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Improving outcomes for children living in families with parental substance misuse: What do we know and what should we do

Sharon Dawe, Paul Harnett and Sally Frye

This paper provides an overview of the research literature on the outcomes of children raised in families with multiple problems including parental substance misuse. We argue that until we have accurate mechanisms for estimating the extent of the problem and policies that include a focus on children and families within the drug and alcohol field, organisational change will be difficult to achieve. Importantly, the field can develop "evidence-informed" treatments but until this becomes core business in drug and alcohol services little is likely to change for the many children living in families with parental substance misuse.

It is well established that children raised in families with parental substance misuse often have poor developmental outcomes. However, parental substance abuse co-exists with other risk and protective factors across multiple areas of family life and it is the sum of these various influences that determine the outcomes of children. In this paper we:

- review the multiple risk and protective factors impacting on child outcomes in families with parental substance misuse;
- consider the extent of the problem and data available on the numbers of children affected;
- examine the place of children and families in national, state and territory policy; and
- review the treatment literature to determine whether there is sufficient information for services to develop an "evidence-informed" approach to treatment.

The multiple risk and protective factors impacting on child outcomes in families with parental substance misuse

The impact of the wider social ecology on the capacity to parent

The ecological model of child development emphasises that child outcomes are influenced not just by parents, but the wider social ecology (i.e., families, neighbourhood and society) within which the family is embedded. The

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influences include the relationships between family members and factors within the social ecology, such as the availability of social support, access to services and the presence of stressors such as inadequate housing and financial strain. The relative contribution and importance of the different influences of the wider social ecology on families has been the subject of a great deal of research (e.g., Cicchetti & Toth, 1997). In recent times, it has become clear that social disadvantage is a relative concept. Children who grow up in families facing poverty have poorer outcomes than children from wealthier families. However, poverty per se is not a sufficient explanation for these poorer developmental outcomes. Rather, social disadvantage prevents individuals and families from participating in society and leading the life to which they believe they are entitled. The lack of autonomy and control over one's life creates a stress that may lead to an unhealthy lifestyle as an attempt to cope with this stress (e.g., substance misuse). For a discussion of the social determinants of health see Box 1.

If the situation of families with parental substance misuse is considered within the context of a model that argues for social determinants of health, then any attempt to improve outcomes for children needs to be viewed within a wider social context. Interventions are only likely to be successful in achieving positive psycho-social outcomes if they empower individuals, families and communities to become more autonomous participants in society. In the following section, we present risk and protective factors operating on individuals and families that assist or hinder the full participation of individuals and families in society.

Key message: Parental substance misuse needs to take into account the impact of the wider social context—any attempt to improve outcomes for children and their families needs to empower individuals, families and communities to become more autonomous participants in society.

Specific risk and protective factors in families with parental substance misuse

The direct effect of intoxication and withdrawal

When a parent is intoxicated, their ability to provide adequate care and protection of young children is compromised. Intoxication will clearly impair the parent's ability to prepare a meal, ensure the child's clothes are clean, and maintain regular routines for school attendance and bedtimes. Importantly, parental intoxication will impact on responsiveness and sensitivity to a child's emotional needs. It is well documented that parental emotional involvement with a child is vital to the development of secure attachment and emotionally healthy children. Intoxication is also likely to lead to inconsistency in disciplinary strategies. Child behaviours that may be ignored during an intoxicated state may be harshly dealt with at other

Box 1: The social determinants of health model

The social determinants of health model originates from the work of Michael Marmot (Marmot, 2004). Marmot's early work included a 25-year longitudinal study of civil servants working in Whitehall, London. A clear relationship was found between the position of civil servants on the hierarchy within the civil service and rates of non-communicable diseases such as coronary heart disease and cancer. This was despite the fact that, irrespective of their job status, all the civil servants had access to clean water, abundant food supplies, access to the National Health Service and all the other privileges of a developed nation. Subsequent studies of health status in economically poor countries found higher rates of non-communicable diseases among the most socially disadvantaged within those countries. Further, and quite unexpectedly, when comparing people across nations, it was found that an individual's position on the social gradient was *a more important determinant* of health status and life expectancy than their *absolute* level of poverty. For example, African Americans in the United States have about four times the income of men in Costa Rica but about nine years' shorter life expectancy (Marmot, 2004).

Marmot (2004) proposed that poor health and lowered life expectancy occurs when people are deprived of two fundamental human needs: autonomy and full social participation. The lack of control over one's life and social exclusion prevents the socially disadvantaged from leading the life that they feel they are entitled to lead. In practical terms, for example, living in inadequate housing in an unsafe neighbourhood that has limited opportunities for meaningful work and poor quality schools, while also experiencing racism and being subjected to community violence is stressful. These social conditions activate biological stress pathways that result in poor health. Stress from social disadvantage is not related to what people actually have in an absolute sense, but what they can or can't do with what they have. In a survey of Europeans, people described themselves as "poor" if they were unable to entertain their children's friends, have a holiday away from home, or buy presents for people (Gordon & Townsend, 2000). These "poor" people suffered from poorer health than the more socially advantaged within their society.

times. A parent who is dependent on a substance will experience withdrawal symptoms when they are unable to use. While the experience of withdrawal varies across substance classes, such a physical state has the potential to impair the parent's ability to focus on the needs of their child over their own immediate physical and psychological distress.

The nature of the substance used also influences parenting capacity. Illicit drugs such as opioids and amphetamine-type substances often require engagement in a range of illegal activities, such as theft or prostitution, in order to support the habit. The use of these substances also comes with risks of exposure to injecting and other equipment, association with other adults who use substances and, for some children, exposure to a physically dangerous environment when substances are being manufactured.

One final issue relates to the specific psychological effects of the substance used. There has been relatively little attention to this issue within the context of parenting practices and parenting capacity. However, substances that result in a state of extreme drowsiness and impaired concentration and attention, such as alcohol and perhaps heroin, clearly impact on aspects of parental capacity, such as parental supervision, thus increasing risk of injury, neglect or harm by others. Substances such as amphetamines may be even more problematic as their regular use is associated with a state of agitation, restlessness and impaired judgement. A considerable proportion of regular users experience heightened levels of suspiciousness and hostility, sometimes accompanied by subclinical features of psychosis that include delusional beliefs of persecution (see Dawe & McKettin, 2004, for further details). These states are clearly incompatible with sensitive and responsive parenting and may indeed increase the risk of neglect and abuse due to the misinterpretation of child behaviour and language on the part of the parent.

Key message: Intoxication will impair the parent's ability to prepare a meal, ensure the child's clothes are clean, and maintain regular routines for school attendance and bedtimes. Importantly, parental intoxication will impact on parent's responsiveness and sensitivity to a child's emotional needs.

The impact of co-morbid psychological conditions

In addition to the immediate impact of intoxication, other psychological conditions that often co-exist with substance misuse problems can impair the capacity to parent. Over 50% of heroin users, 20% of amphetamine users, 16.5% of cannabis users and 11% of high-risk alcohol users reported diagnosis or treatment for mental illness in the past 12 months (Australian Institute of Health and Welfare [AIHW], 2005b, p. 99). When women are considered separately from men, it would appear that the rates of co-morbid conditions are even higher, particularly for conditions related to trauma (Conners et al., 2003; Najavitis, Weiss, & Shaw, 1997) and histories of victimisation (Conners et al., 2003). Women also experience higher rates of depression, which in turn is linked to problematic parenting that includes being less positive and less responsive to their children's needs (Cicchetti & Toth, 1998; Lovejoy, Graczyk, O'Hare, & Neuman, 2000).

There is growing evidence that maternal mental health problems have a greater impact on child outcome than substance use per se (Beckwith, Howard, Espinosa, & Tyler, 1999; Hans, Bernstein, & Henson, 1999). Thus, while the concerns regarding a parent's capacity to provide an optimal environment when there is parental substance misuse are valid, it is equally as important to bear in mind that a mother who is misusing substances but is otherwise psychologically healthy may be equipped to provide a good enough home environment. When mental health problems and substance misuse co-occur (which is the most common situation), children are at an elevated risk of poor outcomes.

Key message: Other psychological conditions frequently co-exist with substance misuse problems and can further impair a parent's capacity to parent.

Financial disadvantage

Disentangling the effects of parental substance misuse from the more general issues and stressors associated with poverty is difficult. Nonetheless, while it is reasonable to propose that not all families with parental substance misuse are economically disadvantaged, many are. The most recent report from the Longitudinal Study of Australian Children (LSAC)—investigating the link between family economic resources and children's learning and social/emotional outcomes—highlights the differential effects of income within Australia today (Bradbury, 2007). In this report, a number of different indicators of family economic circumstances were used, including: receipt of income support; low income (bottom 15% and 30% of families); joblessness; hardship; and a subjective question about how well a family is "getting along". Learning outcomes for children aged 4–5 years was strongly associated with joblessness and having income support as the main income source. Even without taking substance abuse into account, children in Australia who are in the bottom 10% in economic terms have poorer learning and social/emotional outcomes than those in the top 10%. Many families with parental substance abuse are also placed in low income/poverty groups, report high rates of unemployment and have unstable accommodation (Conners et al., 2003; Powis, Gossop, Bury, Payne, & Griffiths, 2000), thus compounding the effects of parental substance misuse with the many other risk factors present in such families.

Key message: Many families with parental substance abuse are also placed in low income/poverty groups, report high rates of unemployment and have unstable accommodation, thus compounding the effects of parental substance misuse.

Social isolation and social disadvantage

Social isolation is a key feature of the lives of families with parental substance abuse. Involvement in criminal activity—and for many women who are dependent on illicit drugs, prostitution—results in even greater exclusion from mainstream support in families lives. Typically, women with substance misuse problems feel unable to attend a range of community activities, such as school functions, fetes, etc., that are often the building blocks of community connectedness and support. Parents who have limited social support and live socially isolated lives are at greater risk for poor parenting practices. This is especially the case when these problems are further compounded by other risk factors, such as parental mental health problems and socioeconomic disadvantage.

Importantly, a key aspect of social support is the importance of *perceived* social support. Often, troubled families have access to a number of different support options that they themselves have

not identified as relevant. Helping families to link to services is important, but equally so is ensuring that the parent finds that the service or network is available and relevant to them.

Key message: Typically, women with substance misuse problems feel unable to attend a range of community activities. Parents who have limited social support and live socially isolated lives are at greater risk for poor parenting practices.

Caregiver, school and community connectedness as protective factors

Connectedness to family, school and community can be defined as a sense of being cared for, personally accepted, valued and supported by others, as well as enjoyment and feeling attached to family, friends, school and the wider community (McGraw, Moore, Fuller, & Bates, 2008). Connectedness plays a key role in the emotional wellbeing of children.

Connectedness to a primary caregiver is vital. One of the most important findings from the literature on resilience is the importance of a caring and nurturing relationship between a child and a primary carer. The quality of this attachment plays a key role in helping children overcome adversity, including poverty (Owens & Shaw, 2003), child maltreatment (Masten & Coatsworth, 1998) or multiple interlinked problems (Werner & Smith, 1992). Clearly, the use of constructive and effective parenting practices is one of the key ingredients for successful child outcomes. However, the importance of a nurturing and loving relationship can be overlooked when children are displaying many behavioural problems. Helping a parent to develop consistent, sensitive and warm understanding and appreciation of their children despite many behavioural difficulties is vital. This can occur through having a strong focus on a child's strengths and through positive, child-focused play. This can often change the balance of the emotional climate of the family from one that is focused on negative behaviours to a more supportive and positive environment.

As children move into their adolescent years, being strongly connected to peers and to schools has growing importance. Feeling disconnected from the school environment increases the risk of a range of mental health problems in young people, in particular depression (Glover, Burns, Butler & Patton, 1998). Indeed, the relationship and connectedness with high school for young people influences both their likelihood of completing secondary school and their substance use in later years (Bond et al., 2007). For young people who are living in families with multiple problems, ensuring a strong connection with the school and at least one key teacher may provide an important protective factor that may buffer the effects of family dysfunction.

Engagement in the wider community again goes to the issue of social connectedness. For young people, membership of groups that focus on sporting, religious or cultural activities is also clearly a protective factor. Unfortunately, there are typically fewer community organisations in neighbourhoods with the greatest need (those in which families affected by parental substance misuse are more likely to live). After-school activities are also generally less available in poorer communities as they are usually fee-for-service, which restricts access (Cauce, Stewart, Rodrigeuz, Cochran, & Ginzler, 2003).

Key message: Connectedness to the wider community through sporting, religious or cultural activities plays a key role in the emotional wellbeing of children, and may protect them from some of the negative affects of parental substance misuse.

Child protection issues

Given the many risk factors described above, it is not surprising that families with parental substance misuse have high rates of child maltreatment. This is highlighted in a number of Australian and international reports of family characteristics of children reported to social services. For example, in a recent Australian report (Department of Human Services, 2002), 52% of parents involved in substantiated cases of child abuse or neglect in 2000–01 experienced significant problems with "family violence", 33% with "substance abuse", 31% with "alcohol abuse", and 19% with "psychiatric disability". However, while substance misuse was clearly a key risk factor for these families, many other problems were also identified.

Key message: Families with parental substance misuse have high rates of child maltreatment. However, parental substance misuse frequently co-occurs with many other problems, the combination of which place children at heightened risk of abuse and neglect.

How many children live in households with parental substance misuse?

It is almost impossible to obtain an accurate estimate of the number of children living in households with parental substance misuse in Australia. There are several reasons for this. The first and most striking is that the national surveys that collect data to monitor drug use and drug trends across Australia do not collect information on parental status or child care responsibilities. Secondly, child protection services do not systematically ask if the parents of children referred to statutory services misuse substances.

Key message: National surveys that collect data to monitor drug use and drug trends across Australia do not collect information on parental status or child care responsibilities of substance users.

Despite these limitations, a general indication of the scope of the problem can be gleaned by collating data from a range of data sets. Dawe et al. (2007) reviewed various national data sets that allowed inferences to be drawn about parental status and substance use. For example, the 2004 National Drug Strategy Household Survey (AIHW, 2005a), included data on substance use and household type for approximately 29,000 households. Household type included categories such as "couple living alone", "couple with non-dependent children" and "couple with dependent children—including the number of dependent children". Using the definition provided by the National Health and Medical Research Council's guidelines for risky and high-risk drinking in the short term, it was estimated that approximately 13% of children aged 12 years or less were exposed to an adult who was a regular binge drinker. The same calculations were conducted for both cannabis use in the last year and monthly users of amphetamine-type substances. Just over 2.3% of children aged 12 years or under were living in a household containing at least one daily cannabis user and 0.8% were living with an adult who used methamphetamine at least monthly and reported doing so in their home. Some children may have been exposed to problem drinking and substance misuse.

Key message: It is estimated that 13% of Australian children aged 12 years or less are exposed to an adult who is a regular binge drinker.

Household surveys such as the National Drug Strategy Household Survey are widely acknowledged to underestimate illicit substance misuse (see Dawe et al., 2007, chapter 1, for a discussion of this issue). For example, other estimates have suggested that there are over 100,000 regular users of methamphetamine, of whom 73,000 are dependent (i.e., daily users; McKetin, McLaren, Kelly, Hall, & Hickman, 2005). Hall and colleagues (2000) reported that in 2000 there were approximately 74,000 people who were dependent on heroin in Australia. While information on parental status is not included in these reports, these data highlight the underestimation of illicit drug use in the National Drug Strategy Household Survey and, by implication, the number of children likely to be exposed to parental substance use. The data from national surveys also typically overlook marginalised and disenfranchised minority groups. Individuals who misuse substances are over-represented among the marginalised and disenfranchised. The exclusion of these groups contributes to a further under-estimation of the extent of the problem. In conclusion, it is not possible to obtain a reliable estimate of the number of children living in a family with significant parental substance misuse. What can be inferred is that a substantial number of Australian children live in households where adults routinely misuse alcohol and other drugs.

The place of children and families in national and state policy

The importance of obtaining some scope of the problem cannot be underestimated. Having some indication of the number of children affected provides a context for the development of policy in relation to families and substance misuse. In turn, policy drives service provision and funding. Dawe et al. (2007, chapter 6) provided a comprehensive review of current policy initiatives and practice guidelines relating to children, families and substance use. This review looked at policy documents at a national and state level that related to drug and alcohol services and child protection services. Particularly important was the investigation into the extent to which the major policy documents specifically identify issues relating to the impact that substance misuse may have on children and families. Dawe et al. argued that, unless there was clear policy that provided a strong mandate for treatment providers to consider the importance of family-focused interventions, any attempt by

agencies or organisations to address the needs of children and families would be ad hoc at best. A clear mandate or policy directive would enable a flow-on effect through which funding would flow to organisations that positioned themselves to undertake such work.

Key message: Unless there is clear policy that provides a strong mandate for treatment providers to consider the importance of family-focused interventions, any attempt by agencies or organisations to address the needs of children and families will be ad hoc.

Clearly, highlighting the needs of children in substance abusing families at a policy level will not directly translate into adequate service provision. But without the inclusion of children and families in drug and alcohol policy, the chance of ensuring that quality, evidence-based treatment develops in a sustainable manner is limited. The review by Dawe et al. (2007) highlighted that across many jurisdictions, there was little focus on the needs of children and young people affected by parental substance misuse. At the national level, the 2004–2009 National Drug Strategy, in particular, and the Aboriginal and Torres Strait Islander Peoples Complementary Action Plan, do not prioritise the needs of children who are negatively affected by parental substance misuse, nor do these documents provide clear operational guidance on how this objective might be achieved. However, it is encouraging that more recent state policies on this issue do explicitly attend to the impact that substance use has on families and children. Queensland (*The Queensland Drug Strategy 2006–2010*) and South Australia (*South Australian Drug Strategy 2005–2010*) have taken the lead in this important area. This opens up the possibility that within the drug and alcohol field there will be a growing focus on families and children affected by parental substance misuse. However, in light of the review of risk and protective factors above, the question that is essential to answer is how should such services develop and what should such services consist of?

Key message: Across many jurisdictions, there was little focus on the needs of children and young people affected by parental substance misuse. Without the inclusion of children and families in drug and alcohol policy, the chance of ensuring that quality, evidence-based treatment develops in a sustainable manner is limited.

The way forward

Parents who misuse substances are likely to require help across many different areas of their family lives. This includes help in controlling their substance use, help with other psychological problems, help with external stressors, such as housing and financial strains, as well as help to increase the social engagement of the parents and their children in society more generally. Interventions should aim to create the conditions that allow the parents to create a safe, nurturing and stimulating environment—the ingredients of family life necessary to ensure the healthy development of children. While this is easy to state, responding effectively is far from straightforward. In this section, we consider the qualities of interventions that are likely to maximise the likelihood of successfully helping these families change.

Content and focus of family-focused interventions: What works?

The few studies that have evaluated parenting programs that target substance-misusing parents have reported promising results. In general, these are ecologically based programs that target multiple levels of family functioning although working out which component(s) of the programs make the most difference has not been addressed. The literature summarising the results of parenting programs that target discrete problems (in particular child conduct problems) provide some useful guidelines on the ingredients of effective parenting programs. However, what works for families with a discrete problem (e.g., maternal depression) may not be appropriate for families with problems across multiple domains of family functioning. Below, we review programs that have specifically targeted multi-problem families. We then compare this with the literature that reviews programs that focused on discrete problems. Finally, we examine whether process issues, in particular family engagement and the development of a collaborative working alliance, may be equally as important as the content of programs targeting multi-problem families.

Key message: What works for families with a single discrete problem may not be appropriate for families with multiple problems.

Parenting programs targeting multi-problem families

The effectiveness of home visiting programs

There have been a number of studies in recent years that attempt to improve child outcomes in multi-problem families. Much of this literature falls under the broad umbrella term of home visiting interventions. Typically such programs occur in the period immediately after a child's birth and are delivered by either nurses or trained lay people receiving supervision (sometimes referred to as paraprofessionals). A landmark study conducted in this area by Olds, Henderson, Tatelbaum, & Chamberlin (1986) demonstrated an enduring effect of the provision of a home visiting service to underprivileged young women. However, this study did not include families where there was significant parental substance abuse. While there is some evidence in Australia that home visiting interventions provided by nurses (e.g., Family Care) are helpful initially (Armstrong et al., 1999), lasting effects have not been found (Fraser, Armstrong, Morris, & Dadds, 2000). The study of Family Care also excluded parents with substance use problems.

Key message: Many studies examining the effectiveness of family home visiting programs excluded families where there was significant parental substance abuse.

The effectiveness of home visiting programs with substance misusing parents

There have been several recent studies of home visiting that specifically targets drug-using mothers with infants. Schuler, Nair, and Black (2002) found that a home-based intervention consisting of weekly visits for 6 months, followed by fortnightly visits from 6 to 18 months had no effect on a range of measures (including child abuse potential and parenting) when compared to a control group who received treatment as usual . A similar finding was obtained in a study of a home visiting model by Nair, Schuler, Black, Kettinger, and Harrington (2003). It is important to note that, although there were no differences in parental stress or child abuse potential at 18 months in this study, children in the home visiting group showed modest improvements in motor and language development. The work of Anne Duggan and her group stands out as methodologically rigorous and includes a long-term follow up. Once again, there was no effect of a home visiting program, the Healthy Start Program, when delivered by trained and regularly supervised paraprofessionals (Duggan et al., 2004; 2007). Finally, in an evaluation of the Healthy Family model across 6 sites serving 21 communities in Alaska, there was once again no measurable effect on child maltreatment (Gessner, 2008).

Key message: Evaluations of home visiting programs with parents with substance misuse problems have been shown to have minimal effect on parenting or children's risk of being maltreated.

The effectiveness of intensive interventions with families affected by parental substance misuse

There have been a series of small-scale studies that have investigated the effectiveness of family interventions in families who were already engaged in substance misuse treatment. Catalano and colleagues (1999) found that parents on a methadone program who participated in an intensive behavioural family therapy program "Focus on Families" had a significant improvement at 12 months on parental problem-solving and illicit drug use. Treatment consisted of clinic-based groups and a series of home visits. Notably, the improvement in child behaviour was confined to those children who were younger (less than 8 years old) rather than the older pre-adolescent and adolescent group.

Luthar and Suchman (2000) compared the effectiveness of a multifaceted parenting intervention, the Relational Psychotherapy Mothers' Group (RPMG), with standard care in a sample of mothers on a methadone program with a child under 16 years. Those in the Relational Psychotherapy Mothers' Group reported significant reductions in child maltreatment risk, improvement in communication and involvement with their child, and a reduction in non-prescribed opiate use. There were trends indicating a reduction in maternal psychopathology, in particular, depression. However, there was no improvement in either limit setting or autonomy, suggesting that a different approach to learning parenting skills may be needed.

Finally, Dawe, Harnett and colleagues evaluated the effectiveness of an intensive home-based intervention—the Parents Under Pressure program (PUP)—for parents on methadone (Dawe,

Harnett, Rendalls, & Staiger, 2003; Dawe & Harnett, 2007), parents identified by child protection agencies (Harnett & Dawe, 2008) and women leaving prison (Frye & Dawe, in press). The Parents Under Pressure program considers influences on family functioning across ecological domains as potential targets for intervention, including parental psychological functioning, child functioning, the parent–child and marital relationships, social support networks, housing, child care, and lifestyle.

For the most part, these studies evaluating intensive interventions with families affected by parental substance misuse involved parents who were already engaged in treatment services. They were all delivered by trained psychologists and, importantly, the follow-up was relatively short (6 months). So, although the findings are more promising than those for the larger-scale studies of home visiting reported above, caution is needed and further research is also needed to demonstrate enduring change.

Key message: The findings from studies examining the effectiveness of intensive interventions with families affected by parental substance misuse are promising. However, caution is recommended, as there is a need for further research to determine if the programs create enduring change.

Parenting programs targeting discrete family problems

Behavioural parent training interventions have been subject to extensive empirical investigation. The results of this body of research have recently been summarised in a series of meta-analyses that provide some useful conclusions on the ingredients of effective parenting interventions. Lundahl, Nimer, and Parsons (2006) conducted a meta-analysis of 23 studies using parent training to reduce or prevent physical and emotional child abuse and neglect. Studies that were included in this analysis required that the parents had been judged to be at risk to abuse a child. Parent training was found to be moderately effective in promoting improvement in childrearing attitudes, childrearing behaviour, and parental emotional adjustment (Lundahl, et al., 2006). Three of the main findings were:

- delivering parent training in the home resulted in better outcomes compared to those interventions that were only clinic-based;
- interventions that focused on teaching specific child management techniques were most effective in changing childrearing practices, but less effective in changing other aspects of parental functioning; and
- individualising the interventions to the specific needs of families enhanced outcomes.

In another meta-analysis, Kaminski, Valle, Filene and Boyle (2008) synthesised the results of 77 published evaluations of parenting programs aimed at enhancing child behaviour and adjustment for children aged 0–7 years. The authors calculated effect sizes separately for two outcomes—parenting skills and child behaviour. Four components of the programs were found to be important for both outcomes:

- requiring real-life practice with the parent's own child;
- teaching skills related to emotional communication—active listening skills, helping children identify and appropriately express emotions;
- teaching parents to interact positively with their children—learning the importance of positive, non-disciplinary interactions, and using skills that promote positive parent–child interaction, such as following the child's interests, offering children a range of recreational options, showing enthusiasm, and providing positive attention; and
- disciplinary consistency.

A surprising result was that those studies that provided both parent training and supplemental services such as anger or stress management, substance abuse treatment or job skills training did not have as large an effect on child behavior as those programs where parenting training was a stand alone intervention. This raises the question as to whether the ancillary services either distracted parents from the key task of learning parenting skills or whether the additional focus on other areas meant that there was less time spent on parenting skills.

However, some caution is needed in extrapolating the results of studies targeting discrete problems (in particular child conduct problems) to multi-problem families. First, the conclusion that the additional services do not improve effectiveness is based on the results of studies with limited outcome measures. Kaminski et al. (2008) pointed out that the additional services may have led

to positive changes in outcomes such as abstinence from substance use and improved economic circumstances (p. 569), but there were no measures to assess if this was the case. From an ecological perspective, improvement in substance misuse and a concomitant reduction in financial stress would be expected to lead to improved family functioning in the longer-term. Unfortunately, not only were these important outcomes not measured, the meta-analyses were restricted to short-term (pre- and post-intervention) changes, a period of time in which the benefits of changes in the social ecology of the family would not be expected to be observed. Second, within many of the studies, the additional services were treated as adjunct treatments raising questions around the extent to which the additional treatments were adequately delivered and integrated within a treatment model. For example, Chaffin et al. (2004) noted that the exact content and quality of the extended interventions offered in their study were not controlled nor delivered systematically.

In conclusion, the review of a large body of parent training literature points to a number of components that seem to be important in producing change. The extent to which programs should target multiple domains in multi-problem families is a complex one. Simply adding services to a program that was designed to target a discrete family problem (e.g., child behaviour problems) does not appear to improve its effectiveness. Rather, the rationale and framework of an ecologically informed program may well be critical for achieving success. In particular, it is likely that the procedures for engaging the family, providing a rationale for the intervention, and developing a trusting working alliance is critical for successful outcomes. This is discussed in more detail below.

Key message: Simply adding services to a program that was designed to target a discrete family problem (e.g., child behaviour problems) does not appear to improve its effectiveness.

Beyond content: Process issues in working with multi-problem families

The following section describes a number of process issues that we believe are important in working effectively with clients.

Engagement

The approach a service provider takes to family engagement and the development of a trusting working alliance is very likely to influence outcomes. Many multi-problem families have had adverse experiences with authorities, resulting in a distrust of health and welfare agencies. For these families, a great deal of care is needed to achieve engagement. The Family Partnerships model (Davis, Day, & Bidmead, 2002) is a manualised intervention for effectively engaging with multi-problem families. The model is based on a detailed description of the nature of the relationship between the parent and helper. This allows the specific steps that need to be taken to engage with families, and the qualities and skills needed in the helper to facilitate the relationship, to be made explicit.

Key message: Many multi-problem families have had adverse experiences with authorities, resulting in a distrust of health and welfare agencies. For these families, a great deal of care is needed to achieve engagement.

Identifying and maintaining a focus on goals

Harnett (2007) has argued that collaborative working relationships can be established with parents, even when they are referred by child protection agencies. A procedure is outlined in which goals are set that both the parents and the child protection agency agree would, if achieved, influence decision-making. That is, that the goals are clinically meaningful while also being manageable targets for change. Under these circumstances, parents are more willing to work cooperatively with therapists who extend a genuine offer to help parents achieve these goals. Even in the absence of child protection involvement, having well-defined goals for change is critical to ensure that there is a clear focus that the family is able to work towards.

Key message: Collaborative working relationships can be established with parents, even when they are referred by child protection agencies, if goals are set and agreed upon by both the parents and the child protection agency.

Presenting a rationale for an ecologically informed intervention to the family

The rationale presented to a family to justify an intervention sets the scene for the parents' response to the intervention. Programs that target multiple domains require a different rationale to programs based on traditional parent training or other family intervention models. For example, the parent training model is explicit in attributing child behaviour problems to parenting skill deficits. Parents are informed that the acquisition of child behaviour management skills and skills to promote positive parent–child interactions will provide strategies sufficient to manage their children's behaviour. From an ecological perspective, other factors are seen to be potentially important determinants of a parent's success in achieving the outcomes they want for their family. A useful way of presenting the rationale for an ecologically informed program is to first identify goals for change. Next, parents are encouraged to identify the range of influences that make it hard to achieve these goals. These influences may include a lack of knowledge of appropriate parenting skills, but may also include factors such as emotional exhaustion, lack of support, and the pressing demands of stressors such as housing problems or financial stress. Identifying the range of issues in their life that are related to the task of parenting normalises their problems. Not only does this approach avoid labelling the parent as having a parenting deficit, it provides a clear rationale for intervention to improve the wider ecology of the family.

Key message: A useful way of presenting the rationale for an ecologically informed program is to identify goals for change and then encourage parents to identify the range of influences that make it hard to achieve these goals.

Individualised, flexible approach

From an ecological perspective, any combination of problems may be hindering a parent in achieving their goals for change in the family. Consequently, there can be no fixed sequence of intervention strategies that will be relevant to all families. An ecologically informed program will need to be flexible in the content of the program, tailoring the program to the needs of each family.

Key message: Any combination of problems may be hindering a parent in achieving their goals for change in the family. Consequently, there can be no fixed sequence of intervention strategies that will be relevant to all families.

Strengths-based approach

An assessment of a family can identify factors that are likely to hinder their success in achieving a specified goal for change. All areas of their family life that are not identified as potential problems are potentially facilitating factors. For example, parents faced with a housing problem may have reduced emotional resources to deal with their children's needs. However, if they have a support network, they can turn to these people for help with the children. Acknowledging the areas of family life that are not problematic is, in itself, helpful to families.

Key message: Acknowledging the areas of family life that are not problematic is, in itself, helpful to families.

Organisational pre-requisites to implement family-focused programs

The importance of having an organisational commitment to the development of family-focused interventions cannot be understated. It is essential that there is organisational support that will ensure that good quality and sustainable services are provided for families with parental substance misuse.

In the first instance, there needs to be adequate funding available to ensure that staff can deliver interventions. It is now well accepted that effective treatment with multi-problem families requires that staff have small case loads. Enduring change requires intensive but time-limited interventions, with case loads of less than ten per full-time clinician.

Key message: Effective treatment with multi-problem families requires that staff have small case loads.

There also needs to be organisational commitment to the provision of an "evidence-informed" model of practice. We have deliberately avoided the use of the term "evidence-based", as the field is unclear what components of treatment for multi-problem families are most effective. However, while there is a number of research studies that will provide some answers in due course, the field

cannot wait. Therefore, evidence-informed practice should draw from existing studies, including meta-analyses, in order to provide family interventions with components that have some evidence supporting their effectiveness, e.g., home visiting, and focus on improving parenting skills.

Working with multi-problem families can be difficult for clinical staff and, in addition to good training and a clear model of intervention, staff need to have regular supervision. Once again, this requires a commitment at an organisational level that values clinical supervision as an essential component of clinical work.

Summary and conclusions

Parental substance misuse is typically one of many problems in multi-problem families. Children raised in dysfunctional environments where there is substance misuse, parental mental health difficulties, financial disadvantage and many other problems do not fare well. However, building on parental strengths can add protective factors. These can include helping a distressed parent to be more emotionally available and more nurturing with their children. It can also involve helping the parent learn better child management skills. The wider social environment, in which poor housing, unemployment and social isolation are key factors, also influences children's outcome. Real world issues such as these also need to be targeted in any treatment approach.

There is no one simple or single solution. Governments need to ensure that the needs of children and families with parental substance misuse are prioritised in policy documents. In turn, treatment agencies and services need to have an organisational commitment to the provision of family-focused services. Clinicians need to be given support and receive ongoing clinical supervision. Finally, the field needs to take what it can from the research literature to help shape evidence-informed practice. Families will fare best when they are engaged in the process of treatment, feel a part of the treatment, have a commitment to the treatment and hold the view that they are working with the service to achieve common goals.

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