Working with parents with substance misuse problems

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Learning goals

This chapter will enable you to:

- **UNDERSTAND** the outcomes for children raised in families with substance-misusing parents
- **APPRECIATE** the effectiveness and key elements of interventions that have been developed to work with parents with substance misuse problems
- **IDENTIFY** the elements of the Parents Under Pressure program and how the Parents Under Pressure Integrated Framework can be used to plan an assessment and intervention
- **UNDERSTAND** the importance of setting goals.

Introduction

PARENTAL SUBSTANCE MISUSE is a serious problem that does not occur in isolation but is typically accompanied by a range of parental and lifestyle problems. This often leads to a family environment that lacks structure, routine and emotional regulation and features lifestyle stressors associated with financial problems and drug or alcohol use. The outcome for children raised in such chaotic and uncontained environments is often poor, with problems compounding as children move from early infancy through to adolescence. There has been some attempt to develop interventions that aim to improve child outcomes in such families. The Parents Under Pressure Program is one of several programs that have an evidence base demonstrating success, at least in the short term. In this chapter, we provide an overview of the key outcomes for children living in families with parental substance

misuse, discuss the evidence for successful interventions and provide an overview of an integrated framework to guide assessment and intervention when working with complex family presentations. We present a case study to illustrate the use of the Integrated Framework in practice.

Outcomes for children in families with parental substance misuse

Babies exposed to substances *in utero* experience a range of difficulties (see Harnett & Dawe, in press). While the direct effects of some substances on development appear to be limited, others such as alcohol are profound and lifelong, with problems associated with foetal alcohol spectrum disorders (FASD) well documented (see Mattson, Crocker & Nguyen, 2011). Prenatally exposed infants may experience neonatal withdrawal symptoms, and may show compromised autonomic nervous system functioning in the early months of life (Porges & Furman, 2011). These babies are then hard to soothe when distressed, unsettled during feeding, and irregular in their sleep patterns. These 'difficult' behaviours are stressful for the parent, creating from the outset an environment that is fraught for both infant and caregiver and can set the scene for early attachment difficulties. When these behaviours combine with other problems in the family, many infants raised in such environments begin to show developmental difficulties in the early toddler years, with high rates of insecure attachments to primary carers. During middle childhood, behaviour problems such as non-compliance, poor attention and concentration, and early school failure emerge. By adolescence, these problems can lead to school truancy or dropping out and early initiation into substance use (Dawe et al., 2007).

It is important to stress that these problems are not solely attributable to parental substance use. Typically parents will have other psychological problems, such as depression or anxiety-related disorders. Many have had traumatic childhood experiences that included neglect or abuse and current life stressors can include severe financial difficulties and social isolation. There are often high rates of conflict between adults in the family and a parenting style that can be either neglectful or authoritarian (Suchman & Luthar, 2000; Mayes & Truman, 2000). As a consequence, family life can feel uncontained and unpredictable for children. It is not surprising that many children living with substance-misusing parents come to the attention of statutory child protection services. Parental drug and alcohol misuse is a key issue for 50 to 80 per cent of children who are placed in care (Walsh et al., 2003; Scannapieco & Connell-Carrick, 2007; Delfabbro et al., 2009). However, in a review of 498 children aged 0–2 that examined their first placement in the care system, approximately 60 per cent were judged to be in need of more formal entry into out-of-home care (as

opposed to respite placement) and of these children, almost three-quarters came from families in which four or more risk factors were present (Delfabbro et al., 2009). Substance misuse is a serious problem, but cannot be treated in isolation from the associated problems facing these socially isolated families, who are living in poverty with psychological challenges to their health and wellbeing. (See also Chapter 10 regarding children in the midst of family violence.)

The intervention context: a brief overview of interventions that help families with parental substance misuse

There is a growing recognition that providing interventions to families where a parent is involved with a substance misuse treatment service may provide a critical opportunity to reduce multiple risk factors present in a child's life. Indeed, there is now growing evidence that early enrichment of a child's environment is a key factor in ameliorating some of the negative effects associated with prenatal exposure (Harnett & Dawe, in press). There is no doubt that the treatment for substance misuse is associated with considerable reductions in illicit drug use and associated crime (Prendergast et al., 2002). This underscores the importance of early intervention for substance-misusing families.

However, while substance abuse treatment helps parents gain control of their substance use, improvements in other domains of family functioning do not automatically occur (Dawe et al., 2000). Additional family-focused interventions need to be incorporated into existing substance use treatment services, or parents need to be able to access support through referral to programs developed specifically for high-risk families. The former strategy has been more widely evaluated. Early work by Catalano and colleagues combined parenting skills and relapse prevention with home-based case management services in a program called Focus on Families for parents enrolled in methadone maintenance. At 12 months an improvement in parenting skills, conflict management and parental drug use was observed in those who received the service, compared to those who had only received standard care. Notably, there was no change in children's behaviour (Catalano et al., 1999). However, when the children were followed up almost 15 years later, boys whose families had received the intervention had a lower risk of developing a substance use disorder, compared to boys who had been in the no-treatment condition. There was no difference in the risk of substance use disorder among the girls from both groups (Haggerty et al., 2008).

Luthar and Suchman (2000) described an intervention designed to increase maternal reflective functioning – the capacity to recognise and understand one's

own and others' thoughts, feelings and behaviours – with the aim of helping parents provide more responsive and sensitive caregiving. In their early work, Luthar and Suchman (2000) reported a significant reduction in the risk of child maltreatment for women on methadone maintenance. In later work by this group, however, initial gains observed in the immediate post-treatment period were not sustained at six months (Luthar et al., 2007). While it is difficult to account for this discrepancy in results, it is notable that the age range of children in both studies spanned 1–16 years. It seemed that for families with older children, who had displayed poor parenting and compromised care over many years, improvement was more difficult. A series of studies now suggest that working with families with younger children may hold the most promise.

Suchman and colleagues (2011) developed an intervention called the Mothers and Toddlers Program. As with Luthar's early work, this program is theoretically underpinned by the concept of reflective functioning. Working with substance-using mothers and their toddlers, gains were sustained at least in the short term at six weeks post treatment. Belt et al. (2012) provided pregnant women with a choice of one of two treatments and compared outcomes at 4 and 12 months on maternal drug use, depression and the quality of caregiving. The active treatment consisted of psychodynamically oriented group treatment, again focusing on reflective capacity, compared to a more general supportive intervention. Gains were found with both interventions, although it is notable that there was a reduction in mothers' hostile and intrusive interactions only in the psychotherapeutically oriented treatment group..

In parallel with much of this work, the authors of this chapter have been developing an intervention, the Parents Under Pressure (PuP) program, aimed at improving family functioning in families with parental substance abuse with children from birth to eight years. The PuP program was developed as an intensive, home-based intervention integrating (1) attachment theory to provide a focus on the central importance of a safe and nurturing relationship with a primary carer(s); (2) parenting skills to ensure that parents have a repertoire of skills that they can use; and, critically, (3) a focus on parental emotional regulation. The quality of the parent–child relationship and the parent's capacity to provide consistent and appropriate parenting skills is seen to be dependent upon the parent's ability to understand and manage their own emotional state. Mindfulness strategies are incorporated into treatment as a strategy parents can use to help manage their emotional state.

The effectiveness of the PuP program was evaluated in two series of case studies, one with parents on methadone maintenance (Dawe et al., 2003) and the other with families referred by child protection services (Harnett & Dawe, 2008). A randomised controlled trial (Dawe & Harnett, 2007b) compared the effectiveness of

the home-delivered PuP program with a clinic-based, brief parenting intervention and standard care in families on methadone maintenance. Substantial changes were found for families receiving PuP in all three reports. Of particular interest in the randomised controlled trial was the finding that child abuse potential significantly decreased in families receiving PuP at six months follow-up. The average age of the children in the study was four years, once again suggesting that targeting families with younger children may be associated with positive outcomes.

This brief overview highlights the point that interventions that have been trialled with parents with substance misuse problems can make a difference and that it may be particularly important to focus treatment as early as possible in a child's life. In the remainder of this chapter, we describe the way in which the Integrated Framework from the PuP program can be used to assess and aid in planning an intervention for families with parental substance misuse. Box 9.1 introduces the reader to a case situation to which the Integrated Framework will be applied.

BOX 9.1 The case of Julie and Beckie

Imagine that you work in an Intensive Family Support service. Julie, a 26-year-old mother of three children (James, age 10; Melissa, age 6; and Beckie, age 18 months) has been referred to your service following concerns regarding her parenting of her youngest child. The two older children have been living with their maternal grandparents under a court-ordered kinship carer arrangement for the last four years. Child protection services originally became involved after concerns were raised about neglect, excessive parental alcohol use and a failure for James to attend school regularly. Julie sees the children most weeks and there is no plan to return them to the full-time care of their mother, as there is a view that they are doing fine with their grandparents.

Julie was in contact with treatment services throughout her pregnancy and reportedly abstained from alcohol use. However, following the birth of Beckie, she began to drink regularly and concerns were raised that resulted in the removal of Beckie at four months and placement with her maternal grandparents. As a consequence, Julie re-engaged with treatment services and Beckie was returned to the full-time care of her mother at 12 months since Julie appeared stable, was managing not to drink and was continuing to attend the Drug and Alcohol Service and Alcoholics Anonymous.

Since Beckie was returned to her care, Julie has continued to have some contact with the drug and alcohol service, although this is sporadic. Her case worker left the service six months ago and she has seen several different people whom she has not 'clicked with'. Annoyed with the service, she has increasingly failed to attend appointments.

Recently concerns were raised about Julie's potential drinking by a neighbour, who believed that she had seen Julie drunk on several occasions with Beckie in the pram. A notification to child protection resulted in a visit from a social worker. Julie denied drinking alcohol and there was no evidence of this in the home. Nonetheless, the home was starkly furnished; Beckie's bed appeared to be with her mother on a mattress on the floor. Julie told the social worker she didn't want any help from anyone, but appeared flat in mood and reluctant to discuss how she was managing. She said everyone had 'written her off as a bad parent' and she didn't need anyone else telling her what a bad mother she was: she knew that by now. She admitted that she often felt judged by her mother and wouldn't ask her for help looking after Beckie; having to have her look after the older two was shameful enough.

During the visit the social worker noticed that Beckie was sitting on the floor holding a doll and watching a children's program on the television. She seemed absorbed in the program, but when it had finished she went up to her mother and said 'Up Mummy, up'. Julie helped her climb onto her knee, stroked her hair and gave her a cuddle and kiss. After five minutes Beckie started to squirm. Julie put her down, saying, 'She's a bit whiny because it's near her nap time; I'd better feed her before I put her down.' The social worker followed Julie to the kitchen, which was untidy with rubbish on the bench and around the unemptied bin. The floor was unclean, although the kitchen stovetop appeared to have been wiped recently. The social worker noted that there was little food in the cupboard or fridge. Beckie was given a drink of milk in a baby's bottle.

Beckie appeared small for 18 months. However, she was walking quite well for her age, and had a vocabulary consistent with her age. It was noted that the environment was lacking stimulation, with no evidence of age-appropriate toys, picture books or soft toys. There were three DVDs Julie said Beckie really enjoyed. Julie described Beckie as a fairly easy baby. Julie said Beckie had not received any immunisation since she returned to her care and that she had not been taken to her 12-month check-up with the child and family health nurse.

Following a case conference with Julie, the drug and alcohol service, the local child and family health nurse, the social worker and team leader, a decision was made to seek from the court a statutory order that enabled Beckie to remain in her mother's care under supervision and on the condition that she accepted a service from your organisation.

The PuP Integrated Framework: a model of assessment to guide clinical practice

It is not uncommon for practitioners to feel overwhelmed by the number of problems in the lives of the families they are asked to help. To make sense of what feels like a chaotic and complex interplay of forces intrinsic and extrinsic to the family's current situation, we developed the Integrated Framework (Harnett & Dawe, 2012). This practice framework, informed by existing models of child development and family functioning (Cicchetti & Cohen, 2006; Sameroff, 2010), moves beyond simply identifying the presence of risk and protective factors to articulating *how* and *why*

specific risk and protective factors are important for a particular family. For example, it is easy to assess that a family is experiencing considerable financial and other life stressors, that the parents employ poor coping strategies to solve difficulties, maybe experiencing problems with low mood or other severe mental health issues, and are abusing substances. What is more difficult, but essential, is understanding how these factors interact and operate to reduce a parent's capacity to meet the needs of the children in the family.

The Integrated Framework integrates information obtained from talking to families, the results of assessments using self-report measures, and observations of the quality of the parent–child relationship and the child's home environment. The aim of the assessment is to identify the key issues that are likely to impact on child outcomes. These issues are used to define clear and measurable goals that represent the changes a family will need to make in order that their children have the best chance of achieving their full potential.

Overview of the Integrated Framework

The underlying principle of the Integrated Framework is that a healthy parent–child relationship is essential in promoting a child's development. An extensive research literature has demonstrated that responsive, sensitive, nurturing caregiving from a primary carer is essential for good child outcomes (see Chapter 11). The early years – indeed months – matter greatly and lay the foundation for the development of self-regulatory skills in early childhood and an understanding of relationships across the life span (Slade, 2005). Parents who are able to provide an optimal caregiving environment are able to tolerate and contain an infant or young child's extreme fluctuations in emotions. This, in turn, allows a child to feel safe in expressing these emotions. Sensitive and responsive parents structure the environment with predictable routines and consequences to help the child organise their behaviour and emotions. They are able to show genuine warmth and nurturance that allows the child to feel loved, and present opportunities and scaffolding to promote cognitive and physical development. However, the extent to which a parent is able to provide an optimal caregiving environment is dependent on a range of factors that are both intrapersonal and situation-specific. The Integrated Framework provides a model in which these various influences can be clearly articulated and both the strengths and areas of difficulties in different domains can then be viewed as potential focal points for intervention.

Assessing developmental outcome

The starting point of the Integrated Framework is to understand the forces at play that will impact on the capacity of a child to reach their full potential across multiple

domains of functioning (see Figure 9.1). Thus it is important to first assess how a child or infant is currently faring in relation to their social, emotional, behavioural, spiritual and cultural development. This can be done through consultation with a general practitioner, health visitor or child health nurse, or teachers, and by the use of developmental charts. There are a number of these charts now available on the internet and they are designed as resources for parents and practitioners alike (see 'Useful websites' at the end of this chapter). They give a reasonable indication of whether a child is developing as expected and allow for both the celebration of milestone achievements and the identification of areas of potential delay. In addition, there are more general measures of child or infant emotional social and behavioural wellbeing, many in the public domain. The Strengths and Difficulties Questionnaire (Hawes & Dadds, 2004; Goodman, 2001), for example, is a good measure of child behaviour problems and is appropriate for children from the age of 2 years. More specialised assessment by appropriately trained professionals is sometimes indicated. This may include an assessment of childhood disorders such as autism or attention deficit disorder and a comprehensive assessment of cognitive and adaptive abilities (language, self-care) if developmental delays are suspected. Importantly, beginning with a focus on a child's current developmental status allows the parent and practitioner to develop a clear understanding of the child's strengths

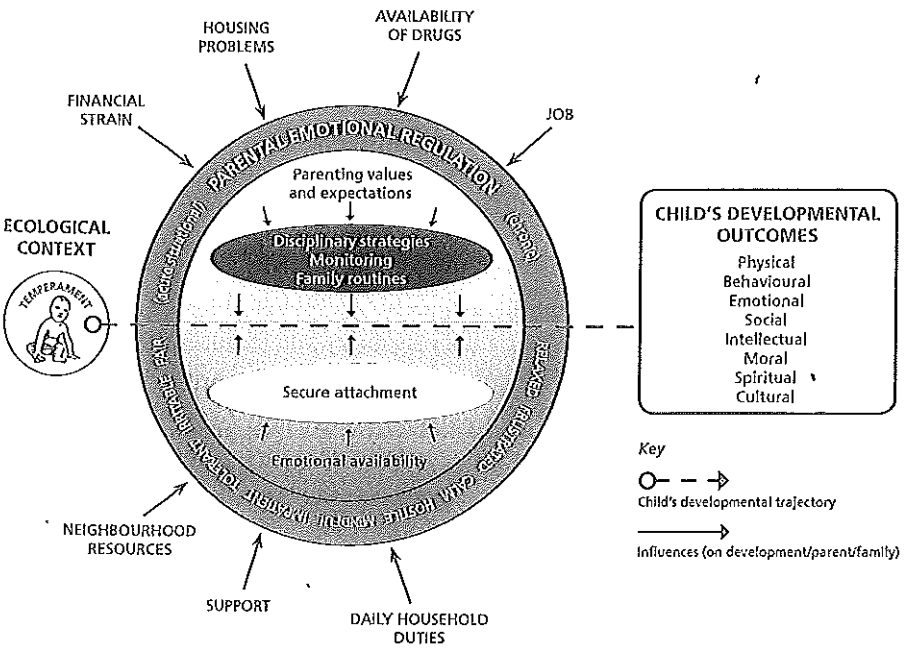

Figure 9.1 The Integrated Framework

as well as difficulties, and emphasises that the intervention is ultimately for the benefit of the child. Some examples that we have found in our own work have been the identification of potential problems with language or motor development, and difficulties in cognitive development. Equally, we often find areas of great strength that can be shared with the parent, such as a baby who is clearly an early walker, or a toddler whose language seems well advanced for their age.

Emotional availability and attachment

A fundamental premise underlying the Integrated Framework is that the quality of the relationship between a child and their primary carer(s) is critical to the development of the child. This relationship may be with a biological parent or parents or with extended family members. What we do know is that there needs to be someone who is able to provide an environment that helps a child feel safe and loved. The construct that is proposed to underpin this is 'parental sensitivity', which can be directly observed by watching the quality of the relationship between child and primary carer. There are also a number of formal observational coding systems that have been rigorously tested to ensure that they do indeed capture this critical quality of caregiving. One of the most comprehensive ways to measure parental sensitivity is the use of a systematic coding system such as the Emotional Availability Scales developed by Zeynep Biringen (Biringen, 2000, 2004). Biringen proposes that emotional availability shapes the quality of the maternal–infant interactions and influences; in particular the mother's ability to be sensitive, responsive and emotionally in tune to her infant's or child's cues (see also Chapter 1). Her model delineates the dimensions of the parent–child relationship that predict the quality of parent–child attachment and other child developmental outcomes.

Four dimensions describe the behaviour of the parents: the ability to respond sensitively to the child (sensitivity); the ability to provide structure to help the child manage their emotions and behaviours (structuring); the ability to promote autonomy (non-intrusiveness); and the ability to minimise angry and hostile interactions (non-hostility). In this research area, there has been empirical verification providing construct validity for the concept of emotional availability (Aviezer, Sagi-Schwartz & Koren-Karie, 2003; Easterbrooks & Biringen, 2005; Swanson et al., 2000; Ziv et al., 2000) and growing evidence that maternal and child emotional availability are related to the security of attachment. Having an understanding of the constructs relating to emotional availability enables a practitioner to observe parent–child interactions with a focus on looking for examples of warmth, sensitivity and an ability to read the infant's or young child's cues.

Assessing parenting values and expectations

A parent's own upbringing embedded within cultural and spiritual beliefs will shape a parental value system. One of the ways of beginning a conversation around values can be asking a parent what they would like their child to be like in two or five years' time. This will elicit different responses and it is then possible to draw from this response some of the underlying parenting values. For some parents, this may be more socially focused – having friends, having fun, being loved. For others, it may relate to connection to culture, or to educational attainment. Helping a parent articulate their own hopes and dreams for their child provides an opportunity for both parent and practitioner to develop a shared understanding of the values that matter to this parent. Setting goals that explicitly build on an underlying value system will both enhance the therapeutic relationship between parent and practitioner and increase the likelihood that the parent will actively engage with steps needed to reach a goal.

Practitioner values can also set a stage for parents' feeling judged. Having strong views about, for example, domestic hygiene, nutritional practices, substance use patterns and immunisation status (to name a few) can at times drive practitioner-identified rather than parent-identified goals. Perhaps there are times when it is actually in the best interest of the child that the goals identified by the practitioner are set, such as school attendance. In such situations, linking the goal explicitly back to parental values and helping the parent see how a goal can achieve multiple outcomes that are going to benefit a child may be the therapeutic component of the intervention. For instance, a parent who values family ties may be helped to see that school attendance gives their child the opportunity to take part in cultural activities, or perhaps become closer to cousins and other family members attending school.

In addition to the construct of values is the importance of understanding parents' expectations around their child's developmental capacity. A parent who does not understand normal child development may have unrealistic expectations of their child – both behaviourally and emotionally. For example, a mother may smack her 12-month-old child for pushing buttons on a television, demonstrating both a failure to appreciate that the child does not have the cognitive capacity to understand why they have been smacked and the use of inappropriate disciplining. Unrealistic expectations are associated with an increased risk of child maltreatment (Milner, 2003). Helping a parent develop realistic expectations of their child requires an understanding of normal child development, which may need to be a focus of the intervention.

Parenting skills, family routines and monitoring

The Integrated Framework acknowledges that a parent's repertoire of parenting skills is an important influence on child development. Do the parents know what to do in a challenging parenting situation? It is important to ascertain whether there is:

1 a skill deficit – the parent does not know what they could do in particular circumstances

OR

2 there is skill inhibition – the parent knows what they should do but for a range of other reasons is not able to put these skills into practice.

Thus, the first step in this component of the Integrated Framework is to ascertain whether there is indeed a skill deficit, or rather a skill inhibition. Clearly the former would lead to helping the parent acquire parenting skills. However, the latter implies that there are other factors in a parent's life that are preventing the parent putting the skills that they possess into practice. It is surprising the number of parents we have worked with who actually know 'what to do' but are not able to do so. Sending parents in this category off to another parenting program is undermining; their existing repertoire of skills has not been acknowledged. It also fails to identify the impediments to using the skills and thus is unlikely to change parenting practices.

For parents who fall into the first category, provision of parenting skills is central to improving the outcome for the child. There is a substantial literature on the effectiveness of behavioural parenting skills in improving child behaviour (Wyatt Kaminski, 2008), underscored by the sobering statistic that 60 per cent of 3-year-olds with conduct disorders still exhibit problems at the age of 8 years if left untreated. Further, at least half of these children will have significant problems in adulthood, including antisocial personality disorder (NICE, 2007). Thus, helping children learn how to behave by providing clear and consistent parenting is a key aspect of helping children develop to their full potential.

Included under the heading of parenting skills is the importance of family routines for younger children and infants. These are also important because they provide a sense of harmony and predictability in young children's lives. While behavioural models of parent training have their theoretical roots in learning theory, the need for structure in a child's life is integral to the concept of emotional availability. Within the Integrated Framework we conceptualise the capacity of a parent to provide structure through family routines and effective, non-punitive discipline, which are important in promoting a child's sense of security. This enables a child to develop a perception that their parents are capable of containing and regulating both the child's behaviour and their emotional state (see Katz, Maliken & Stettler, 2012).

It should be noted that, while behavioural parenting skills are helpful for families with parental substance misuse, there is now clear evidence that group-based parenting programs are not effective for complex families with children (NICE, 2007). This suggests that programs are more effectively delivered on an individual basis, although a caveat must be made regarding the appropriateness of providing parenting interventions within a context of family violence (see Chapter 10). Individually focused parenting programs need to be responsive to a range of family issues that impact on a parent's ability to put parenting skills into practice. Most proximal is the capacity for a parent to remain calm and to manage a range of intense emotions in challenging parenting situations.

Parents' state of mind

The Integrated Framework places considerable emphasis on the parent's state of mind. By this we mean the parent's capacity to be calm and emotionally in control, as this directly impacts on the way in which parenting skills are practised. A parent who is unable to control extreme mood states, such as anger, or who typically acts impulsively, will be less consistent and more punitive in their disciplining style (Dawe et al., 2007). Equally, a parent's state of mind will impact on the extent to which the parent accurately perceives their infant's or child's cues. For example, a depressed parent typically fails to notice their child's cues and is less sensitive to signals of distress.

Determining how and what to assess about a parent's state of mind depends in part on the nature of the intervention and on the areas of concern that are believed to be impacting on parenting capacity. It is generally considered good practice to administer a tool to measure parental mood as recommended, for example, in the UK Department of Health Framework for the Assessment of Children in Need and Their Families (see 'Useful websites' below). Anxiety and depressed mood are clearly linked to parenting capacity and so a measure such as the Depression Anxiety and Stress Scale (Lovibond & Lovibond, 1995) would be a useful tool to gauge parental mood (see 'Useful websites'). Importantly, this measure is also sensitive to change, so it is possible to determine whether there has been any change in scores across the course of the intervention. In addition to measuring the symptoms associated with depression or anxiety, it is also possible to measure a wide range of beliefs, attitudes and other psychological constructs.

The wider social context

Finally, the Integrated Framework incorporates the extensive literature that demonstrates how living in chronically stressful conditions (such as overcrowded

homes, domestic violence and poverty) leads to a variety of adverse outcomes. These outcomes for children include heightened emotional and physiological reactivity, social problems with peers, and poor problem-solving ability – factors that can lead to failure at school, the increased likelihood of antisocial behaviour, and health problems (Repetti, Taylor & Seeman, 2002). Importantly, the evidence shows that these negative outcomes are not inevitable. Studies of resilient children (children who display positive developmental outcomes in the face of adversity) have identified that the ongoing presence of a nurturing primary caregiver during infancy, positive parent–child relationships, high parenting efficacy, and consistency in the use of fair disciplinary practices by the parents are important factors in promoting resilience (Cowen et al., 1990; Masten et al., 1990). Thus, while the wider social context is important to assess, there may be other ways of improving family functioning that can militate against contextual issues that are not amenable to change.

ACTIVITY

Reread the case study of Julie and Beckie in the text box above. While there is clearly a need for much greater assessment of this family, use the Integrated Framework above to reflect on the areas of potential strength and difficulty when considering how best to support Julie. Afterwards, check whether you have identified all of the areas of strength and difficulty by looking at the Integrated Framework in Table 9.1.

The importance of setting goals

In the process of using the Integrated Framework to guide an assessment, you will have identified many areas of strength and significant challenges for the family. This will allow you to set specific goals for change with the parent. Goals can be identified by asking the question, 'What needs to change in the family for this child to meet his or her developmental potential?' The goals for change should be mutually agreed. Both the parent and practitioner should have a shared understanding that they are working towards an agreed-upon outcome and a commitment towards achieving the goal. Goals that are assigned tersely and without a clear rationale ('Do this') and goals that are perceived as imposed and unjustified lead to frustration, anger and resistance. Including the parent in the identification of goals typically leads to greater goal commitment (Locke & Latham, 2002).

Goal commitment would be particularly important when working with Julie. She does not necessarily want to be involved with your service and one of the key aspects of relationship building in this case would be to hand control over to Julie to make

Table 9.1 The Integrated Framework: considerations for assessment and intervention

Domain of functioning	Areas of potential strength	Areas of potential difficulty
Child Developmental Outcomes	Appears to be meeting milestones including walking, talking. Is able to settle for appropriate amount of time watching age-relevant program on television. Goes to mother with clear expectation that she will be warmly received.	Small for age. Has not organised immunisation or 12-month check-up. Check diet – some evidence that this may need to be improved, given that lunch was a bottle of milk and not much food in the kitchen. Cognitive development may need to be considered: Little evidence of age-appropriate toys, picture books, so perhaps limited stimulation in environment.
Emotional Availability	Sensitivity – notices Beckie's bids to be picked up; interprets whining as cue Beckie is tired. Responsivity – picks Beckie up for an appropriate length of time, recognises hunger cues – provides bottle before her nap. Warmth – gives her kiss and cuddle. Structuring – some evidence that she is able to respond to hunger cues and has regular sleep times.	Low mood exacerbated by limited social support may interfere with her capacity to be consistently emotionally available at times.
Parenting Values and Expectations	Wants to be a 'good mother' for Beckie – committed to her.	Unclean house inconsistent with her values, but lacks energy to clean regularly.
Parent's State of Mind (emotional regulation)	Does not display hostility towards Beckie.	Annoyed at drug and alcohol service for changing staff. Low mood likely to be related to moderate depression. ? Drinking as a means of coping.
Ecological Context	Adequate housing.	Financial difficulties. Due to the shame she feels in not being able to cope with two older children, she does not turn to or accept support from her mother.

some decision on how to address the concerns raised by the statutory services around her capacity to parent Beckie. This process should also be empowering for the parent, as she is making decisions rather than simply following instructions such as 'You need to go to counselling' or 'You need to do a parenting course' (Davis, Day & Bidmead, 2002; see also Chapter 8). Success in attaining the goal is critical, so ensuring that all is in place to maximise success is essential. Attaining the goal will also help build trust and a working alliance between the parent and practitioner.

Framing the meaning of the goal is also important. One could question, for example, the meaningfulness of a 'clean floor'. Is this simply a practitioner's set of values around household cleanliness? If you and Julie have both decided that cleaning the floor is the first goal, then the context for this goal needs to be clearly articulated for both Julie and for professionals involved in the case. The following could be one such scenario (see Box 9.2).

BOX 9.2 Julie's first goal

You have spent several hours with Julie and Beckie and identified a range of areas of strengths and difficulties. Julie commented on several occasions that she feels overwhelmed by the state of the house – she can't believe that it has got so bad and it just goes to show what a bad mother she is... Julie has many negative beliefs about herself as a mother, including guilt about her inability to provide a good home for her two older children, her drinking following the birth of Beckie and the current involvement of statutory services. She knows she can't change what has happened in the past but feels overwhelmed and immobilised, with no sense that she can create any good out of disorder and mess.

You have discussed the strengths you have observed. Further, rather than trying to solve any of the very significant issues raised above, you have acknowledged that they are influences that are making it tough to be a good enough parent.

You then talk about taking some small, practical first steps towards making things a little better. You get Julie to talk about how Beckie learnt to walk, in gradual stages achieving small goals along the way: rolling, crawling, holding herself up with the furniture, tiny first steps. You talk about how Julie helped along the way, but ultimately it was Beckie's job to do the walking.

The use of this metaphor is obvious to Julie and so, when you suggest that just for today you both identify what would be the equivalent of 'rolling' for Julie right now, Julie agrees. Julie considers what could make a difference – what the very first small step may be. Let's say in this case Julie says the dirty kitchen floor bothers her a lot. She hates having Beckie sit on a dirty floor and she hates the idea that there are ants and other insects that crawl across the floor. Together you make a very practical plan around cleaning the floor; maybe you even help in executing the plan.

Framing this goal within the Integrated Framework: Julie showed a commitment to change by developing a meaningful and manageable goal with the practitioner. The goal was driven by Julie's concern for her baby's health and wellbeing (Child's Developmental Outcome). Achieving the goal made Julie feel that a small change was possible (Parent's State of Mind) and she felt supported by someone (Social Support) who was going to be there for her to help achieve bigger gaols (Development of Therapeutic Alliance). What may initially seem trivial (Julie washed the kitchen floor) is in fact an important first step in helping frame goals that are achievable, manageable and meaningful to Julie.

Conclusion

This chapter provides an overview of the Integrated Framework to help guide practice and intervention planning for complex families. The framework guides intervention planning for the PuP program, but it is not linked to only one program. It is possible that many different programs could be conceptualised as fitting within the Integrated Framework. In the case of Julie, there may be both adult mental health services involved to assess and treat depression, perhaps using a Cognitive Behavioural approach. If alcohol does indeed appear to be a problem, this could be addressed using Relapse Prevention, with a re-referral to a drug and alcohol agency. There may be further issues around housing, or support with finances, that help improve living conditions. Ultimately, from a parenting perspective, the support Julie receives to deal with all these issues will influence her capacity to parent. What we can glean from this brief scenario is that Julie has a capacity to respond sensitively and warmly to her baby and that she appears to have been able to provide sufficient structure to help Beckie reach her developmental milestones. Along the way, Julie has done much that is right. She, like many other families with whom we have worked, is struggling with her own complex history around child protection and substance use problems. She and daughter Beckie deserve the best chance of being supported to overcome adversity, and to help Beckie reach her potential.

Useful websites

Australian Centre for Child Protection: **www.unisa.edu.au/childprotection**

Babycenter website, information about developmental milestones and other useful information: **www.babycenter.com**

DASS, Information about the depression, anxiety and stress scale: **www2.psy.unsw.edu.au/DASS**

PuP program website, for further information about the PuP program: **www.pupprogram.net.au**

UK Framework for the assessment of children in need and their families – the assessment framework, practice guidance, questionnaires and scales, assessment recording forms: **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008144**

Youth in Mind, information for researchers and professionals about the Strengths & Difficulties Questionnaires: **www.sdqinfo.com**