – these concerns are addressed below in Section 3.3.8.

The FDMs were able to help the partner sites improve their contacts with relevant local agencies, leading to increased mutual awareness of service provision by children's centres and these agencies, role shadowing, the development of personal contacts between centres and agencies and improved referral pathways. One children's centre manager, for example, explained how FDM facilitated links had affected her centre's working:

'Myself and [FDM's name] had been to the Drugs and Alcohol Team [DAT] meeting [...] they meet together and discuss issues that crop up across all the different teams. It's a bit of a networking meeting for them. Myself and [FDM] because of the partnership that we're doing, we were invited along to that, and just to update people that are working in these services about what we are trying to do. And from that, the [DAT] manager suggested doing the training that I delivered for the Addaction staff around what it is a children's centre offers to other drug and alcohol services, which I was more than happy to do. That made sense to me, and also getting their staff to come into a children's centre and see what a children's centre was like, and then having a full day of training [...]' (11/M)

This manager also explained about building links with a number of local agencies, including the social services families team, a specialist midwife, and maintaining and growing links and contacts across the area. Workers from this children's centre had, in fact, *'been out to all the different substance misuse agencies in the area, and I think there's 11 of them'* (11/FSW3). All this was typical of the type of work that FDMs and partner sites undertook in order to extend integrated working.

In terms of the day-to-day impact of this work, the training and shadowing enabled workers in the different universal and specialist settings to have a clearer idea about the services that they could refer families into, and gave workers in these differing settings the knowledge about whom to approach in order to extend the service opportunities available to families with whom they worked. For example, an early years worker explained the following in terms of her centre's partner site status:

'We've got that support now of them [other local agencies] being on the other end of the 'phone [...] Somebody saying to us, "Just ring if you need any help or support" is really reassuring to go back to, and then seeing them regularly popping into the centre just keeps us a tight working partnership, just keeps it going and ticking over.' (1/EYW)

### **3.3.4 Partner site working and engagement and retention**

At the heart of the First Steps project was the fourfold aim of identifying, engaging, supporting and retaining families affected by substance misuse. The interviewees from the partner site children's centres were asked about the impact of First Steps on engagement and retention (identifying being one of the earlier learning goals of the project). The interviewees all felt that they had increased their capacity to engage and retain parents/carers affected by substance misuse. For the children's centres one of the key incentives to take part in First Steps had been the hope that, by accessing additional training, and developing new links with other agencies, the children's centres would be more effective at engaging and retaining families affected by substance misuse. There was also recognition, on the part of the majority of centres, that there was scope for development in this area. For example, one

manager explained that the main hope and expectation that she had on becoming involved in First Steps was:

‘to get more people into our centre so that it’s well used. It is well used, but you can always improve to get things to be more well-used [...] so that we can engage a different type of person possibly [...] it’s just about including everybody really, and giving the support they really deserve. And the bottom line is that, if we can support the parents, then the children are better supported.’ (11/M)

The managers at the partner centres all believed that their engagement with First Steps, and their partner status, had led to improvements in engagement and retention of families affected by substance misuse; as one manager explained:

‘I think we have found that, through the [First Steps] project, and I think it is still on-going, where we are working with families and supporting them into substance misuse services, we have good engagement and retention because we work whatever way suits that family really; we’re very flexible, and we’ve got highly skilled staff that have done a lot of training [...] so we find that we do retain those families.’ (6/M)

This was a typical response, with the manager arguing that First Steps had fed into, and extended, the already existing culture and practice of children’s centres in order to extend the support available for families affected by substance misuse.

### **3.3.5 Partner site working and safeguarding**

The aim of the First Steps partner site work in relation to safeguarding and child protection was to review, and if applicable, extend children’s centre protocols in relation to safeguarding to incorporate measures specifically relating to children of parents/carers who substance misuse. This was linked to measures designed to enable the identification of substance misuse issues by children’s centre staff, so that routine risk assessment processes would be implemented when parent/carer substance misuse was identified, and that safety plans would be implemented. These developments took place in the partner sites as part of the overall task of revisiting policies and procedures, and developing these in relation to working with families affected by substance misuse. An example of a newly developed procedure was given by a partner site manager:

‘We’ve updated our procedures and we’ve got a flow chart of what we can do, so, for example, if a parent came to collect and a practitioner recognised that they could, say, smell alcohol on somebody’s breath and the parent was presenting as drunk, then there’s a procedure where they would come and get the designated safeguarding lead who cover them in nursery while they went to have a chat with the parent, if that’s what they felt they could do, in a private place [...]’. (1/M)

The development of safeguarding with particular reference to work with families affected by substance misuse typically involved the further adaption of existing protocols to incorporate changed understandings of work with such families. For example, one manager explained how that although they had not changed their child protection policy at the children’s centre, they had revised the referral protocols:

‘What has changed is that sometimes we’ll have a family come in and into a group and the staff may have been concerned that she may have been

drinking or taking drugs, they were a lot clearer now on who they could go to for support. So, it doesn't necessarily mean it's got to go straight to the child protection route, it could go to the drugs and alcohol services worker, who has been introduced to the team here.' (9/M)

### **3.3.6 The role of the children's workers**

Earlier interviews (reported to Steering Group in autumn 2012) with children's workers (includes Early Years workers and Play and Learning workers) in the partnership sites indicated that, while the one day training increased their knowledge and confidence around the issue, that and the partnership work had had limited impact on their day-to-day work although it had improved their confidence about how to approach the topic with parents if needed. At that time, we thought the lack of impact on practice might be explained, in part, in terms of the differing role remits of family workers and children's workers in the centres, which can mean that children's workers may not know whether or not parental substance misuse was an issue affecting a child or children in their care.

In the final round of interviews, the impact of First Steps on children's workers was more evident. For example, in one partner children's centre (Centre 20), because of the First Steps work, which had included specific training for the Play and Learning team on the impact of parental substance misuse on children, the team were working much more closely with the Family Support team to support the families affected by parental substance misuse. Joint home visits were conducted so that the children's worker could support the parent at home in terms of aspects of parenting such as play and so that there would be a familiar face on the Play and Learning team when the family visited the centre.

In another centre (Centre 13), an Early Years worker described how she had been able to use what she had learned from First Steps training during a home visit when she noticed drug-related materials lying around in reach of the children:

'I managed to talk to mum about it and she was really understanding, she realised what she'd done. She is a regular cannabis user and we are aware of that as a team but it's just making sure that the children aren't affected by it and making sure that she's got the right sort of support to try and help her if that's something that she wants to stop. So it's just making sure that I can point them in the right direction, to just talk about how it's affecting her, how it's affecting the children. It sort of started the ball rolling. OK she's going to need a bit of extra support here, because she did talk to me about it and it's something that is an issue for her. So now it's like, 'Oh well actually I know what I can do for her now'. And just in terms of the other professionals that are working with her as well I just feel like I'm a lot more knowledgeable about what to do and how to approach it and things like that.' (13/EYW)

This worker attributed her ability to deal with this real life situation to the fact that centre staff had role-played holding discussions with parents about substance use with Addaction staff, as part of First Steps. This had resulted in her feeling 'prepared' for the situation and being able to deal with it appropriately.

Across the children's workers, there was an expressed desire for 'refresher' or 'top-up' training. This may reflect the fact that they did not all deal so much with parents as did family support workers.

### *Children's centre support for children of substance misusing parents*

Improving outcomes for children was the ultimate aim of First Steps. Our interviews therefore also included a question asking children's workers about how they currently worked with vulnerable children, and seeking their views on what more they thought they could do to better support the needs of children of substance misusing parents. In response, children's workers said that they were already trained to be highly sensitive to the developmental needs of children and that all their work was geared to supporting this. Some agreed that it could be useful for them to be informed that specific children were affected by parental substance misuse but they believed they were already putting in place all the support and activities required to support vulnerable children, based on skilled observation of the children in the sessions they attended. This view was corroborated by the very positive views of parents interviewed (see Section 3. 6) regarding the benefits their children gained from attending the centres.

The types of support for the children of substance misusing parents that were mentioned by children's workers were:

- knowledge of the different schemes for providing free childcare;
- provision of respite places in the centre crèche;
- working with the parents around keeping the children safe i.e. harm minimisation such as methadone boxes, storing out of reach of children, minimising use in the presence of children;
- all the normal centre groups and activities for the children to attend;
- special play sessions for that family only in the crèche if the parents don't feel confident enough to attend a larger group;
- support to access other community activities for families;
- helping the parents to apply for nursery or school places and to make use of government-funded schemes providing early education for two year olds in families claiming Income Support;
- accompanying parents to medical and other appointments relating to the children (or just reminding them to attend);
- nurturing sessions;
- positive play sessions;
- organised and subsidised or free family trips out;
- support to access charitable schemes arranging free holidays for families;
- showing the parents how to cook healthy meals for the children.

### **3.3.7 The positive experience of partnership working**

The dominant experience of partnership working was one that was highly positive in most areas. Managers and staff welcomed the additional training opportunities, the co-working with FDMs, the access to FDM knowledge, the opportunities for greater integrated working with local agencies, and the positive impact of these elements on children's centres' ability to offer support for families affected by substance misuse. The positive experience of this work was summed up by one children's centre manager:

'Fantastic, everything, everything about it; it's made us really sit back and reflect and really evaluate what we're doing, and so much of it overlaps into all areas that we work in within the children's centre. It's brought us together as a team because we're all working on a goal with shared interests. There's been staff team members that really didn't want to do it at the beginning, didn't think it was appropriate, and wasn't needed, but actually have come

back and said “I’ve really enjoyed that”; so, yes, it’s been a really good team exercise. To have families walk in, like today, and just disclose and talk, that is better than your wildest dreams to be honest from when we first started out.’ (20/M)

Nonetheless, there were a number of issues raised in relation to partner working in the First Steps project.

### **3.3.8 The experience of Partner Site working: issues**

Three sets of issues emerged in relation to partner site working. Two of these related to specific children’s centres, and the experience of problems in relation to First Steps in these cases can be generalised to understand the barriers that can exist to the effective implementation of a project like First Steps (see also Section 3.2, Figure 3.1). The third area was experienced more widely, and was a specific issue relating to integrated working with local Addaction teams.

#### *Centre specific barriers to engagement*

Among the 12 centres providing final round interviews, two partner sites (13 and 3) experienced difficulties in engaging with First Steps. Their experiences illustrate the barriers to engagement summarised across all 15 centres in Figure 3.1. In the case of partner site 13, the barriers to engagement were acknowledged and voiced by the children’s centre manager and staff. This contrasted with the case of partner site 3, where there was no acknowledgement of barriers, with the centre manager and staff arguing that their children’s centre had no need for a project aimed at supporting families affected by substance misuse.

Partner site 13 faced, from the outset of First Steps, barriers to engaging with the project. These included being an understaffed children’s centre, long term sickness suffered by staff, and operating in an area of high levels of deprivation. The centre staff were, therefore, operating under unusually high levels of work overload and stress. Further, the centre was not consulted about its inclusion in the First Steps project, which was presented to it as a *fait accompli* by the local strategic manager for children’s centres. Given the context in which the children’s centre was operating, this latter was problematic, as the manager noted:

‘I think one of the major things was not to be ... and this isn’t anything to do with the project or [the FDM], it is about our local management really – we were never consulted, we didn’t know anything about the project, it was virtually just dumped on us, “Oh, by the way, you’re going to be doing this”, and the next thing, you’ve got people ringing and you weren’t told, and you weren’t expecting it.’ (13/M)

Although some of these circumstances also applied to other participating children’s centres, the problems encountered at partner site 13 were possibly more severe.

The centre also had to deal with being one of the very early centres to be involved in First Steps, and the fact that the project underwent a period of learning in the early stages, involving changes being made, for example, to the nature and content of the one day training. These factors combined with the earlier staffing issues led to friction between the centre staff and the First Steps worker. As two of the centre workers explained:

‘We did feel as a centre that [the FDM] was quite negative towards the centre, we felt that within the training that [the FDM] felt that we weren’t talking to

families about substance misuse, and that we didn't know how to approach it, and things which I think some of the staff felt a bit hurt by really because we were being honest with parents, we were asking them the questions, and I don't think [the FDM] took that on board, and I think she made us feel that we didn't really know what we were doing.' (13/CCW2)

'I feel as though [the FDM] has come in with the attitude that we don't do that [work with families affected by substance misuse], we don't know how to do that, which devalues what we do I feel.' (13/CCW1)

Over time, the relationship between the children's centre staff and the FDM improved, but the difficult start to that relationship and the constraint impacting on this centre (low staff numbers further depleted by long-term sickness of key staff numbers) imposed limits on the success of First Steps with this centre. Nevertheless, interviews with staff showed that even in this centre, there were positive impacts on staff awareness that enhanced practice, as well as improved working with local treatment services that benefited families affected by substance misuse.

In the case of partner site 3, the barriers to full engagement with First Steps were different, and focused primarily on the manager and staff believing that they did not need to work on supporting families affected by substance misuse because this issue was not relevant to the families using their children's centre. This denial of the issue was maintained throughout the centre's involvement with First Steps. In the evaluation interviews over the lifetime of the project the centre manager repeatedly returned to the theme that the context of the centre's work meant that substance misuse was not an issue:

'I suppose to contextualise where we've been with this project overall, and this might be a recurring theme in some of the questions actually, where we are in the area we work in [...] it's a more affluent area than other parts of our local authority area [...] So, we've actually not necessarily had a great involvement, or seen a great increase, in the number of service users with substance misuse issues accessing our provision, certainly that we're aware of. We may have some people coming through universal services, of course, that we don't know the full history of. So we've not really had any recourse, I don't think, to make use of the [First Steps] practice guidance to inform our practice.' (3/M)

This comment was made towards the end of the First Steps involvement with the centre, and was also reflected in the interviews with the centre staff. There was, in fact, little evidence that the centre staff had really engaged with First Steps or the messages contained in the project. For example, one of the centre workers noted that the First Steps training had been 'quite useful [...] but unfortunately we haven't really had any families that we've been able to refer on' (3/FFW).

#### *Challenges in relation to successful integrated working*

The development of more effective patterns of integrated working was very positively valued by almost all partner sites. Managers and staff welcomed the opportunity to build more effective links with other support and treatment services at local level, and were aware of the value of strengthened referral pathways. Partner sites had, largely, taken advantage of this, and most interviewees could give examples of families they had referred to other local treatment and support agencies. However, there were concerns across the partner sites that this increase in referrals was too much in the way of being referrals *from* the children's centres *to* local treatment services, with few

referrals into the children's centres from local treatment services. In four cases where the local treatment provider was Addaction, this was viewed by centre staff as particularly disappointing as they expected First Steps, as an Addaction project, to be supported by the local Addaction substance misuse workers. For example, a partner centre development co-ordinator expressed her concern about what she saw as being a lack of response from a local Addaction team to working in partnership with the children's centre:

'I was quite shocked because, from our point of view, [...] First Steps was something Addaction had approached *us* about, so we obviously took it for granted that *they* were open to working with us, whereas when we met [local Addaction] staff they seemed very sceptical about working with us as a family support team. [...] They weren't open to it. [...] I thought we were all open to [integrated working] and that we were moving forward together, but it was like that ground work hadn't been done. I think they needed to gain our trust as workers, and I don't know if that's actually happened because it hasn't been represented, well it's been proven really in the amount of referrals – we haven't had *any* referrals from them.' (6/PPDC)

The lack of referrals from local service providers was remarked upon by managers and workers from five partner sites, of which four referred to local Addaction adult treatment teams. This issue was something that the Family Development Managers became increasingly concerned about throughout the project and led to their calls for Addaction promoting a version of the First Steps training for adult treatment services, including some of Addaction's own services.

### **3.4 Working protocols**

The FDMs were also tasked, working alongside the partner sites, to establish joint local protocols, and facilitate the implementation of national standards of good practice. These took the form of the development of Practice Guidance, and Core Standards (see Appendix 1) with a related Action Plan, for each partner site. Typically the work to develop initial drafts of the Practice Guidance documents was undertaken by the First Steps team, supported by an external consultant, Wendy Robinson. These drafts were then shared for discussion with and feedback from partner site managers. In some cases other children's centre staff were also actively involved in feeding back comments and in developing their centre's First Steps action plan.

The development of Practice Guidance was a later stage of the First Steps project, and the initial drafts were informed by learning from the work in the partner sites. At the time of the final interviews with the partner sites (late 2012/early 2013) implementation of the agreed guidance and associated action plan was at an early stage in the majority of partner sites, but in a small number of centres, almost everything on the action plan, covering all five core standards, had been put in place.

Partner site managers reported that the FDMs had actively involved them in developing these protocols for children's centre working with families affected by substance misuse, and that as a result, there was a sense of ownership of the resulting Practice Guidance documents, which were seen to reflect local conditions and needs. The process of developing the protocols was essential to ensuring partner site buy-in, and, hence, their successful adoption:

'I sat down with [the FDM] and we went through it [Practice Guidance and the Core Standards Action Plan] and we went through it in quite a bit of detail.

[The FDM] showed me the draft that was already available, and there were some good examples of where some of the ideas in it had come from through some of the other projects [...] We went through it and looked at it, and there was quite a lot in it I agreed with, and making sure that it was practical and making sure that there was enough clarity in it, but, at the same time, not tying us down too much so that it became a bit heavy and difficult to work with, and also that it was flexible because I know that not all children's centres and not all projects work the same, depending on their set up in the local authority and that kind of thing.' (11/M)

The protocols were also seen to have more general applicability than solely in respect of work with families affected by substance misuse; one manager noting that:

'a lot of the information is applicable across our other work as well so, what we've learnt from this pilot project and the core standards and the framework, we can apply to other pieces of work' (5/M).

Partner sites appreciated that the development of the Practice Guidance, and the Core Standards including the related Action Plan, would be applicable beyond the project itself, and for children's centres that had not been partner sites in First Steps. For example, one manager said:

'I could see that if I was not part of the pilot, and thinking, "I've got to sort out work with families with drugs and alcohol issues", it did give you a step by step, this is what you need to be doing, and some ideas as well that I might not have thought of, like one of them was something like a tour for every family you pick up from the drug and alcohol services, which I thought was nice because we do struggle to engage some families through having something specific for them.' (9/M)

In addition to the Practice Guidance documents, FDMs worked with partner sites to develop Action Plans that would form a blueprint for the further development of children centre work with families affected by substance misuse. As with the Practice Guidance, partner site managers expressed their satisfaction with the Action Plans that emerged. For example, one manager explained how she and the FDM had developed the plan:

'We had a copy of the old Action Plan, an original one, and what we've done is we've gone through and completed our own Action Plan, and [the FDM] took areas from it, and transferred some onto it as well; so it's a kind of amalgamation of the two.' (20/M)

It was this model of joint FDM-partner site development of the Action Plans that underpinned the successful creation of plans for each partner site. It was important that the plans were related to existing policies and procedures employed by the centres, as one manager explained:

'They fit in with our policies and procedures in terms of we all have the same policies and procedures across the children's centres, so they fit in with them. So they work because we're following that policy and procedure as well, and because they [Practice Guidance and Action Plan] integrate well into it.' (1/M)

Overall, the development of the First Steps initiated working protocols was a successful process, that was welcomed by the partner sites and helped embed the project.

### 3.5 Exit strategy

The desire for the First Steps project work to be embedded was underscored by the final stage of work with the partner sites, conducted after the evaluation interviews, in which the FDM worked with the centre manager to produce an exit strategy summarising the work achieved and noting where the work would continue to be taken forward locally. Ten of these exit strategies were made available in full to the evaluation, of which **eight showed strategic commitment from children's centre and treatment service leads to extend the First Steps work** from the individual partner site across the local area.

The exit summaries encapsulated the fact that *in each of the three areas*:

- there was one outstanding example of a centre that had embraced the First Steps vision and made substantial changes and developments in supporting families affected by parental substance misuse
- there was one example of a centre that did not engage fully with the project for a range of legitimate reasons
- there were three centres that were somewhere in between these extremes in the progress made around implementing the Core Standards and the associated best practice.

However, by the end of the First Steps project, **positive changes in practices had been made in each of the 15 partner sites, including the least engaged.** (For example, in one local authority where the *partner site* work did not progress as far as originally planned, the efforts of the First Steps worker to address the barriers stimulated the development of a regional strategy for integrated working between treatment services and children's centres.) In addition, each centre was left with the legacy of an Action Plan, the Core Standards, the Best Practice Guidance, and access to an e-learning package as a framework on which to continue to develop their work identifying and supporting families affected by parental substance misuse.

### 3.6 The impact of the work on parents

#### 3.6.1 About the interviews

Seven parents (six mothers and one father), drawn from three of the partner sites, were interviewed. Five were interviewed as individuals, two as a couple<sup>5</sup>. Between them, they had 15 children, of whom 10 were under 5s. Two of the interviews were conducted using a centre family worker acting as translator. The parents were asked their views of their children's centre and also asked their views about their children's centre staff having received training and support from Addaction's First Steps project. Their stories, summarised here, are testimony to the need for work such as First Steps and for the effectiveness of First Steps itself.

#### 3.6.2 Parents' views about their children's centre

All of the parents greatly valued the specific children's centre they used, in terms of what they perceived their child/ren to have gained from going there. Figure 3.3 summarises the range of issues, **in addition to parental substance misuse**, for which they received support either directly from the children's centre staff or through other services to which the centre staff introduced them.

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<sup>5</sup> Four of the interviews, including the one with the couple, were not recorded but notes were taken at the time with permission and written up. The other two were recorded with permission and transcribed.

All seven parents said **they actively encouraged other parents they knew to use the centres too** and gave examples of friends and relatives they had successfully persuaded to come along with them. Once through the door, these other parents had also continued to use the centres. The only negative comments made across all of the interviews focused on the fact that the high demand for particular groups meant that families had to be turned away.

**Figure 3.3 The issues the children’s centres supported these parents with**

Parent (all pseudonyms)	Issues supported
Parent 1, Rashida partner in treatment for drug misuse	<ul style="list-style-type: none"> <li>• child’s delayed speech and language development</li> <li>• learning English as an additional language – Rashida had begun ESOL classes</li> <li>• partner’s drug misuse</li> <li>• access to primary health care</li> </ul>
Parents 2 and 3, Kanz and Asad Asad in treatment for drug misuse	<ul style="list-style-type: none"> <li>• emotional support for Kanz</li> <li>• learning to play with the children</li> <li>• Asad’s drug misuse</li> <li>• rebuilding positive family relationships</li> </ul>
Parent 4, Farhanah husband misused drugs	<ul style="list-style-type: none"> <li>• learning to play with her baby</li> <li>• support to access Addaction’s <i>Breaking the Cycle</i> service (holistic family support around substance misuse)</li> <li>• returning to employment – Farhanah had started an Access course</li> <li>• health care advice, with support to use GP</li> </ul>
Parent 5, Tamsin husband misused cannabis; Tamsin had previously misused drugs and still used cannabis sometimes	<ul style="list-style-type: none"> <li>• information about childcare to support return to employment</li> <li>• isolation</li> <li>• son’s sleep problems</li> <li>• poor state of housing</li> <li>• threat of eviction for rent arrears</li> <li>• poverty and debt (increased by husband’s cannabis misuse)</li> <li>• health problems</li> <li>• husband’s cannabis misuse</li> <li>• psychological problems</li> <li>• drug dealing neighbour</li> <li>• faulty gas meter</li> </ul>
Parent 6, Mary Mary is a recovering alcoholic	<ul style="list-style-type: none"> <li>• recovery process (from alcoholism)</li> <li>• state benefits</li> <li>• poverty (use of food bank)</li> <li>• attending hospital appointments related to daughter’s heart defects</li> <li>• needing someone to talk to</li> </ul>
Parent 7, Sandra ex-partner was a violent alcoholic	<ul style="list-style-type: none"> <li>• help with Job Centre</li> <li>• help to attend hospital appointments</li> <li>• help in dealing with the local council</li> <li>• support for Sandra’s mental health</li> <li>• support to deal with effects of previous relationship with violent alcoholic ex-partner</li> <li>• son’s attachment issues</li> <li>• son’s speech and language development</li> </ul>

Source: interviews with 7 parents affected by their own or their partner’s substance misuse.

The interview data suggests that mothers all **enjoyed** attending various groups at the centres because it gave their children a chance to play with other children and it gave them a chance to meet other parents, as well as **to relax and have some fun**. All their young children loved attending the respective centres. For example, Sandra and her little boy enjoyed attending 'Chill and Chat', a group especially for young parents. She and her son have lunch there and the last time she'd visited they'd made sock puppets and peek-a-boo blankets. She'd enjoyed chatting and socialising with the other young mothers there. Similarly, Mary and her daughter loved to attend 'Fruity Friday' focused on healthy eating. She described her most recent visit to that group in very positive terms:

'The group we go to, it's in the morning, it's called Fruity Friday. So the lady who runs it always does something about healthy eating, like we'll have fruit or salads or anything like that and gets the kids to join in and actually makes something. Later on, after they've had a little play or whatever, then they have it as a snack. So she made bunny rabbits out of pears last week with little marshmallows and stuff like that. She done painting, plays in the sand, lots of messy play. [...] I was doing it with her. Singing with them, playing musical instruments. Then they go in like a soft play area, it's got like the ball pond in it and they go in the ball pond and then they go on like the soft play and then they go like little toys and they go in like another little room links onto it and it's all lit up with like a strobe light effect, it's meant to help kids with autism and stuff like that, but it's for all the other kids as well. Then we all went back, had a snack and some songs with the instruments and said good bye and then we went home. That's all in like an hour and a half.'

All the parents gave similar, **very positive descriptions** of their most recent visit to their respective centres.

### **3.6.3 Parents' views about the impact of First Steps**

All of the parents interviewed were **very definite about the value of First Steps**. Some extended case studies are given to illustrate this. (Case study 1 is in Section 2.3.5, where Sandra talked about the impact of the First Steps training in enhancing how staff supported her needs.)

One effect of the First Steps work was that the children's centre staff were able to introduce the First Steps worker to the parents affected by their own or their partner's substance misuse and, through this, then introduce them to suitable support. For Rashida, (Case study 2) this involved linking her up with Addaction's Breaking the Cycle service, which provides holistic support for the family as well as treatment for the substance misuser.

#### **Case study 2 Rashida, mother of two children – support for both partners**

Asked about her views of the First Steps project, Rashida said she had found it really helpful. It had raised her awareness of drugs and alcohol and had given her signposts to other support [Breaking the Cycle] where she could have *her* needs met. She has seen some changes since the children's father has stopped using drugs because of the links to treatment made through the First Steps worker.

The success of the adult treatment in supporting Rashida's husband to stop using drugs was mirrored in the case of Kanz and Asad who also attended the same children's centre (Case study 3)

### **Case study 3 Asad, a father of four children – support into and after treatment**

Asad said the First Steps project had been useful. He and his wife, Kanz, had needed that support. It was great to have a place for his wife and children to come to. He acknowledged that life had been stressful at home because of his using drugs. The Centre had given his wife and children somewhere to go outside the home where they could meet different people. It had been nice for the children. Also when his wife had had too much on her mind she had been able to talk to Falisha, the family worker. He said that, at times, Falisha had been more of a trusted companion for Kanz than he had been able to be because of his drug use.

Asad also said that coming to the Centre had given Kanz ideas for new activities to try at home with the children. These fun activities had helped him to rebuild his own relationships with his children.

Asad said that it was because of Falisha that he had been willing to meet with the First Steps worker, Stuart. He liked Stuart and listened to what he had to say. After a few days, he woke up one morning thinking, 'That guy talked some sense', and agreed to go in to treatment. Stuart made that link to treatment for him. At the time of the interview, Asad had been clean for eight months.

In addition to the positive results of the First Steps work for their family, Kanz and Asad (Case study 3) described the benefits that they as a family had obtained from the normal everyday work of the children's centre – especially learning how to play and sing songs with their children. This was echoed by other parents – that using the children's centre enhanced the quality of their life as parents and of their children's life, with benefits at home as well as during the time they were in the centre. It was **the high quality children's centre 'service as usual' with the added benefits of the First Steps partnership** that **combined** to make such an impact on the parents.

In a different children's centre, Mary (Case study 4) described in detail the support she received from the centre staff to support her through the 'hell and torture' of her alcohol detoxification programme ('detox') and acknowledged how much it meant to her that the staff paid attention to her every time she visited the centre and phoned her up if they hadn't seen her for a while.

## Case study 4 Mary, mother of 3 children – support through detox

### *Support through 'detox'*

'Every time I go in, like I go in tomorrow and the first thing Angie, who runs the group, 'how are you today?'. I'm like 'I'm fine'. 'How's your week been?' and I'll say 'I'm still sober' and she starts laughing. She goes 'Good; I'm proud of you'. I've had the manager ring me up and say 'How are things going? I've not seen you for a while' because she's doing this that and the other. 'I'm alright; I'm doing this and that'. She's like 'I'm really proud of you; well done for what you've achieved'. And that is a real inspiration to carry on. She doesn't have to go out of her way to ring me up. She's got God knows how many families to see to but she always goes out of her way to show me respect and to ring me up and see if everything's okay. That means a hell of a lot. [...]

### *Support for other aspects of her life*

Before Christmas, because of alcohol issues, I had a Family Support Officer and she couldn't do enough for me and [my daughter] either. Always really, really good with her, like taking her to a hospital appointment and stuff like that. They didn't have to do that but they chose to.'

### *Mary's views of the value of the First Steps training for children's centre staff*

'The training will give [the staff] the support they need because, if someone walks up to them and asks them for help, and they haven't got a clue what they're doing, they could give them a wrong answer or a negative feedback which could make [the person] either drink or go back to drugs even worse. So [the staff] need to handle a situation like that with full care. It's a very delicate situation to be in. The people who are attending are very vulnerable, so whatever response they get from any person it's a very sensitive issue. The training would be an absolutely fantastic idea for them and maybe it will help more people as well. If they haven't got the training how would they know somebody is on amphetamines? How would they know someone is a heroin user if they haven't come across drug users before? You wouldn't know that. You've got to be aware of the certain symptoms, and awareness of drug users or alcohol users, to know the signs that they are dependent or they're not.'

'Since approaching them and telling them; they knew anyway I was an alcoholic, it was blatantly obvious, but the support that they gave me, knowing that I was going to be doing on a detox course, knowing that I was going to be coming out on a detox programme and trying to get myself back in the community, then I think the awareness has helped them a hell of a lot more because they've given me a hell of a lot of support.'

### *Mary had noticed posters and leaflets around the centre*

'What is it now? 'Think about what you're drinking' or something. It's a blue and a white poster and it says, 'how much do you drink?' or something like that. I can't remember exactly. And there's little leaflets around in the foyer and I think there's some up on the notice board as well. I'm not too sure but I know there's definitely a poster there and there is leaflets around.'

The case of Tamsin (Case study 5) illustrates the importance of children's centres in terms of being somewhere parents can rely on when life takes a turn for the worse. Tamsin had three children under five and lived in a block of flats with no lift. She found it hard to motivate herself to leave the house, and since her oldest under-5s child had begun to attend nursery, she had stopped making the effort to take her twins to the children's centre. The centre staff did not stop making contact with her, however, and continued to offer practical help to attend and to return home again. They invited her in to be interviewed and Tamsin used this opportunity to tell the centre manager that her husband was misusing cannabis again.

#### **Case study 5            Tamsin, mother of 4 children – support after relapse**

Tamsin explained that, through the First Steps work at the children's centre, her husband had been put in touch with Lifeline, a cannabis treatment organisation. However, he had stopped attending. Tamsin said that he had reduced his use and had promised that he would stop. The situation was difficult because they were now in debt and facing eviction from their flat. Tamsin did not want to lose her home. She had told him that he would have to leave her if he did not stop using. Thomas was spending £10 a day on cannabis, plus money for Rizlas and cigarettes, adding up to 'a hell of a lot'. Tamsin and the children were going without as a result.

Tamsin explained that in the past she had had problems with drugs. She said her history of having given up completely made her less sympathetic to Thomas's struggles to give up. She questioned why he had to reduce use before he could stop using. However, she did explain that he had been a regular user of cannabis from age 15 to 28, whereas she had only used for a short period of time and had started when she was older. She explained that Thomas' years of use could make it harder for him to give up.

Thomas had attended Lifeline when the children's centre worker went with him but had not returned on his own. Tamsin thought he would go if she went with him but she didn't want to have to take all the children to that office as it was not very nice for the children to see other drug users.

Tamsin had used the excuse of coming in to the centre to do the evaluation interview as an opportunity to update the centre manager of her situation regarding Thomas' use, and also that they had had another fire at the block of flats, this time it being the fire exit that caught fire. (Tamsin explained she had a terror of fires because of two previous experiences.)

By the time Tamsin left the interview room, the Family Support lead and the centre manager had organised immediate support for Thomas's drug use and counselling for Tamsin.

For Faranah (Case study 6), a young mother of a small baby, the First Steps work at the centre was an added bonus to the support she would have received there anyway through a designated family support worker.

#### **Case 6 Farahah, mother of a baby – support to understand more**

Farhanah explained that she had been using the Centre since her daughter was born. She said that her husband had been a drug user and had been in prison. Because of this, Farhanah had had a special social worker and midwife. Her midwife had put her in touch with Shuja, a family worker from the Centre.

Shuja had come to her house and had helped her to learn to play with her baby. He had also introduced her to Stuart, the First Steps worker, and he in turn introduced her to Sharmin, an Addaction 'Breaking the Cycle' family worker. Farhanah described Sharmin as a really sweet girl who visited her at home every other week which she found really helpful. Through Sharmin, Farhanah had increased her knowledge and understanding around drugs and alcohol so that now she was able to tell if her husband was using or not and could challenge him about that.

The interviewer asked how her husband reacted to her using the Centre. Farhanah replied that he didn't mind. She valued the fact that the Centre was a secure place for her to come to and that her worker had given her emergency numbers to use at any time of the day or night when necessary.

When asked directly about First Steps, Farhanah said she thought it was a very good idea. She was involved because of her husband. She confided that she had been ignorant about drugs and said that if she had known beforehand that her husband was using, she would have been more careful, especially about getting pregnant. Because of the help she had been given through Breaking the Cycle, she knew what signs to look out for and could question her husband. She stated that there were a lot of people using drugs in the area.

Before Breaking the Cycle, her husband had always denied that he used drugs but because of the regular visits to the house from Sharmin, the Breaking the Cycle worker, he had opened up more about why he takes drugs and what had happened to him in the past that led to that. Farhanah liked that her husband was now more honest about his drug use.

#### **3.6.4 *The value of First Steps***

The six case studies included in this report, vividly illustrate the added value that was created for families affected by parental substance misuse by the partnership between children's centres and Addaction's First Steps project.

Through the project, centre staff were able to use the '3-stage model' to respond appropriately:

- stage 1 – information for all
- stage 2 – brief advice for those affected by substance use
- stage 3 – brief intervention (if trained in this) and arrange meeting with substance misuse worker

The cases of the parents interviewed show the effectiveness of the First Steps work.

## **4. THE AIMS OF THE FIRST STEPS PROJECT**

### **4.1 First Steps Aims**

The First Steps project had two key, overarching aims:

- to improve children's centre staff skills, knowledge and working practices in relation to families affected by substance misuse;
- to facilitate a 10% increase in the engagement and retention of substance misusing parents/carers at the partner site.

The evaluation sought to capture data on both these aims, with changes in skills, knowledge and working practices being measured by pre and post one day training questionnaires and follow-up questionnaires administered from six to eight months following training day participation. Partner site interviewees were also asked about changes in these areas. In addition, qualitative and some quantitative data was gathered from partner sites and the Family Development managers relating to engagement and retention rates.

### **4.2 Skills, knowledge and working practices**

#### **4.2.1 Quantitative data**

- Analysis of pre-post questionnaires consistently showed statistically highly significant ( $p < .001$ ) improvements in knowledge, skills and confidence around supporting parents where substance misuse was an issue in the family (N = 2041 pre & 2014 post).
- Analysis of follow-up questionnaires completed 6-8 months later (N = 363) showed that the mean total score for knowledge, skills and confidence remained significantly higher than the pre-training score ( $p < .001$ ).
- This statistically highly significant increase from pre-training, maintained 6-8 months later, indicates that the training was effective in creating a lasting impact on knowledge, skills and confidence.
- 6-8 months after the training, 94% 'agreed'/'strongly agreed' that the training had improved their knowledge of how to support families affected by substance misuse; 91% their skills to do so; and 90% their confidence to engage such families.
- Most of those who received a Participant's Handbook after the training found each section 'useful' or 'very useful' (66-91%).

#### **4.2.2 Interview data**

All the interviewees from the partner sites were asked to reflect on the impact of the training day, and on the experience of being a partner site, and to assess to what degree they were better equipped to support families affected with substance misuse. In particular, the interviewees were asked to think about their skills, knowledge and working practices.

The data suggests that partner site managers and workers all perceived their involvement in First Steps to have strengthened their skills, knowledge and working practices in relation to supporting families affected by substance misuse. Further, staff also felt that, as a result of improved knowledge, skills, and clearer referral pathways and links with local treatment and support agencies, they were more confident in their ability to identify, engage and support families affected by substance misuse.

The combination of the First Steps training day and the partner site work was seen to have provided children's centre staff with strengthened skills and new or refreshed knowledge that enabled them to better support families affected by substance misuse. For example, one manager explained that:

'I think because of the training they [the staff] are much more open to looking out for signs. I think they feel much more capable of asking questions. I think we cover it more when we're doing our CAF forms. I think we cover it in supervision.' (5/M)

The training day was valued because enhanced knowledge and understanding was perceived to have led to improved confidence, resulting in a greater readiness to identify and engage families:

'It [the training day] just made me more confident in talking to families. I feel a little bit more knowledgeable, and, obviously, having more knowledge gives you more confidence.' (6/FSW)

Partner site work built on the initial training, providing centre staff with additional knowledge, further training, and new and reinforced links with other local agencies. The developments in promoting integrated working were particularly welcomed, with managers and workers saying that their improved awareness of the available substance misuse treatment and support services, and of the referral pathways into them, gave them a greater confidence in tackling the issues. Examples included:

'I think they [the centre staff] are more confident about where they would go for support and stuff.' (9/M)

'I think that it [being a partner site] has been effective [...] I just think that all the staff, myself included, we're just more aware of what's available for families, so we're just really positive and how to have those conversations as well.' (11/FSW2)

These changes in knowledge, skills and confidence were perceived to have led, in turn, to changed practice in the majority of partner sites. These included an increased willingness to ask parents/carers about substance misuse issues to changed centre protocols, and recording and referral processes. Staff in partner centres appeared, on the whole, to feel more capable of assessing situations involving substance issues, as one family support worker explained:

'We go out on home visits. If we had seen our parents on drugs or alcohol in the past we'd have done an immediate referral. We no longer do that; we look around at home conditions, the health and well-being of the child, where and what the child is doing. And I think it has stopped us doing referrals in, which nine times out of ten we did get bounced back to us, but there's a lot of paperwork and time and write-ups involved with that.' (9/FSW)

### **4.3 Changes in engagement and retention at partner sites**

#### **4.3.1 *Measuring identification***

As reported in the End of Year 1 report (Cullen, Cullen, Lindsay, Barlow, 2012), all the partner sites were asked to provide baseline data on the identification of substance misusing families and the support available. 'Baseline' was defined as 'the situation as at end of January 2012'. A short template was provided and termly

updates were requested. This approach to measuring increased identification was not successful because only a minority of centres returned the information requested. As reported at the end of Year 1, eight of the 15 partnership centres provided information. At that time, numbers of families identified ranged from 0 to 20, with no or a very few families identified being the norm.

For the final round, only two centres provided update information. In both cases, there was an increase in families identified. In one centre, this had risen from 0 to 23; in another from 12 to 16. Feedback from the partner children's centres suggested that being asked to collate figures on this topic was a step too far for the majority within the lifetime of the First Steps project. For example, one manager indicated that it simply wasn't feasible, given the centre's workload, while another e-mailed to explain that they had not had a system in place to provide the information requested but had developed their case auditing process so that numerical data on parental substance misuse was incorporated:

'Our struggle in terms of providing data was that we did not have a system in place to provide you with accurate numbers. This has been a great learning opportunity for us and we have incorporated it into our caseload auditing process.'

Qualitative information from the interviews with centre managers and staff, and interview and written information from the First Steps Family Development Managers, indicate that identification of parental substance misuse increased in at least 10 of the 15 centres. In one centre, for example, identification did not increase because the manager did not support any changes to practice that would have enabled neutral questions on this topic to have been routinely asked of parents. In the other four centres, not enough information was provided to either the Family Development managers or us, to know for certain whether or not more families affected by parental substance misuse had been identified.

#### **4.3.2 Evidence of increased support, engagement and retention**

As a measure of support available to parents/carers identified as misusing substances, centres were asked how many identified families they had referred on to a local treatment provider.

At baseline (January 2012), we received information from 8 of the 15 centres. In two of these eight children centres, centre staff had referred at least some families to the local treatment provider. In two other centres, identified families had already been referred to the local treatment provider by other professionals. Two centres had not referred any of their identified families. Finally, two centres had no identified families. By the end of the project, data from the Family Development Managers' Exit Summaries, and from interviews with centre managers and staff, suggests that referrals from the majority of the 15 centres to local treatment providers had increased in line with new identification of families affected by parental substance misuse. In addition, where projects such as Addaction's *Breaking the Cycle*, which also support affected members of a user's family, existed, referrals were made to these services too. For example, in Area 12, four of the five centres had increased referrals out to local treatment providers.

Referrals in from local treatment providers to the children's centres had also increased in some cases – again using Area 12 as an example, four of the five centres had experienced this, an indicator of improved knowledge about the what children's centres do and how they can play a role in supporting recovery.

As a measure of the joint working practices between the local treatment provider and the children's centre, at baseline in January 2012, centres were asked to identify how many times staff from the centre had had face-to-face contact with any staff from the local treatment provider/s (including meetings attended by a centre representative and a local treatment provider representative. Prior to the beginning of the First Steps partnership working, five of the eight children centres had had *no* face-to-face contact with any staff from the local treatment provider, whereas three had. By the end of the project, a combination of interview and written information indicated that in each area four out of five centres had established face-to-face contact with at least one local treatment provider. In addition, as discussed in Chapter 3, there were some strong examples of both strategic and operational integrated working involving children centres and local treatment providers.

To illustrate what increased engagement and retention looked like in the context of a children's centre, the centres were asked to submit quarterly anonymised logs of at least 1 and up to 10 families where parental substance misuse was identified. To protect against biased examples, centres were each given a random letter of the alphabet and asked to choose the first one or more families whose surnames began with that letter or with the next closest letters in the alphabet. As with the numerical data request, this approach was also unsuccessful, for the same reason that it required additional work from the centres. Only two centres returned summary logs – in one of these instances, the centre returned quarterly information on all families where parental substance misuse was identified. Although only two centres provided information in this format, these two examples gave a rich picture of what engagement and retention looked like in practice. Figure 4.1 provides a flavour of this.

**Figure 4.1 What engaging and retention means in practice**

Analysis of anonymised logs of one children's centre work with parents affected by substance misuse demonstrated:

- the complex needs of the parents e.g. own or partner's substance misuse, debt, poverty (e.g. requiring food vouchers), housing, domestic violence, drug dealer harassment – each of these was addressed directly or by linking the parent/s to other specialist support services
- the developmental and special needs of the children e.g. speech and language development, attachment issues – these were addressed both by centre workers and by specialist therapists
- the patience and persistence required from family support workers to retain the engagement of the parent – often when contact was desired, multiple attempts were required using, for example, phone, text, knocking on the door.
  - For example, one randomly selected case log recorded 85 entries (including contact with a range of professionals) over three months before substance misuse came to light through talking to the GP about domestic violence reported by the mother. In the following 6 months, a further 98 entries were logged before the case was closed.
- the complexity of the interagency working required to coordinate efforts across, for example, health, social services, housing, drug and alcohol treatment service/s – multiple letters, phone-calls, e-mails and meetings

Source: anonymised casework logs for 23 families affected by parental substance misuse at one of the partner children's centres

## 5 CONCLUSIONS

Based on the evaluation data, the 'First Steps' pilot has been a successful and beneficial project.

### 5.1 The one-day training course for children's centre workers and colleagues

- The one-day training course had **2351 participants**, about 150 short of the target KPI of 2400. The number who booked on the training day **exceeded** the target; the small shortfall was due to people cancelling, or not being able to turn up on the day, due to unforeseen circumstances.
- Analysis of pre-post questionnaires consistently showed **statistically highly significant ( $p < .001$ ) improvements in knowledge, skills and confidence** around supporting parents where substance misuse was an issue in the family (N = 2041 pre & 2014 post).
- Analysis of follow-up questionnaires completed 6-8 months later (N = 363) showed that the mean total score for knowledge, skills and confidence **remained significantly higher** than the pre-training score ( $p < .001$ ).
- This statistically highly significant rise from pre-training, maintained 6-8 months later, indicates that the training is **effective in creating a lasting impact** on knowledge, skills and confidence.
- 6-8 months after the training, **94%** 'agreed'/'strongly agreed' that the training had improved their **knowledge** of how to support families affected by substance misuse; **91%** their **skills** to do so; and **90%** their **confidence** to engage such families.
- Most of those who received a **Participant's Handbook** after the training found each section '**useful**' or '**very useful**' (66%-91%).

In Year 2 of the pilot, the training was offered as a commercial product, priced at £35 per head, with reductions for bookings of 20 or more.

- Despite great efforts on the part of the First Steps team, the income generation KPI target of £40000 was not reached within the timescale of the pilot.
- There was evidence that, given a longer timescale, this could have been achieved. For example, opportunities to train large numbers of staff were negotiated but could not be finalised and timetabled until after the pilot.
- Without the security of proven income generation, the First Steps team was viewed as unsustainable and disbanded. The demise of the team, despite the high quality and lasting effects of the training, illustrate the harsh reality of having to move from grant funding to commercial funding without the availability of transitional resources to bridge the gap between delivering on the grant and gearing up to achieve commercial income to scale.

*Legacy:* the First Steps training will continue to be offered by Addaction.

### 5.2 The partnership work in 15 children's centres

Analysis of interviews with the First Steps Family Development Managers, and of their summary logs of work with the 15 centres, showed that the creation of an effective partnership between Addaction, the children's centre, and local treatment agencies was a complex process, and involved dealing with:

- the complexity of each local area's structures and environment within which each partner children's centre operated;
- multiple agencies in each local area, including health, social work, educational psychology, family support, adult treatment service/s, drug and alcohol action teams;
- numerous barriers to progress that required patience, persistence and creativity to overcome; for example, the impact of the wider economic situation on job security; of local restructuring or recommissioning of children's centre delivery; of competition among drug and alcohol service providers, and of normal operational issues such as turnover of managers.

Because of these barriers, progress in embedding the First Steps work progressed at different rates in each of the centres. By the end of the pilot, **positive changes were evident in practice in all 15 centres.**

Partner site work was, in general, highly valued, and managers and staff provided a wealth of positive feedback on partner working and future hopes and plans in this area. In particular, partner working was valued because of:

- the in-centre visits, co-working and knowledge of the Addaction Family Development Managers giving children's centre managers and staff access to support and specialist knowledge surrounding substance misuse
- the development of integrated working with other local agencies and services. In a minority of cases, partner children's centres already had an active referral network, but for the majority of partner children's centres, the opportunity to build local networks and referral pathways was a new, and highly valued experience
- shadowing opportunities were seen to be important and valued, both in terms of children's' centre workers shadowing colleagues in adult treatment services, and these colleagues shadowing children's' centre workers
- the opportunity that partner working provided for children's centres to showcase to a range of relevant local support services the range of provision that they offered universally to parents and families.

The **Practice Guidance**, and the **Core Standards Action Plan** were welcomed by children's centre managers as providing informed guidance for work in relation to substance misuse. In addition:

- managers welcomed the opportunity, often shared with other centre staff, to input into the development of the Practice Guidance and the Core Standards Action Plan.
- For the majority of the partner sites (at the time of final interviews) the implementation of some points on the Action Plan was still a work in progress but many positive changes in practice were evidenced and commitment was strong to continue to work on making other changes beyond the life of the pilot project.

It was not possible to assess the number of centres which achieved the KPI target of improving by 10% the engagement and retention of substance misusing parents. The data proforma designed to evidence this were not returned by every site (8 of 15 did so at the baseline point; two at the final point). Feedback from some partner sites suggested that being asked to collate figures on this topic was not viable within the lifetime of the pilot project (at least one centre manager had set up systems to do this for the future and others had this on their action plans). **In the two centres that**

**returned baseline and final data on this measure, identification of parental substance misuse rose** significantly (for example, from 12 to 17 families; from 0 to 23 families), with **evidence** from case work files and activity registers **of successful long-term engagement of these families.**

In the three least successful partner sites (one per area), there were barriers to full engagement in the pilot not related to the initiative. For example, local children's centre reorganisation, staffing problems (long term sickness, understaffing), staff cuts resulting in over-stretched centres finding it difficult to take on a new initiative, local managers not ensuring a voluntary buy-in to the initiative. To enable engagement, these situations required the First Steps team to show sensitivity to the good work of, and pressures faced by, such partner sites and to work with them at the speed and in the ways that best fitted their situation.

*Legacy of the partner work:* In addition to the Core Standards, Practice Guidance and online learning, typically, partner centre managers and staff hoped that the First Steps initiative would mean continued engagement with the issue of supporting families affected by substance misuse. In particular it was hoped that:

- links with local agencies and services would be maintained and extended;
- more referrals from adult treatment services of substance misusing parents/partners in to children's centres would result from greater integrated working, in addition to referrals by children's centres of such parents to local treatment and support agencies and services;
- refresher training would be available for children's centre staff around substance misuse;
- the learning from the project would be shared locally to extend good practice as part of area strategy.

At least eight exit strategies documented local strategic commitment, from children's centre leads and adult treatment service leads, to taking forward the First Steps agenda across the local area.

### **5.3 Conclusion**

Based on the evaluation data, although the 'First Steps' pilot did not achieve all its target KPIs in full, there is evidence to show that it has been a successful and beneficial project leaving a legacy on which further work can be built.

The **one-day training** has been of high quality with a lasting effect on staff knowledge, skills and confidence 6-8 months later. The KPI for 80% satisfaction with the training was exceeded (98%); and the KPI for 2400 trained was achieved (allowing for the fact that some who booked did not turn up on the day). Although the KPI for £40000 of income generation was not achieved within the lifetime of the pilot, there was evidence of large-scale interest post-pilot. The training continues to be available through Addaction, although the First Steps team has been disbanded.

The **partnership work** has been highly valued. The KPI of a 10% improvement in engagement and retention in *each* centre was not achieved (e.g. one centre manager saw no need for improvements in this regard) but qualitative data indicated improvements in identification, engagement and retention in the majority of centres and quantitative data provided examples where the KPI improvement target was far exceeded. Difficulties encountered in a minority of partner centres have led to improved understanding of the factors critical to success which is important for how

Addaction takes this work forward. In a majority of the local authorities where the partner children's centres were based, there was strategic commitment to spread the First Steps work across all children's centres. The Core Standards, template Action Plans, and Best Practice Guidance provide a framework for such an expansion in these, and other, areas.

## **6 Recommendations**

'First Steps' was a pilot project from which much has been learned that is of continuing relevance to the Department for Education which provided the pilot funding; to Addaction, the organisation that designed and delivered the project, to children's centres, and local adult treatment services. The following recommendations are made:

### **6.1 Recommendations to the Department for Education (DfE)**

- To consider how the development of the First Steps training, the Core Standards, and the Best Practice Guidance for children's centres can best be taken forward, alongside Addaction and others in the sector.
- To consider issuing guidance to children's centre and adult treatment service providers, emphasising the mutual benefits of working together to improve outcomes for families affected by parental substance misuse, and encouraging them to implement the First Steps Core Standards and Best Practice Guidance.

### **6.2 Recommendations to Addaction**

- To consider how best the work of the First Steps pilot can be taken forward strategically, working with the Department for Education and sector partners.
- To work with *all* their local adult treatment services to ensure family-focused work is embedded in each area, and that all their treatment services are routinely linking in with universal services, including children's centres, to support recovery for users who are parents of young children, to support the developmental needs of those children, and as a gateway to holistic support for the whole family.
- To plan strategically to avoid the loss of expertise and experience built up during pilot projects, such as First Steps, when these come to an end, seeking to ensure a source of alternative funding to bridge the inevitable gap between grant-funded pilot projects, on the one hand, and fully commercial income streams on the other.
- To draw on the expertise of sales and marketing professionals, if appropriate, to support development of fully commercial income streams through direct selling of training, such as the First Steps training.
- To commit to marketing the First Steps training.
- To consider using the members of the First Steps team as consultants to train up trainers to deliver it across the country.

### **6.3 Recommendations to children's centres leaders**

- To adopt and implement the Core Standards (including a local version of the Action Plan template) and Best Practice Guidance developed through the First Steps pilot project.
- To work together strategically with drug and alcohol treatment service leads to improve the operational delivery of holistic support for families affected by substance misuse.

#### **6.4 Recommendations to local drug and alcohol treatment services**

- To engage with local children's services to develop an understanding of the role universal services, such as children's centres, can play in the recovery process.
- To support local children's services to implement the aspects of the Core Standards and Best Practice Guidance that require collaborative and integrated working.

## REFERENCES

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## APPENDIX CORE STANDARDS

### 1. **ORIENTATION: The Children's Centre is orientated towards working with parents who use alcohol and drugs.**

**Visual aids & printed materials:** Easily accessible visual and printed literature providing information about substance misuse, sources of help and support, and the children's centre own services and policy with regards to parental substance misuse.

**Identification & Advice:** Early identification of parental substance use via initial assessment processes and supportive harm-reduction advice provided at the earliest opportunity.

**Competent & Confident Staff:** All staff in all roles feel confident to talk with parents and families about substance use/misuse and competent to signpost clients for appropriate additional support.

### 2. **WORKFORCE DEVELOPMENT: Children's Centre staff have the knowledge, behaviours and skills that demonstrate an ability to engage & support children and families affected by substance misuse.**

**Included in Induction of all new staff:** All new staff to be inducted into the centre's policy and practice in relation to parental substance misuse & training needs identified.

**Initial & on-going Training & Development:** All staff to attend regular training in basic drug & alcohol awareness and multi-agency approaches to parental substance misuse via local DAAT, LSCB and specialist substance misuse services.

**Supervision & Specialist Support:** Parental substance misuse standard agenda item within line management supervision and provision of specialist consultation via centre lead and/or local specialist substance misuse practitioner.

### 3. **INTEGRATED WORKING: All those working in and with the Children's Centre work effectively together to meet the needs of children and parents affected by substance misuse.**

**Comprehensive service delivery model:** Addaction 'First Steps' 3-stage response model adopted and developed to meet local need.

**Partnership working & collaboration:** Identification of key partners (universal & specialist agencies) and involvement in holistic packages of care for parents affected by substance misuse.

**Data collection & targeted service delivery:** routine collection of parental substance misuse data via assessment and referral documentation and developmental of service response in line with local need.

**4. ENGAGEMENT & RETENTION: Families affected by substance misuse are proactively engaged with by Children's Centres and provided with ongoing support.**

**Outreach & Satellite services:** Development of partnership working with local universal and specialist services to offer children's centre services in other locations & settings.

**Substance Misuse Lead worker & Joint working with specialist services:** Lead worker identified who will develop specialist parental substance misuse knowledge, skills & joint working arrangements with a range of specialist services to ensure comprehensive response to parental substance

**Service-User Involvement:** Creation of informal service-user consultation group of parents with experience of substance misuse issues to guide on appropriate service development.

**5. SAFEGUARDING AND CHILD PROTECTION: Ensuring that children of parents who misuse alcohol and/or drugs are safely and effectively cared for**

**Identification & Risk Assessment:** Routine risk assessment process implemented when parental substance misuse has been identified & safety plan agreed.

**Local Protocols & Procedures:** Identify & sign-up up to local protocols between children's services and drug/alcohol services and implement safeguarding and child protection recommendation.

**Partnership working with specialist services:** Management from each agency to develop & facilitate co-working arrangements.

Source: Addaction, with Wendy Robinson, 2012. *Addaction: First Steps. For Children's Centres working with Parental Substance Misuse. Best Practice Guidance*. London: Addaction.