Addaction's Breaking the Cycle service: Annual Outcomes Briefing 2015 to 2016

1 A PORTRAIT OF THE BREAKING THE CYCLE SERVICE

The long term ambition of Breaking the Cycle is to break the cycle of transgenerational substance misuse[1]. To address this, Breaking the Cycle seeks to achieve three key outcomes: i) to reduce the harms associated with substance misuse; ii) to support children in relation to child protection and safeguarding; and iii) to promote positive parenting efficacy and family functioning. Addaction practitioners have identified that families may slip through the net of support when dual diagnosis criteria such as substance misuse treatment and mental health interventions for anxiety and depression cannot be coordinated together (even if they are not delivered by the same providers). Likewise, where child protection and parental substance misuse needs exist, practitioners advocate for engagement with multi-agency, including statutory partners to facilitate uptake and retention with key services. Thus, Breaking the Cycle intends to provide a single point of access and works in partnership to coordinate the support for families at their point of need. A recovery plan and integrated outcome monitoring package are routinely built into this process.

The core inclusion criteria for referrals to BTC are: one or more primary caregivers in the family who experience problematic drug or alcohol misuse and one or more children within the family home who are at risk of harm as a result of the substance misuse problem. Interventions range from direct work within family homes establishing routines and pro social family behaviours to the provision of specialist alcohol and drug support with a specific focus on the impact of substance misuse upon children, parenting support, advice and advocacy, consultation with children discussing 'lived experience', signposting and referrals to an extensive range of statutory, primary care, community midwives and voluntary community based services.

[1] The terms 'Breaking the Cycle' and 'BTC' are used interchangeably throughout the briefing document.

Examples of the partnership organisations across Breaking the Cycle services are provided in the table below.

Partnership examples across the Addaction Breaking the Cycle service.	
• Social services	• Culture, gender sensitive drug services
• Community drug team	• Pregnancy and early year providers
• Community alcohol team	• Homeless centres and hostels
• Children's centres	• Crisis support services
• Family centres	• Domestic abuse and violence services
• Parenting, family intervention services	• Mental health and community services
• Primary healthcare services	• Local solicitor companies
• Finance and benefit support services	• Community or peer support groups
• Criminal justice services	• Education services
• Residential rehabilitation units	• Employment services

Common difficulties experienced by BTC families include substance misuse or challenges to prevent relapse and issues relating to parenting skills, challenges that arise during pregnancy, meaningful occupation, finance and budgeting difficulties, concerns about domestic abuse, anti-social behaviour and the safeguarding and protection of children. A flexible approach to the coordination of interventions is therefore essential. The table shown below lists the range of interventions that were coordinated by practitioners over the last year.

Interventions coordinated by the Breaking the Cycle Practitioner.	
• Advice, information and advocacy	• Needle and syringe exchange
• Pregnancy support	• Peer support and volunteering
• Domestic violence and abuse interventions	• Mutual Aid
• Parenting and family interventions	• Community recovery groups
• Brief interventions	• Family social network support
• Motivational interviewing	• Psychodynamic interventions
• Housing support	• Practical interventions
• Job centre, employment and careers support	• Counselling
• Money management and budgeting	• Cognitive behavioural therapy
• Relapse prevention interventions	• Prescribing and pharmacy interventions
• Troubled Families support	• Targeted support for Bangladeshi families
• MPACT family intervention	• Specialist young person support

Regular home visits within BTC provision means that parents do not need to fund or coordinate childcare in order to engage with the service. Similarly, the therapeutic relationship that is developed with this form of social care between practitioner and service user often serves as a buffer against previous mistrust and poor engagement with services. For example, parents have identified their support from Breaking the Cycle as being a salient component in re-engaging with children's services. Ideally a family would be expected to engage with Breaking the Cycle for a duration of between 6 and 12 months. Families who require longer term support may be referred to additional support services on discharge. When transfer to another service takes place, practitioners typically work with families during the process, using a planned approach, to facilitate uptake and engagement in the receiving service. The key referral routes are through social services and child protection teams, adult treatment services, family focused services, primary health care teams and self-referrals.

Families who provide informed consent allow their anonymised data, identifiable only by a single serial number to an independent evaluator who is based at the University of Bath. This enables bi-quarterly and annual analyses of the outcome monitoring data to take place using a single sample, pre and post intervention mixed qualitative and quantitative evaluation design.

2 DISCHARGE OUTCOMES SUMMARY

Three hundred and forty two families discharged from the Breaking the Cycle service between 2015 and 2016. The majority of parents used alcohol as their primary problematic substance (49%). Almost a third of parents used drugs as their primary problematic substance (29%). A minority of parents used both alcohol and drugs problematically (12%). A small percentage of service users were family members (or concerned others) (7%)[2].

In total, 70% of the families who completed their engagement with the service experienced a planned discharge. In contrast 30% of families did not experience a planned discharge. The table below shows the discharge situations for families in relation to substance use outcomes.

Substance use outcomes at discharge.

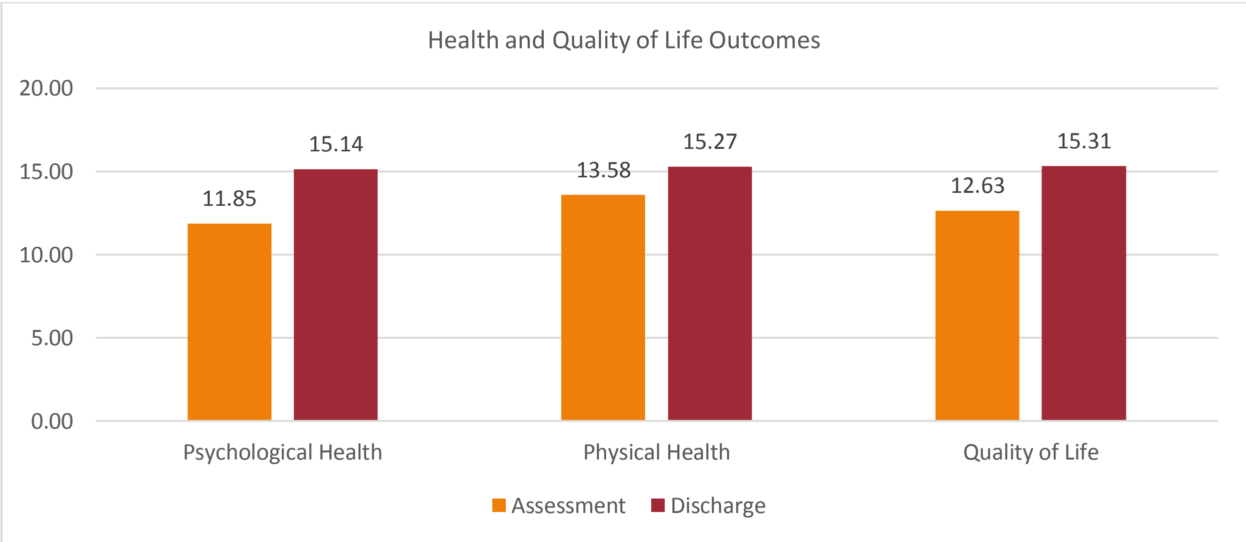
Planned - Family Member	Planned - Complete alcohol abstinence	Planned - Complete drug abstinence	Planned - Occasional use only	Planned - Transferred successfully to adult treatment	Unplanned -Did not engage due to drop out, not commencing, withdrawal or refusing treatment	Inappropriate referrals	Total
7%	20%	13%	12%	18%	27%	3%	100%

[2] National database information was missing from 3% of the sample.

3. PARENTAL HEALTH OUTCOMES SUMMARY

Parents identified health and quality of life aspects of their lives as being influenced by the support they were given whilst engaging in the Breaking the Cycle service. Parents were asked to rate these three domains every twelve weeks throughout their engagement with Breaking the Cycle. The data presented in this briefing report displays the findings from assessment and at the point of discharge.

The bar chart illustrates the ratings that were provided by parents. The lowest rating option was zero (poor). The highest rating option was twenty (good). On average, there were positive changes in the ratings provided by parents in each of these three domains. Parents attributed these changes to being supported to address substance using harm related problems that impacted on health and quality of life. This is especially the case when using harms on assessment were being attributed to unstable and chaotic substance use. The greatest change occurred, on average, in relation to psychological health. There was less change in relation to quality of life. However, the smallest amount of change occurred in relation to physical health, although this domain was the least problematic to parents on assessment, as shown in the chart.



Depression and Anxiety: In addition to improvements in health, significant change also occurred with the reduction of severe symptoms associated with clinical depression and anxiety. The tables on the following page demonstrate the positive outcomes for parents. The majority of parents successfully tackled frequent and restrictive symptoms that can impact negatively on emotional bonds with offspring and close family members, especially to compound substance misuse. Often, parents value the process of reflecting upon these distances travelled and can appreciate their investment in working towards the reduction of substance related harms and achieving positive mental health, physical health and quality of life.

Importantly, where signs of clinical depression and anxiety were persistent, targeted referrals occurred to ensure that parents received appropriate support. The productive relationships that Addaction holds with partnership organisations and mental health services ensures that referrals occur promptly to meet the needs of the families. This process is supported by the use of industry standard tools that are widely acknowledged within primary healthcare settings. The outcome measure findings for these two domains can be seen below.

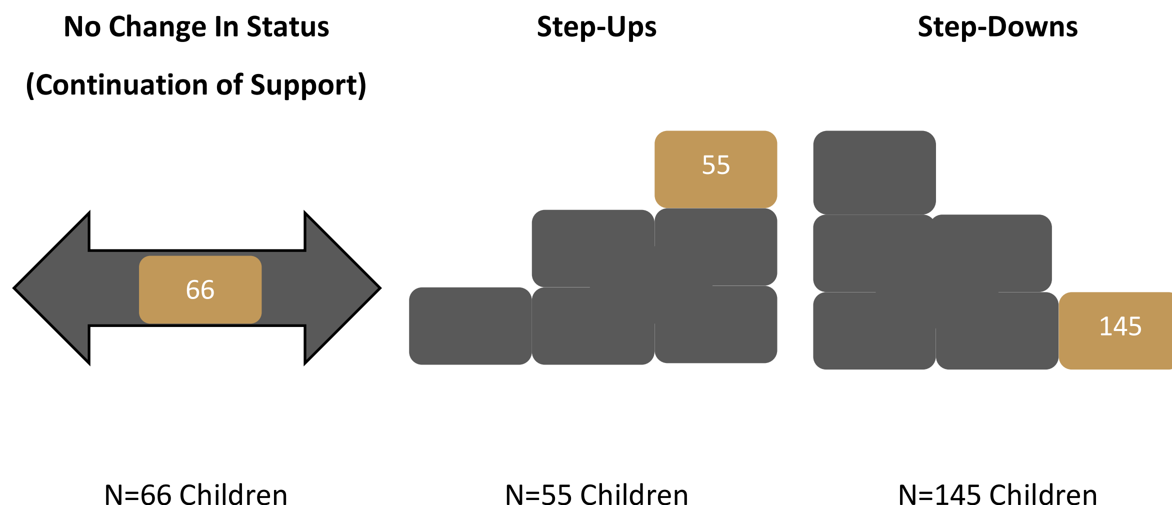
Depression diagnostic criteria with the Patient Health Questionnaire-9 findings.		
	Responses at assessment (%)	**Responses at discharge (%)**
No clinical symptoms	25	66
Mild depression	25	25
Moderate depression	27	7
Moderately severe depression	12	0
Severe depression	11	2

Anxiety diagnostic criteria with the Generalised Anxiety Disorder-7 Scale findings.		
	Responses at assessment (%)	**Responses at discharge (%)**
No clinical symptoms	23	71
Mild anxiety	32	22
Moderate anxiety	22	4
Severe anxiety	23	3

4. CHILDREN'S SAFEGUARDING AND DEVELOPMENTAL OUTCOMES SUMMARY

SAFEGUARDING OUTCOMES DATA were submitted to the evaluation team from 278 children who were aged from 0 to 18 years of age. Breaking the Cycle practitioners fulfill a key role in supporting families to adhere to child protection and safeguarding support and in working closely with partners to identify children who could benefit from a needs and risk assessment and case study review.

In the context of outcome analysis, when children's protection and safeguarding status is the same on assessment as it is on discharge, no change in outcome is noted. When the status of a child involves the escalation in the intensity of support required through partnership working with children's/social services, the term "step up" is utilised. One example of a step-up would include the case of a child who was classified as a "Child in Need" who then engaged fully with a Child Protection Plan. When the status of a child involves the reduction in the intensity of support, the term "step down" is utilised. One example of a step-down would include the case of a child who was classified as "Child in Need" who then fully re-integrated with family life with no support from statutory services regarding their child protection and safeguarding situation. The three diagrams below demonstrate that the child protection status changes for the children engaged with the Tower Hamlets Breaking the Cycle service.



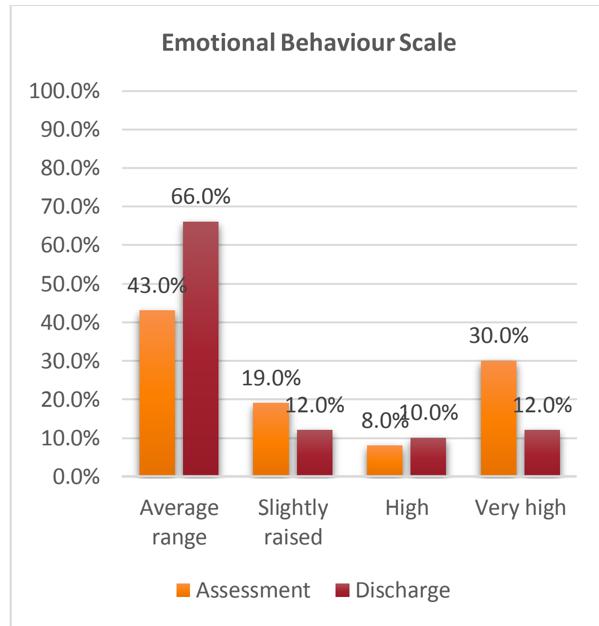
Step downs represent a salient outcome for families to demonstrate the distance travelled in reducing the harms that deleteriously impact upon children's safety, welfare and development. However, Breaking the Cycle practitioners are strong advocates for identifying where child protection and safeguarding support is needed and where support should continue, in general, but also especially when harms associated with substance misuse are continuing to represent a risk to children. The diagram on the previous page highlights these outcomes, demonstrating that practitioners support families who may be continuing on their journey to reduce the harms to which children are exposed and those families who required more intense support whilst they engaged in the Breaking the Cycle service.

School Attendance Outcomes: Whilst Breaking the Cycle practitioners do not provide direct educational interventions to children, they do help families by coordinating support from education providers and children's services. Thirty five per cent of children were too young to attend school (under 5 years of age). As expected, emerging data shows that a decrease in school attendance occurred most often where families experienced an unplanned discharge from the Breaking the Cycle service (10%). Arguably, these families would benefit from continued interventions, especially to support children and parents to reduce the harms associated with problematic substance use and the impact it has on offspring. Attending school and scholastic achievement are likely to be protective factors that can buffer against the risks that offspring of parental substance misuse experience. As such, practitioners welcome families who return to the service appreciating that supporting parents to reduce problematic substance use and to engage in recovery is not usually a linear one direction journey. There was no change in school attendance for 7% of children, where typically, school attendance was high and where the majority of these families experienced a planned discharge from Breaking the Cycle. Likewise, there was increase in school attendance for the remaining 48% of children, again where planned discharges also tended to occur from Breaking the Cycle for the majority of families. Whilst direct causation is not being implied, it will be interesting over the next year to analyse further the nature of the support that practitioners offer families in coordinating

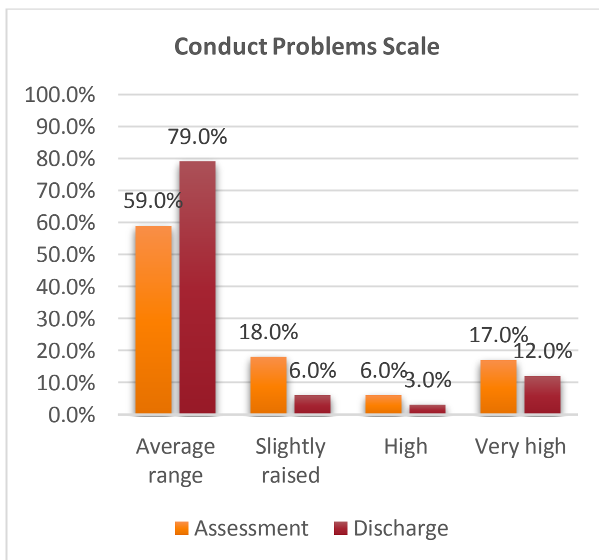
education interventions and to share findings with these partners, especially given the attributions of Breaking the Cycle support provided by parents.

DEVELOPMENTAL OUTCOMES: Breaking the Cycle collects data about children's developmental outcomes that focus on emotional behaviour, conduct problems, hyperactivity and attention issues, peer relationships and pro social behaviour domains. Using the Strengths and Difficulties Questionnaire, this data is analysed to classify outcomes that are distributed from an 'average range' to outcomes that indicate 'slightly raised', 'high' and 'very high' scores respectively. The Strength and Difficulties Questionnaire contains 25 statements in total which map onto the five domains cited above (Goodman, 1997). Based on professional observation, conversations with parents, children and clinical notes or documents, the BTC practitioner allocates an appropriate score (using a 3 point likert scale) to each of the statement items. The measurement of children's outcomes originates from a large study that was undertaken as part of an Office for National Statistics Department of Health study with British children. The Questionnaire can be used for children who are aged between 4 and 17 years. The data that follows demonstrates that the majority of children's behaviours do not reach the clinically problematic threshold across the outcome domains by the point of discharge. Where children do experience potential developmental risks, specialist and targeted referrals to support these children and their parents are reinforced by the Breaking the Cycle practitioner.

Emotional Development:-



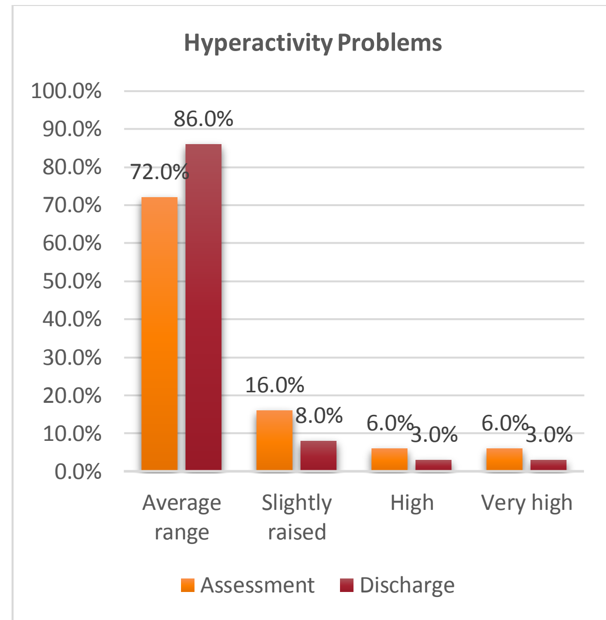
Almost half of the Breaking the Cycle children presented with average scores for normative emotional behaviours (43%). Examples of average range emotions include general emotional stability and the absence of intense worry, fear, nervousness and anxiety. By discharge, 66% of children were in the average score range. Where scores were raised for children, there was a reduction in severity over time. Practitioners were able to ensure that support was in place for these families, especially where scores were very high.



Conduct Problems:-

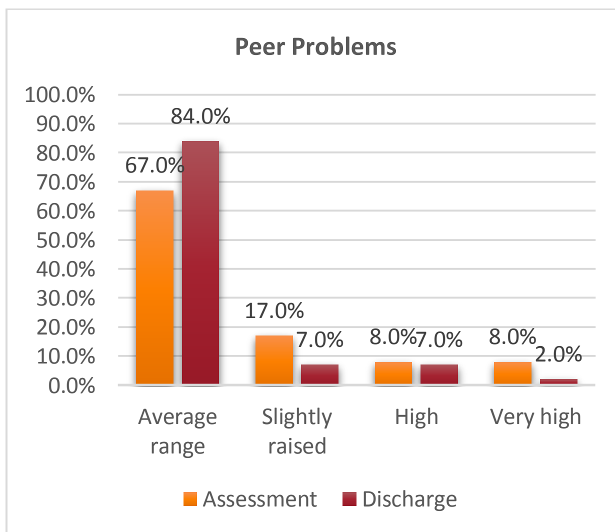
Forty one per cent of children were identified as having some difficulty with behavioural conduct at assessment. Conduct problems included being oppositional and quickness to anger (such as temper tantrums). By discharge, this percentage had reduced and 21% of children experienced problems relating to conduct. The parents of these families were supported to learn strategies to prevent and/or manage responses to children's behaviour. Where necessary, onward referrals for support for children and their parents were also made.

Hyperactivity Problems:-



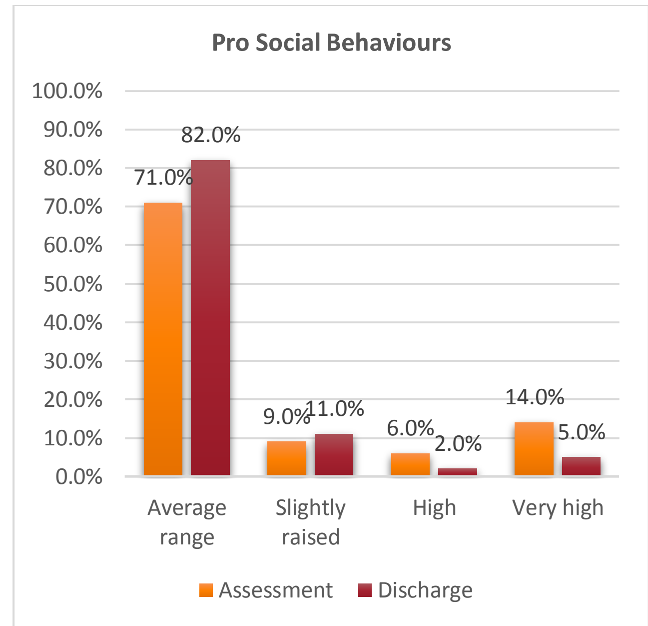
The majority of children did not have significant issues relating to hyperactivity when they first engaged with Breaking the Cycle (72%). However, 28% of children struggled with hyperactivity to some extent. Examples of hyperactivity typically included being restless, easily distracted, unable to complete tasks and taking action before thinking things through. By discharge, 14% of children continued to experience some difficulty with hyperactivity. Although the majority of the problematic scores were classified as 'slightly' raised, from a practice perspective, this was an early indication of the need to refer and coordinate more targeted support for these Breaking the Cycle families, especially the 6% of children with high and very high scores.

Peer Problem Outcomes:-



The majority of children did not experience problems in their peer relationships on assessment (67%). Examples of peer problems are a lack of same-age friends, preferring solitary play, feeling bullied or being picked on by other children. Thirty three per cent of children experienced issues with peers. By discharge, 16% of the children experienced peer problems that were scored within a threshold that presented clinical concern that required further support within the families to help children begin to tackle these emerging issues.

Pro-Social Outcomes:-



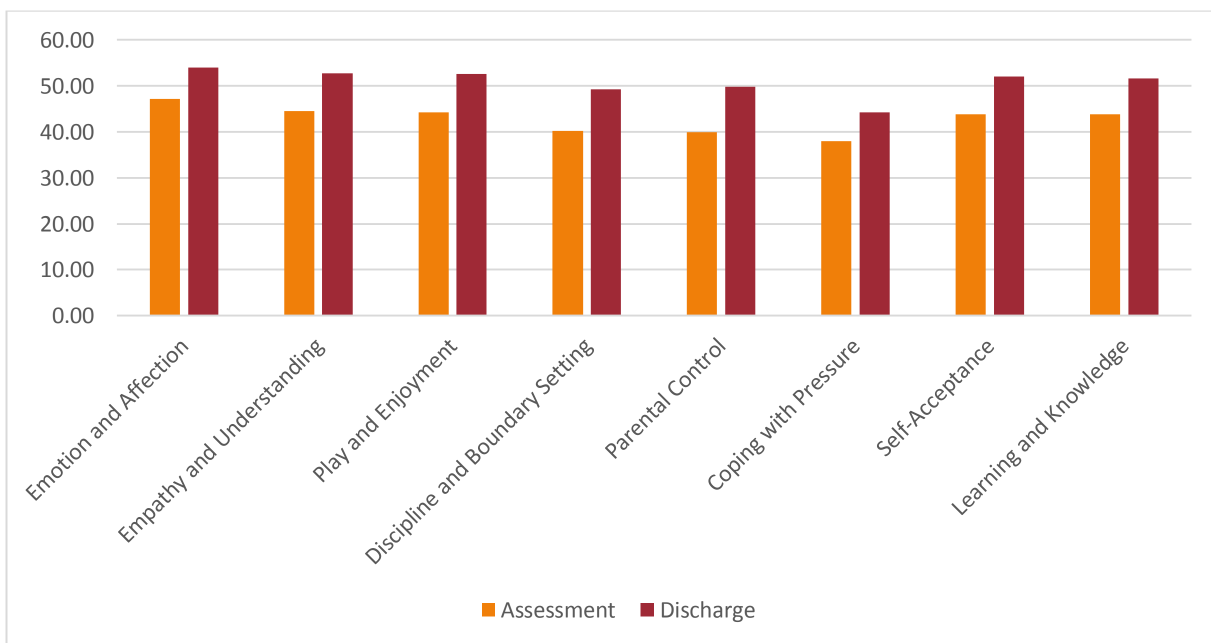
Seventy one per cent of children engaged in normative or average pro-social behaviours throughout the families' involvement in Breaking the Cycle. Twenty nine per cent of children were classified as demonstrating issues with problematic (or a lack of) pro social behaviours on assessment. By discharge this had reduced to 18% of children who had raised scores. In the case of clincial concerns, the additional behavioural domains can be explored and if the scores are also raised, it is possible for practitioners to work with parents with establish the intensity needed with interventions and/or support children's healthy development.

5. PARENTING EFFICACY AND FAMILY FUNCTIONING OUTCOMES SUMMARY

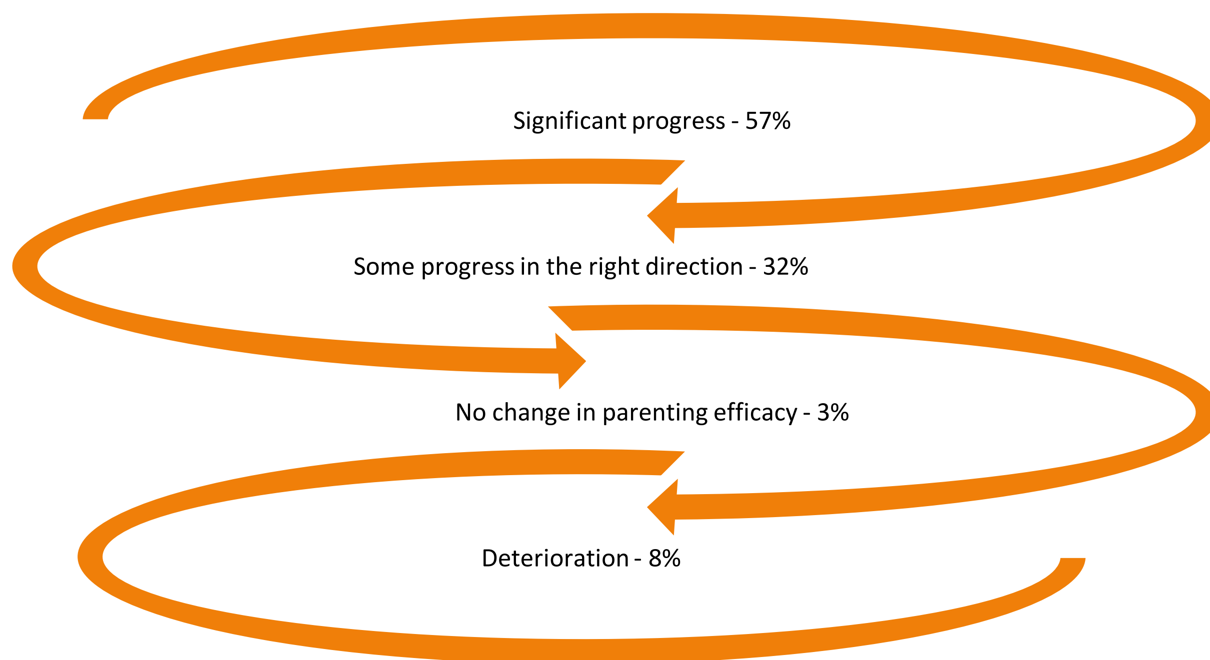
PARENTING EFFICACY: Parenting efficacy may be broadly defined as a parent's belief in their ability, skills and resources to parent effectively, to protect their children from negative influences (risks) and to promote positive outcomes in their offspring. For the purposes of Breaking the Cycle, family functioning refers to the way the family "gets along" in relation to focusing upon the needs of children in the context of the family unit and family interactions. Parenting efficacy is evaluated as an outcome at discharge, relative to the experiences of parents when they first engaged with Breaking the Cycle. Family functioning is evaluated by asking practitioners to work with parents to assess family interactions as part of the assessment and then to compare (or contrast) to the situation at discharge. It is anticipated that there may be an association between improvements in parenting efficacy and family functioning with positive relationships with offspring and improved developmental outcomes of children. Whilst a proportion of children continue to be impacted by parental substance misuse, especially where

unstable or continued use occurs, the majority of children either continue to attend school regularly or successfully increase their school attendance by the point of discharge from Breaking the Cycle.

The bar chart on the following page shows the average parenting efficacy scores on assessment and discharge from Breaking the Cycle. The outcome measure scale contains 48 parenting efficacy statements divided by 6 statements across 8 domains. The scores that parents allocate to cite their agreement with each statement range from 0 (lowest score) to 10 (highest score). The chart demonstrates that on average, the greatest change occurred in relation to parent's confidence and belief in their ability to manage (or control) themselves in the context of their parenting role. The least change occurred in relation to coping with external pressures and expectations from others. The prioritisation of the needs of children and developing upon parenting skills are the most commonly cited treatment goals of parents.



Whilst the bar chart above demonstrates that on average across the sample, there is a positive change in the expected direction from assessment to discharge, the diagram below highlights the proportion of parents who achieved each of the possible parenting efficacy outcomes.



FAMILY FUNCTIONING OUTCOMES: In addition to identifying changes over time to parenting efficacy, there were also improvements in the frequency of positive family functioning activities. The table below presents the findings of the family functioning domains. These are: regular family meal times together, family routines (such as setting patterns for meal times, getting ready for school, relaxation in the evening and bed times), setting aside time to support children with their homework and engaging in play and leisure as a complete family. In general, there is an increasing trend for families to improve upon family functioning by the point of discharge from the service. Breaking the Cycle practitioners work closely with families to prioritise the needs of children in the context of the family unit and to establish positive family functioning as a normal expectation within family life.

Family functioning outcomes.

	Not Applicable	Never	Rarely	Occasionally	Weekly	Daily
Meals Together - Assessment	03%	13%	12%	22%	15%	35%
Meals Together - Discharge	08%	04%	06%	12%	11%	59%
Routines (Bedtime etc.) - Assessment	03%	14%	12%	13%	17%	41%
Routines (Bedtime etc.) - Discharge	11%	3%	06%	10%	06%	65%
Homework slots - Assessment	15%	24%	09%	13%	28%	11%

Homework slots - Discharge	23%	08%	06%	09%	21%	34%
Family leisure time - Assessment	03%	10%	18%	32%	23%	14%
Family leisure time - Discharge	06%	04%	06%	25%	37%	22%

6. A PRACTITIONER PERSPECTIVE

Concerns were raised by social services that they were working with a parent using cannabis and possibly binge drinking, whilst in care of two young children. Concern was also raised about the mother's emotional health as she experienced domestic violence from her partner. The issue was raised as to whether the mother had the ability and resources to protect her children from exposure to domestic violence.

The mother was feeling isolated, low in her mood and discussed loss of confidence and post traumatic difficulties due to DV. She had rejected support previously as she mistrusted other practitioners and/or services. It was essential to slowly build trust with the mother. The key areas of focus were to:

- Increase coping strategies to manage stress
- Increase coping strategies to support the decrease of cannabis use
- Increase confidence and activity levels
- Decrease the need to binge drink when with friends
- Ensure the ability to make safe choices about friendships and relationships
- Prioritise herself and children, and stay away from violent relationships
- Manage the children's behaviour better and enjoy time with them

Using techniques from motivational interviewing, cognitive behavioral and solution focused therapy models, interventions and sessions have included:

- Play sessions to model parenting strategies to mother
- Outings to parks and riverside
- Attendance at children's centre groups
- Play sessions and outings
- Holding discussions with the mother's eldest teenage child;
- Whole family interventions
- Engagement with The Incredible Years' Programme
- Referral for specialist domestic abuse support, mental health services, specialist housing support and the engagement with the support team at the local children's centre

In relation to safeguarding both children remain in care of the mother and the child protection plan has ended. They have contact with their father through paternal grandparents and this protects the mother. They attend the children's centre and are calmer. The older child has started nursery sessions and mother says "he loves it!"

Mother has ceased smoking cannabis and does not feel the need to binge drink when she goes out. She continues to prioritise her own needs and those of her children. She has no contact with her ex-partner. She is enjoying her children and states that she is happier. She is continuing to build her relationship with her older daughter. She asks for help from professionals if she, or her children, require this. The family situation is now safe, calm, positive and inclusive. There is great affection and boundaries to ensure the children's safety have been implemented. The delivery of interventions and the coordination of services has been a core part of Addaction's Breaking the Cycle service with this family..