

**Integrating parenting support in alcohol and drug
treatment program for mothers and their children:
a study of practice innovation**

REPORT TO PARTNERS

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This report is dedicated to the memory of our inspiring and gifted friend and colleague, Professor Alison Lee, who died in September 2012 after a short illness. Alison initiated and directed this study, and energised it throughout. Her vision was for more than a research project, but also for a way of making a lasting difference to the lives of vulnerable women and children.




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1. INTRODUCTION

This report presents the preliminary findings of a small exploratory study of an innovative Integrated Program for substance-dependent women and their children. The program is provided to women and their young children living at Kathleen York House (KYH), a residential alcohol and other drug (AOD) rehabilitation service for women in inner Sydney in collaboration with Tresillian Family Care Centres, a provider of child and family health (CFH) services.

In 2008, KYH approached Tresillian to assist with the development and implementation of an Integrated Program of parenting support within the AOD rehabilitation program. A review of initial collaborative activity between the two agencies identified the need for:

- a more substantial, embedded and interprofessional team-based approach, incorporating CFH and parenting knowledge into KYH program activities;
- research to document and analyse the further development of this program (DeGuio, Maddox & Davies 2009).

The project was funded by the University of Technology, Sydney through the Partnership Grant program. The three research partners were UTS, Kathleen York House and Tresillian Family Care Centres.

The study used qualitative methods to investigate the implementation of the program and its impact on the women, their children and the staff members involved. The project aimed to contribute new knowledge about the process and implications of service redesign and practice change within the areas of AOD rehabilitation and CFH service provision. It also aimed to add to an emerging body of research documenting and theorising the implementation, impact and sustainability of interprofessional and collaborative practice and consumer-informed shared health care.

WHAT IS THE PROBLEM?

This project is about families with young children who have lived with the consequences of trauma, poverty and social exclusion. Many mothers and young children in the study have experienced these consequences across several generations. For some families, an inter-generational cycle of ill health, poor service provision, abuse, domestic violence and social dysfunction may result in disrupted family lives affecting children's development and placing them at risk of learning poor parenting skills themselves (Heath et al. 2011) (HREOC 1997).

Thousands of Australian children are born every year into families with determinants that limit their access to healthy and positive life experiences. Growing up this way will impact upon their well-being and opportunities to be a responsive parent in future. Disrupted parenting often results from the coexistence of earlier life disadvantage with experiences of mental illness, substance dependence, incarceration and/or trauma arising from these events. The relationship between these factors is complex, and the long-term negative implications for these children and their families are well documented (HREOC 2007; Raphael, Delaney & Bonner 2007; Sheehan 2010).

These experiences have an impact on substantial numbers of children and families. The following statistics highlight the numbers, if not the social distress involved for these families.

Incarceration

- Approximately 38,000 Australian children have a parent in prison each year (Quilty 2005, p. 256).

Substance dependence

- More than 450,000 children are raised by adults who misuse alcohol or drugs, approximately 13.2% of Australian children (Dawe et al. 2007, p. vii);
- An estimated 60,000 Australian children have a parent attending drug treatment (Gruenert, Ratnam & Tsantefski 2004, p. 5);

- Parental substance misuse is involved in approximately 50% of all substantiated cases of child abuse or neglect in the child protection system in Australia (Dawe et al. 2007, p. 11).

One study of a Victorian AOD service found that

- 70% of clients reported that their children had witnessed or been distressed by their active drug use and its effects;
- 50% of parents stated that their children had been negatively affected by their exposure to family violence, police intervention or abandonment or separation due to family breakdown, incarceration, death or out-of-home care. (Gruenert, Ratnam & Tsantefski 2004, p. 8).

Existing services rarely cater for the needs of these children and families. Services are generally not funded to deal with multiple problems that are common in many families – for instance, a parent who has experienced trauma and mental health issues, who then self-medicates by overusing alcohol or other drugs, and who also has the care and responsibility of a child.

Services that only address part of the problem, for instance, by focusing on addiction or on problematic parenting, are rarely able to address the complex interplay of the issues identified above, thus missing an opportunity to intervene more effectively and with greater impact. Early intervention not only requires a timely response but a response commensurate with the degree of trauma and social exclusion experienced – a response tailored to a particular individual or family, mother or child.

WHY IS RESEARCH NEEDED?

Evidence suggests that parenting support is often a key element in breaking the cycle of

disadvantage and trauma created through situations as described above (Travis & Combs-Orme 2007). The social and emotional health and well-being of all children requires stable and secure attachment, achieved through effective parenting (Belsky et al. 2005).

When women become mothers they are often highly motivated to make a real difference for their children (Mayet et al. 2008). However, some mothers may be constrained by a range of barriers arising from their own lack of positive parenting experiences (Kumpfer & Fowler 2007) and limited access to parenting knowledge and appropriate information and support. Services can make a real difference to these women's confidence and capacity through supporting their needs and expectations (Dawe et al. 2003; Trifinoff et al.). Achieving and sustaining significant change requires a holistic service model that addresses the many complex and inter-woven needs of children, parents and their families, with input from skilled health professionals and a nurturing, supportive environment.

Whilst there is an increasing recognition of the need to design and implement services that engage with clients holistically, the current research has a purposeful focus on parenting as well as on substance dependence and trauma. There are relatively few services that provide such a spectrum of support for families, and even fewer studies that document and analyse how such services operate and what they achieve.

The KYH program provides an integrated family-sensitive service that focuses on both client/mother and child, and on managing AOD issues in conjunction with re-building parenting confidence and capacity. This research provides a unique opportunity to learn more about how such services are designed, implemented and, ultimately, experienced by clients – mothers and children – and staff.

2. BACKGROUND

NATIONAL & INTERNATIONAL PRIORITIES FOR HEALTH SERVICES

This research addressed three critical challenges confronting local, national and international health systems and services:

- to build health systems and services that are more effective, sustainable and responsive to individuals and families;
- to engage health consumers more actively in the management and maintenance of their own health;
- to develop research-based understanding of implementing and sustaining significant change in health services and professional practice.

In response to these challenges, increasing policy, organisational and educational attention is focused on the importance of collaborative, interprofessional and partnership-based approaches to health service development and practice. These approaches are identified as more flexible, sustainable, efficient and capable of effectively addressing the complex and diverse health needs of individuals and communities (Council of Australian Governments 2009a, 2009b; National Health and Hospitals Reform Commission 2009; World Health Organization 2010). There is, in parallel, increasing emphasis on the need for greater participation by health consumers in the development and delivery of health care (Dunston et al. 2009; NSW Health 2009). These changes all require new kinds of knowledge and practice skills, different from previous profession-specific knowledge and practice capabilities that have traditionally been the focus of health and social care practitioners. They require evidence-based models of support, driven by consumers and responsive to their multiple needs.

Yet, despite widespread recognition of the need to build new forms of interprofessional and collaborative practice and partnerships, and co-produced health care, little is known of the implications of implementing such practices, in particular, what is at stake for local service

providers and clients (Bate, Mendel & Robert 2008; Dunston et al. 2009).

SERVICES FOR CHILDREN & FAMILIES

This research aimed to contribute both knowledge and service improvement in areas that align strongly with national and state health policy priorities (Council of Australian Governments 2009b; NSW Department of Community Services 2009; Wood 2008).

Children and their mothers who are substance-dependent are extremely likely to have intensive and extended surveillance with child protection agencies (for example see Department of Education Employment and Workplace Relations (2008). This establishes and entrenches a problematic relationship for many families with police, child protection and corrective services, which can set up a generation of systemic violations, further breaking down parenting capacity and life chances.

National and international research provides significant evidence about the importance of the first three years of an infant's life, the relationship with parenting practices and the value of early intervention (Edwards et al. 2009; Karoly, Kilburn & Cannon 2005; National Scientific Council on the Developing Child 2008). Early intervention services for children whose parents have multiple and complex vulnerabilities, such as substance dependence, have become a priority for government. Currently, several national and state policies are being developed to support services for parents and their young children (Council of Australian Governments 2009a, 2009b; Schmied et al. 2009).

ADDRESSING THE INTER-GENERATIONAL SOCIAL & ECONOMIC COSTS OF AOD DEPENDENCE

This research provided an important opportunity to investigate the implications of implementing new practices in one complex and challenging area of health service delivery, AOD rehabilitation. AOD dependence potentially impacts on the lives of all Australians. Having a mother with AOD dependence places children at risk of harm and long-term physical and mental health problems (Dawe et al. 2007), outcomes

with significant financial implications for the health system and the individual's ability to contribute to society. Such children are at risk of poverty, abusive and disrupted parenting, as well as internalising and externalising problems, oppositional defiant disorder and conduct disorder in childhood and a higher risk of criminality, mental health problems and substance abuse as teenagers (Dawe et al. 2007; Evans et al. 2007).

AOD and CFH services have not typically engaged in active partnerships to work collaboratively with mothers and their children. Instead, parenting program models commonly use an overlay approach, with AOD treatment as the key focus and parenting input provided in a discrete and limited manner e.g. Parenting under Pressure program (Dawe et al. 2003). Although there is no one ideal model, current literature suggests effective interventions require multi-dimensional, collaborative and interprofessional approaches bringing together AOD and CFH parenting

expertise, to provide new forms of AOD rehabilitation programs enhanced through well-tested models of CFH therapeutic practice and theories of child development (Advisory Council on the Misuse of Drugs UK 2003; Dawe et al. 2007).

AIMS

The aims of the project were:

1. to generate new understandings about support for AOD-dependent mothers and early intervention for their young children;
2. to address significant research and knowledge deficits in relation to health service redesign in the area of AOD rehabilitation and, more broadly, in the areas of health service, professional practice reform and health consumer participation/co-production;
3. to contribute to service improvement and capacity building for the two partner organisations (KYH and Tresillian).

3. THE STUDY

THE RESEARCH PROJECT

The project consisted of research collaboration between three organisations:

- University of Technology, Sydney – both the Centre for Research in Learning & Change (Faculty of Arts and Social Sciences) and the Faculty of Nursing, Midwifery and Health (now the Faculty of Health);
- Kathleen York House – a residential AOD rehabilitation service for women;
- Tresillian Family Care Centre – a state-wide provider of child and family health services.

In addition, the research team included two researchers – Associate Professor Carolyn Day (Discipline of Addiction Medicine, Sydney Medical School, University of Sydney) and Dr Libby Topp (formerly of the Kirby Institute, University of New South Wales) – who were then also members of the Board of KYH. Members of the Research Team are included in Appendix A.

The project was funded under a UTS Partnership Grant (Reference RM2010001429) awarded in 2010 for 18 months. It commenced in March 2011.

During the course of the project, the research team also formed a partnership with the Rotary Club of Drummoyne as a source of additional financial and strategic support – see Section 8, *Partners in Hope*.

THE FOCUS OF RESEARCH – THE KYH INTEGRATED PROGRAM

KYH and Tresillian jointly developed the KYH Integrated Program in 2008 to address the needs of women with AOD dependence who have young children. It was designed to provide early intervention for these high-risk families who pose significant challenges for AOD services, for the health system and, more broadly, for the education, child welfare and justice systems.

The Integrated Program comprises three areas of innovation:

- integrating effective parenting understandings as central elements of AOD rehabilitation;
- developing new forms of interprofessional and collaborative practice between practitioners from differing disciplinary and agency backgrounds; and
- actively engaging women residents in the co-production¹ of the rehabilitation program.

The Integrated Program aims to intervene in and disrupt the intergenerational cycle of dysfunctional parenting that frequently occurs in AOD-dependent families as a consequence of their histories of trauma, mental illness, incarceration, disadvantage and social exclusion. It thus aligns with national and state/territory government priorities to maximise early childhood health across all sectors of the population.

It also focuses attention on topical issues such as AOD rehabilitation, early intervention, health service redesign and professional practice change, with particular regard to the development of interprofessional and collaborative practice approaches.

METHODOLOGY

The research built on theoretical and methodological frameworks that allow a close examination of significant practice change situated within the organisational contexts in which it is being implemented. Our investigative focus drew on a developing body of theorisation, in particular Schatzki's *Practice Theory* (2001) and research that seeks to understand practice and practice change not as static, individual, cognitive and competency-based accomplishments, but rather as social practices that are situated, embodied and accomplished in particular settings over time.

Our methodological approach was to develop rich

¹ Co-production locates health consumers alongside health professionals as competent and resourceful participants in health service development, health maintenance and improvement (see Dunston et al 2009).

accounts of practice, recognising that practices are dynamic, complex and situated achievements, and that practice change takes place between individuals in different settings and within different relationships. The study aimed to analyse how new forms of participation, new approaches to decision-making, and new ways of utilising and developing expertise are achieved (eg (Green 2009; Lee & Boud 2009; Lee & Dunston 2010).

A key methodological principle informing our research approach was that those closest to the implementation of new forms of practice are best positioned to generate materially-grounded accounts of the practice. We accordingly engaged closely with clinicians, managers and mothers at KYH as to their experiences and understandings of the dynamics and dilemmas of implementing new service models and approaches to parenting. We endeavoured to develop nuanced accounts of the new practice 'ecology' (Kemmis 2009; Lee & Boud 2009; Tsoukas 2008) created through the interprofessional collaborative practices in the Integrated Program.

RESEARCH DESIGN

The research utilised a combination of participatory and more traditional ethnographic methods.

Six key questions provided a framework for analysing practice change over time and changing patterns of participation, decision-making and expertise. These provided an organisational framework that allowed us to produce detailed accounts of the implementation and experience of practice change in the context of KYH.

The six questions were:

1. How do two different groups of health professionals (AOD and CFH) and mothers work together to generate new service, practice and parenting approaches?
2. How do health professionals and mothers experience the Integrated Program?
3. How do the organisations support and/or constrain the development of the Integrated Program?
4. What do mothers and practitioners learn from their experiences of the Integrated

Program?

5. What are the impacts of the program for those involved, especially the mothers and their children?
6. What are the key success factors that enable organisations and individuals to prepare for and engage with significant practice change?

We used observation, interview and participatory methods to establish a baseline, to map the organisational and practice cultures and dynamics, and to explore how new forms of practice are negotiated and achieved, based on a participatory methods (Bate, Mendel & Robert 2008).

DATA ELEMENTS

Data from the study consisted of

- ethnographic field notes of interactions between clinician team members and between clinicians and the mothers;
- audio-recording of meetings of clinicians and of mothers working with clinicians;
- in-depth interviews with clinicians, mothers, managers; and
- key documents relating to the Integrated Program provided by KYH management.

An additional piece of data was the DVD *Partners in Hope*, developed as part of the project (see Section 8) and produced with the collaboration of staff and mothers at KYH.

PARTICIPANTS

Individuals involved in the Integrated Program participated in the study in a range of ways, consistent with the method. This included staff members from KYH and Tresillian, KYH Board members and mothers, in the following combinations:

Interviews with

- Four mothers (one current resident, three in the after-care program);
- Three current KYH staff members (acting manager, program manager, art therapist);
- One former KYH staff member;

- One Tresillian nurse; and
- Three KYH Board members.

Observations of

- Two Tresillian nurses, each working with a mother;
- Several mothers participating in group activities (art therapy, psycho-education);
- Two 'graduation' ceremonies involving several KYH staff members, women and children;
- An admission process involving one mother and one staff member;
- A Friday weekly review meeting involving one staff member and six mothers and their children;
- General interactions in the KYH Office, involving up to six staff members; and
- Two staff meetings, involving up to eight staff members.

Group discussion with

- Approximately six staff members and
- Approximately 15 women, including past and current residents of KYH.

DATA ANALYSIS

We utilised a two-layered approach to data analysis. First, we undertook thematic content analysis, using the qualitative data management software, MAXqda. Written data sources were uploaded into the MAXqda software, enabling analysis of the data into broad themes, initially identified by two members of the research team, and described in Sections 4 and 5. Using this process enabled the team to classify material into each of the identified themes.

These groups of data were then distributed to members of the research team who analysed the data in more detail.

Secondly, team members reviewed the available data to confirm the fit with the identified themes. To confirm the themes and strengthen the findings of the analysis these data were drawn from multiple sources (as described in the data elements above).

We use a descriptive approach to work with these data within this report. Further more in-depth analysis will be used for future publications.

ETHICS

The project received approval from the UTS Human Research Ethics Committee in May 2011, Reference Number 2011-016A. Given the vulnerabilities of the women and their children, particular care was taken throughout all stages of the project, including during the consenting process, data collection and reporting of the findings.

All KYH residents and clinicians involved, and the two Tresillian clinicians gave informed consent to participate in the study. Participants' names have been changed or removed to enable de-identification of these data.

All participants were informed that they could withdraw from the research project at any stage and that withdrawal would not compromise their care by either KYH or Tresillian.

4. THE INTEGRATED PROGRAM – ACCOUNTS OF PRACTICE DRAWN FROM THE RESEARCH

This section presents accounts of what was occurring as part of the KYH Integrated Program. The accounts of practice, together with the experiences of staff and clients participating in the Integrated Program, have been developed from four sources: what participants told us in the interviews and focus groups; our observations at meetings, KYH events and, more generally spending time at KYH; a review of documentary sources, information leaflets, reports etc.; and, finally, our discussions as a research team.

The Integrated Program is an example of collaboration between two very different organisations. KYH is a relatively small inner-city AOD organisation, first established in 1991, providing abstinence-based residential rehabilitation for six women and their children, and supporting another nine clients and their families through the long-term aftercare program. The program is offered to women who are: homeless, have engaged in prenatal harm, have children under three years of age (with additional support for their children up to 12 years of age), at risk of losing their child, have been drug dependent for more than five years, with numerous failed treatment episodes, involvement with criminal justice, and compromised physical and mental health (Kathleen York House 2009). Staff members comprise a clinical psychologist, and Drug and Alcohol (D&A) workers.

Tresillian is a large, long-established, statewide early parenting service for families with children up to the age of five years. In addition to direct service provision to families through residential and outpatient facilities, Tresillian runs a 24 hour parent help line, an on-line parenting support service and provides education for parents, health professionals and community agencies working with parents of young children across NSW. The majority of staff are CFH nurses and allied health professionals.

The two services had little commonalities except for the belief that all children deserve a healthy and safe start in life... Both organisations held the belief that early interventions based on evidence that combined drug and alcohol and parenting expertise could only enhance the crucial child parent relationship resulting in optimal health and wellbeing outcomes for the family (DeGuio, Maddox & Davies 2009).

In 2008, KYH approached Tresillian's Education and Research Unit to provide support after recognising the service gap in the parenting component of their program. KYH initially requested Tresillian to provide parentcraft education for KYH clients. The request was discussed by the Tresillian staff who identified that a more individualised, comprehensive, evidence-based program would be more effective and sustainable, and discussed this perspective with KYH staff. Managers and senior clinicians from both organizations discussed the collaboration and drew up a Service Agreement. A Memorandum of Understanding covered child protection, privacy, medical records, risk of harm, relapse and other issues associated with mandatory child reporting.

KYH identified the intended outcomes of the Integrated Program.

Expected outcomes include: improved women's ability to provide a positive nurturing environment for their child, enhancement of the relationship, increased maternal confidence and self-esteem, effective stress management and greater coping skills, relapse rates reduction and lower intensity of relapse episodes. Staff expected outcomes include: increased understanding of positive parenting, and increased ability to facilitate the maternal child relationship (Kathleen York House 2009)

The collaboration between KYH and Tresillian did not generate extra funds for either organisation. However, it did enable both organisations to

extend their scope and expertise. Both KYH and Tresillian identified the value of partnership, especially for under-resourced community organisations. This project is part of building evidence to demonstrate the value of this approach. The partnership implicit in the Integrated Program was beneficial to staff in both organisations as a means of increasing their expertise and professional development, and enhancing capacity for both parties:

My sort of underlying driving force was to say, well, if these were the women and children with some other disease, like cancer or something, they would be offered the best quality healthcare ... from a range of disciplines ... why should it be that we're dealing with some of the most unwell children and women in the community, and we have \$4.50 to do it? We should be able to offer them the best that's on offer, and the way we do that is to find partners.

KYH staff member

[The manager] rang Tresillian wanting - because she'd identified that they were having children there and that they needed additional support - the parenting skills weren't within their organisation ... [We] could see that our nurses, the Tresillian nurses, didn't have the mental health skills and the drug and alcohol skills that were really essential to working in an area with such vulnerable families and mothers. So the model was set up so that the nurses went in and ... the drug and alcohol worker that was assigned to the mother would be there with the nurse for the hour or so ... That was so for a couple of reasons. It was about capacity building, about the drug and alcohol workers learning about parenting, and because we use some particular techniques, but also about the nurses learning capacity building around their ability to manage and work in that environment with mums and babies that had a substance issue. Also that the drug

and alcohol workers could carry on the strategies once the nurse left so that it wasn't just a bandaid effect ... that they would go in - and [the manager] set up some really fabulous things in the first instance of making sure the nurses came to supervision and case discussions. There was a lot of information sharing and it worked really well.

KYH Board member

This approach was summarised in documents in support of KYH's application for a grant from the Commonwealth Attorney General's Department.

KYH clinicians sought Tresillian's help with the management of parenting needs of women in their care. The opportunistic partnership was based on good will and optimism but the demand for increased and more complex clinical intervention and development of a systematic program has been identified. This has included the identification of the potential to break intergenerational punitive approaches to parenting that frequently leads to criminal behaviour and trauma. Sustainability through development of KYH staff knowledge and skills has been identified as crucial. The program includes clinical and educational components. (Kathleen York House 2009)

One KYH staff member summed up the critical value of strategic partnerships for a small organisation supporting a vulnerable group of people and the way partnerships were utilised to enhance access to professional expertise and resources.

So, this notion that we have to step up as staff, we have to professionalise. But also, because we're so under-resourced, we have to partner and we have to partner with clinical psychologists. We have to partner with psychiatrists that can help assess and manage and review and do all these things.

KYH staff

These extracts illustrate the importance of health professionals gaining knowledge from their colleagues in other sectors. This is a valuable recognition of the growing need for effective support for families given that alcohol and other drugs are commonly used as a form of self-medication for unresolved stress and mental health issues. The collaboration between KYH and Tresillian also demonstrates the importance of greater professional understanding and insight into the lives of families who are frequently stigmatised by the health and child protection systems.

A DIFFERENT FORM OF SERVICE PROVISION

The Integrated Program offered a service that was unique in many ways. The key distinguishing components include:

- A focus on each mother as a whole person with needs spanning a wide range of psychosocial issues separate from (but related to) their addiction;
- A focus on women as parents and as part of a wider family and community;
- A focus on residents' children and their distinct circumstances and needs; and
- A focus on learning between two groups of health professionals.

The program has the potential to build a sense of different cultures, by sharing information and being open to other ways of providing care. Not only do the health professionals learn from each other, they also provide vital mentoring for the mothers in the program, offering new and different ways of knowing and doing.

The whole person

The KYH program responds to the women's immediate needs for treatment and rehabilitation, but also addresses areas arising from their past history and their future goals. It addresses the fact that many of the women have complex and painful previous experiences of trauma and abuse, at times stretching back for some generations.

The Integrated Program helps women with issues such as physical and mental health, employment,

parenting, housing and legal support, all of which are closely interrelated and compounded by their substance abuse.

Mothers in the program value the fact that they are viewed as a whole person, not just an AOD problem, and that staff provide professional support in their efforts to deal with the many complex issues in their lives.

....you're working with women and children, women who have complex trauma histories and co-morbidities and children from different fathers and different places and different relationships with the fathers and [DoCS] ... the profile of the clients we are working with are much more complex – mental health, child protection, homelessness and long histories of untreated (often self medicated) trauma both from childhood and adulthood.

KYH staff

It's a holistic program ... that takes account of so many aspects of people's lives.

Mother – group discussion

A lot of us did come in here broken, and from my experiences I didn't think I'd be back to reality and full function, and I finally made it. I think that happened with the staff members here - I wouldn't be the person I am today, with all the stuff that I had to deal with. Not just myself I had to deal with. I've had a child in my care - my seven year old girl. She's been in my care for over a year now. I've dealt with homelessness, plus dealing with the court on top of the problems I've had to deal with in myself. They've supported me through all of that.

Mother – group discussion

So I needed the chance to be part of the group therapy and everything, but I also needed my individual issues – I needed help with them. Like my DV – domestic

violence relationship and the AVO. I had a staff member come to court with me every time, and when [my daughter] stopped breathing, I had to go to hospital for 11 days with both the children because I didn't have any family support to take [my son] while I was there. I had Tresillian come to visit me at the hospital. I had a psychologist ... I had the residents here. The girls came and brought the NA meeting to me, to the hospital bed. To [my daughter's] little hospital cot. So that was really touching. I think that was part of the family thing. So I know that each of the women is so different and the children are all different, and I think the way that the program here is focused on not us fitting to their program, but they really provide that individualised stuff.

Mother – group discussion

Some respondents contrasted the ability of the program to address a range of issues with many health services that do not respond to specific clients' needs. They attributed this to the fact that KYH is a small service, able to maintain a personal approach, as well as the length of time mothers are engaged in the different elements of the program (6 months residential and 12 months after-care). This has merit in terms of developing commitment, trust and enabling mothers to feel more comfortable addressing long-standing issues. It also has therapeutic advantages.

I think again we're small enough to be able to really respond to the individual's needs. ... In big organisations, it's much harder to do that.

KYH staff

[We] also follow up a year after they leave aftercare. So they don't actually get rid of Kathleen York that readily. Just keeping in touch by phone, and all of them are really happy to chat on the phone and let us know where they are. So it just shows that level of engagement

that Kathleen York provides... You're not going to get that in a six-week program.

KYH staff member – group discussion

I think part of the difference for us is that we are in [a] longer service. So just the nature of the individual's brain starting to heal and then them being able to think more clearly, along with the longer they're here the more they test us and the more we don't fail, you would hope, the more trust they put in us in turn as they drop more barriers. So we can do bigger, deeper work with them. We get to see them longer. We get to see more where the issues are, and in terms of the clinical stuff, we constantly talk about where they're at and what we see and all that sort of stuff.

KYH staff member – group discussion

The longer-term involvement of clients in the KYH program enables a more comprehensive system of care and support. This avoids families relying on the emergency health system when problems arise. This is the recourse for many vulnerable people, who often find the experience to be cold and insensitive.

KYH residents as parents

The concerted focus on parenting at KYH supports the more holistic approach to the women, taking into account their relationships with their children. Staff recognise the demands involved in caring for infants and young children, which can add further stress to their efforts to deal with their dependence and underlying psychological issues. Acknowledgement of their role as parents also had an impact on the effectiveness of their treatment.

So that was a gap there. It also, in my mind, had this notion of separateness. So, you're an addict over here or you're a drug-dependent woman over here, and you're a parent over there. How absurd. Again, it's one of those things that we've been doing for such a long time. In drug and alcohol you're so under-resourced.

You might have a bit of a parenting program and you might have a bit of childcare, but your drug and alcohol rehabilitation is separate. So what I was thinking was that it's not separate at all, that obviously this is a family recovering from trauma and drug dependence. How do we make it about the whole?

KYH staff member

So, learning to become abstinent is enough without then having to then parent at the same time. If you think about, in very simple terms, that drug dependence is often about self-medication of untreated trauma, or there is a pathology underneath there, the learnt behaviour around not being able to tolerate any emotional distress that you might feel and again, thinking in simple terms that your emotional intelligence is being stunted by the dependence; so that natural maturation process has been intervened on. So not only are you learning and trying to tolerate your own distress once you've taken the medication out of the scenario; you've also got a two or three-year-old and a baby and not much family or social support, and the expectation is that you're not going to use any substances. So, here you are, just done six months' rehab, you've been in this very supported, structured environment, have been using daycare options and doing A, B and C and now you've got to go and live in a community with these two children and learn how to tolerate your distress and theirs. So I noticed very early on that this was a real trigger for relapse.

KYH staff member

Some of the other places that I've heard about just don't cater to mothers and

children the way that they're supposed to.

'Ruby'²

It was just about the adults and their plans for the day or whatever, and introducing into that morning group discussion was, so, how did baby sleep last night, how many feeds did you have to have, whatever. Just to normalise and integrate again, in a very simple way. Just by doing that, trying to normalise it a bit, you know. You don't talk about your recovery over here, and you have this parenting issue over there.

KYH staff member

In establishing the Integrated Program, KYH staff and managers recognised that it was vital to provide information about parenting, in a way that was appropriate to the culture and experience of the mothers. They understood the complexity of the problems faced by this group of mothers, both in the present time raising their own small children and in the past when they may have experienced painful or punitive parenting during their own childhoods.

But there is a bit more of a push for drug and alcohol services to engage more in parenting practices ... Some services purport to be doing that is by implementing things like [parenting behaviour management strategy] ... but to me, many of those programs are designed for nice, middle class mothers who are kind of just struggling to cope, which is really normal, and giving them some skills in order to help them do that... Even if they're developed for more challenging clients, I wonder at what point they were developed for this level of challenge. I'm concerned and will be interested to see how it plays out in the future, which is [why this research] is

² KYH residents and past residents who were interviewed are all given pseudonyms.

really important. Whether or not that will be the cop-out for governments to say 'we're doing parenting' and it's very concerning that when people continue to fail on really what was poor or inappropriately-matched programs ... if the Kathleen York workers were just trained, went off to a couple of training days, even fairly regularly for some time, to be trained by Tresillian nurses, I just can't see that that could ever be effective because of the complexity of the clients.

KYH Board member

back to me after being away for three years. Especially with Molly³ because she was three and she had been removed at nine weeks ... Well it was helping me understand that ... it was they had their own trauma and now they had their own issues, instead of it being all about me and my issues and how I'm affected by it. I got to understand that they actually were their own individual people now and they had their own baggage, just like I do. And I'm just the person that has to help facilitate that so they can get well.

'Jo'

A central part of the learning within the Integrated Program is helping each mother to acquire insight into the unique perspective of her child or children. These participants – a health professional and a mother - discuss the process where the mothers move from their own view of their world and learn to identify that their children are separate individuals with separate experiences.

You can put in as much parenting information and education as you like, but unless you deal with the mothers' insightfulness, their mindfulness, about being able to see where the child is coming from and the child's view on the world and the child's experiences, then you're wasting your time. Parenting programs, behavioural programs, have good initial outcomes because people can spout [parenting behaviour management strategies]. But in the long-term, they don't change the mother's insight, and that's really what's important. And that's what these women often lack is insight, because they're so, I think, inward-looking and trying to protect themselves, and outward-looking in fact, being hypersensitive to the world.

KYH Board member

[the manager] explained to me ... it's about their [my two daughters'] distress. It's not because I've done anything wrong. This is their distress at coming

Inter-generational trauma requires sensitive intervention. If it is ignored it is perpetuated. By focussing on parenting issues, the Integrated Program aims to address some of the underlying causes of substance dependence, arising from a history of trauma, disadvantage and insecure parenting. However, it also uses parenthood as an incentive, recognising that substance-dependent mothers are often very motivated to change their lives to give their children opportunities and compassion that they didn't have.

It was really to integrate parenting processes into Kathleen York and to give these mums an opportunity that they often missed out because of their avoidance of mainstream services. So that was I think the aim, really. Because [KYH Manager] really had the vision that she could see that it was pointless looking after the mothers and worrying about their issues if you didn't include the children. In fact, I think the children are a hook as far as helping mums sustain their recovery.

KYH Board member

This process is illustrated vividly in this mother's account of how her children inspired her to start

³ Pseudonyms are used for the children mentioned in the study

the painful process of addressing her dependence.

I could have gone either way. I was just lucky. It's not even luck. Just that I was so mentally in despair and my love for my two girls just made me make that right decision ... the turning point was once was that I was sitting out in my backyard and I looked at Maddie my daughter, who was 10, and I thought, you know, I need to let her know she's enough. She's enough to stop mental illness. She's enough to stop drugs. She's enough for me to change my life. Because I had grown up with the knowledge that I wasn't enough for my mum to stop drugs and alcohol. I wasn't enough to stop sexual abuse. I wasn't enough for my mother to choose me over men. I wasn't enough for my mum to change her life. I took that into every area that I went into for my whole life until I was 40 years old. I thought if the only thing I pass on to her is that she's enough, she's enough for her mum to make a decision to just go to Kathleen York ... I thought if all I pass on to her is that she's enough for me to change my life, even if I don't do it well, just to let her know that she is important enough to me to do it differently.

'Jo'

Some of the mothers at KYH do not have custody of their children. The Integrated Program addresses this by offering these mothers the *Parenting from Afar* program run by Tresillian nurses⁴. It aims to assist the mothers make the best use of the brief times they have contact with their young children. It assists the mothers to identify strategies they can use to increase the emotional connection with their children even if they are not physically present. This program focuses on issues of attachment and separation,

⁴ Parenting from Afar was an adaptation of the Department of Corrective Services *Mothering at a Distance* program (for further information see Perry et al 2011)

as well as providing valuable knowledge about child growth and development.

Another thing that's really been important for me so far is the Tresillian with Parenting from Afar, which I'm absolutely valuing my sessions with that. I really look forward to it on the weekly basis. Especially it's keeping me more in touch with [my child] practically in my side at no time at all really and trying to fit my love into one day for him. To know where he's up to on an emotional level as well at two years old is really fantastic.

Mother – group discussion

All parents out there would not have a handbook to go on, and it's absolutely invaluable the things that they teach you with Tresillian. They work with so many diverse individual cases in here. Parenting from Afar, as you said. I've got custody of one child, but two are with their father. So I'm learning two different parenting styles. I think if they also work with you, because they instill a - I had absolutely no confidence in myself as a parent, because I'd lost two children. So I had a great fear of what I was going to be like as a parent with the child that I just got back. So they basically worked with me to get my own self-confidence back. Instilled that yes I was doing the right things, made me look at certain ways the baby behaved so that I could understand what I was dealing with. It was just absolutely invaluable.

Mother – group discussion

FOCUS ON CHILDREN – UNDERSTANDING THEIR DISTINCT CIRCUMSTANCES & NEEDS

One of the unique features of the KYH program is the way in which children become a focus for intervention as well as their mothers. Children become clients and are involved (age permitting) in the service's activities and routines, as well as its celebrations – a 'graduation' for a mother leaving the residential service for aftercare included her young baby (born shortly after she

moved into KYH) as part of the ceremony. The other mothers paid tribute both to the woman and her child as part of the farewell. Children are often victims of the cycle of trauma, substance dependence, mental illness and disrupted parenting. In this instance they are vital to the healing relationships supported by the KYH program. For many mothers, they are the key – if these women did not have children they would not have entered the program. Moreover the children often provide an incentive for their mothers. They provide the context for the difficult process of rehabilitation and change, a reason for the mothers to work directly with their pain.

Staff members involved in the Integrated Program discussed the central importance of focusing attention on the children who attend KYH, as distinct from their mothers.

Could I just say there, I don't think it's just drug and alcohol. I know with mental health issues that people, specifically people with schizophrenia and things like that, that when they go for treatment or see their psychiatrist or whatever, a lot of the mental health teams don't always think about the child involved.

Tresillian nurse

For me unless you give children the respect that they deserve in what they've tolerated in their life, if we're talking about these type of children, at risk children, they've been through so much that they deserve the respect to have them be given an opportunity about whether or not they want strategies, what part of the truth they want about their lives. They deserve the respect and opportunity to be self-determining, and I don't see enough of that for children today, especially marginalised children.

KYH Staff member

I guess the mother's ability to tolerate the child's emotional needs and respond

appropriately. I think that's been the hugest sort of achievement I've observed in many of the mothers that have come through. Just their capacity to just be with their child, whatever that might be, rather than escape or struggling to tolerate whatever the child might need in that moment or recognising, actually developing an awareness of what a child might need in any given moment.

KYH staff member

One mother described the change for her daughter following the family's admission to KYH.

Massive. I think that she never - she couldn't trust me. I wasn't anything secure for her. I was her mother and of course all kids love their mother. But I wasn't safe ... I could never say that back then because I thought I was mother of the year. But now, with what I know, I couldn't imagine what they went through.

'Lucy'

Another mother reflected on how the program helped her overcome her guilt and focus on becoming a more consistent parent.

I started to enjoy them instead of trying to work out why they were doing everything they were doing, why their distress was - you know what I mean? I just felt so horrible about what I'd done to them. I was trying so hard to make it up that it just became punishing to be a parent. Therefore I got more depressed and more tired and more overwhelmed and was unable to parent. They've never suffered physical abuse. But they were put into care because of my drug use. For that, [my daughter] has experienced loss and grief and stuff in her life. The only way I can correct that is by being consistent now with stuff.

'Jo'

The family-like environment in the House helps familiarise clients with the experience of having children as part of their lives, while providing the support to help mothers deal with specific demands of their children's behaviour. This recognises the critical importance of children's connection with their mothers and the value of security and continuity in the healing process. The program thus offers preventive care and the support necessary to reduce the risk of their becoming hurt and injured parents in the future (Belsky et al. 2005; Travis & Combs-Orme 2007).

However, KYH does not receive funding to assist with the additional costs of supporting the children.

Often good things come out of desperation, really. When I started working at Kathleen York, we were funded to [provide programs for] women and children and there was absolutely nothing for children. In fact, there wasn't even a baby seat.

KYH staff member

Funding remains a continuing issue for such programs as they stretch already limited resources and the goodwill of staff. Unfortunately this lack of funding undermines the sustainability of programs like this one. Lack of certain funding also means that services cycle through different programs, developing and implementing programs when financially able and then having to wind them back and often times ultimately relinquishing them when they are unable to financially sustain. This jeopardises the longer-term benefit of programs such as this.

ALLOWING CHILDREN TO BE CHILDREN

The children in residence at KYH have experienced varying degrees of dysfunction and separation during their lives. Their attachment to their mothers is frequently insecure and is a reflection of the mothers' limited ability to adequately respond to and care for their children in the past. With assistance from the Tresillian nurses, the KYH program aims to reverse this by supporting the mothers to provide more timely,

appropriate and sensitive care for the children. The Tresillian nurse provides an example of outcomes for the young children in the program:

But these children are learning that when I cry, an adult will care or will give me what I need, I need a change, I need to be fed, I need to be loved and learn to trust and all those things.

Tresillian nurse

From a very early age some of the children at KYH were put into the position of having to take on significance responsibility.

No, no. I was really active in all the school aspects of their life and all that. But emotionally I wasn't even available for them. I was never there for them emotionally. I was just I suppose a food giver and that was it. So they pretty much were raising themselves really ... [My 10 yr old daughter] mainly took over the parenting role ... It's the emotional nurturing they need and for it to be consistent, but also relevant to the age group and mental development that they're in, as opposed - like treating a little one too old. Too many responsibilities for a little child, they can grow up too quick. Or as opposed to babying them down. So I think it's why I'm trying to find the grey area, as opposed to just black and white. But I definitely think the secure base is a very - that I need to be strong and secure ... If I'm wobbly - yeah. They notice it. Then they get that wobbly. I've noticed that.

'Lucy'

Fortunately, this mother has now identified her lack of emotional connection with her children. She recognises the repercussions of her actions for her children. The mother has now gained an insight into her daughter's experience and is working to repair the relationship. The use of art therapy has also started to assist the daughter explore her emotions.

When we first came to here, she was parenting me as well ... But I need to give her the opportunity to say 'you were my mother and you really hurt me. This is how I feel.' She is very open with her feelings. Because I think, maybe through the art therapy as well, that she needed a way to communicate her feelings a lot more. She's very equipped to weigh up I've hurt her feelings.

'Lucy'

The art therapy program aims to assist children through developmentally-appropriate interventions to regain a sense of security and safety. Continued support for the mother is crucial to enable her to repair the relationship.

FOCUS ON LEARNING BETWEEN THE PROFESSIONS

A critical element of the Integrated Program is its capacity to facilitate learning between two groups of professionals – CFH nurses and AOD workers. It recognises that individually, these groups do not have the necessary expertise to address the needs of the mothers residing at KYH. However, the strategic vision aimed to enable the two groups to learn from each other in order to address the range of complex needs amongst this group of women.

The other bit was to include the Tresillian nurses in our fortnightly case conferencing. So, to bring them into that discussion so they could tell us what was happening and what the expectations were in terms of developmental issues, with babies or whatever. We could talk about what the mother was working on clinically, and background stuff about transference, whatever, and what we'd observed with parenting relative to what the Tresillian worker had observed. Bringing those bits of information together to take into the next treatment plan.

KYH staff member

One mother recounts her experience of the integration of the work of AOD and CFHN staff, which resulted in a consistent approach and compassionate support in her efforts to help her child learn to sleep in his own bed.

So the staff knew what I was working on with [Tresillian nurse] at that time. So when I was working on – having [my son] sleep in his own bed. One of the staff members stayed up with me for about three hours one night at one o'clock in the morning, telling [my son], no you have to sleep in your own bed. I gave it a go myself for about two hours and then I couldn't take it anymore. So I went and got the staff member and she was saying, Mummy's patted you enough, it's time to go to sleep ... Then when [my son] was two and [my daughter] was a newborn, I'd never settled a baby in a cot before. Because [my son] I just used to have sleeping in bed with me. But it's not SIDS safe. So I was doing it the proper way. Sometimes it would take about – the usual an hour or something – to settle her into bed and make her sleep. You walk out of the room – wow. So I think [AOD worker on night shift] especially, but everyone would help. All of the staff would help me with that. When I couldn't take it anymore I would go down and they would help me out with it. They knew what I was working on and they knew what to help me with, without smothering my mothering.

'Sarah'

The original vision of the Integrated Program was that both the AOD worker and Tresillian nurse would work concurrently with a client.

Again, that's why having the AOD worker in there was really helpful in building the trust with the Tresillian person. Also, being able to say, 'that's bullshit and you're only saying that because you're scared that if you tell the truth she's

going to [report you to DOCS and they are going to] take your child away'. So, if you – fundamentally most of our clients have a fear of having their child removed if they haven't already had their child removed. So there's this sort of reticence to be honest about the struggles with parenting. So what would happen is that once some clients had worked with the Tresillian nurses, they would tell the other clients that they can be trusted and it's okay and sometimes we'd have to do – a lot of reinforcing around, look, they're not going to report, this is the MOU, this is what it looks like, they don't do the reporting, they do – they're a part of the KYH program – so all that, really explaining, giving the client the information about how the relationship works organisationally would help them develop trust around working with Tresillian and that this is not about child protection, this is not about assessing you as a parent for risk of harm. This is about assessing where you're at and giving you the support and education that you need to make your life a little bit easier.

KYH staff member

One mother described how the parenting techniques she learnt from the Tresillian nurse were then incorporated into the work of the AOD workers. She discusses how, in learning to take her children's perspective, she has insights that will benefit her future role as a mother.

Like she's [nurse] given me a lot of techniques that work, like the 1-2-3 Magic and just information. But the actual tools have come from KYH because they've made me aware of my emotions and what they trigger. Just basically what emotions are in the first place. If I can't identify what's going on with me, I

definitely can't identify it in my children. So yeah. Once I can handle myself, then I'm better equipped to [help] them.

'Lucy'

One of the Tresillian nurses was asked if they observe that the KYH staff reinforce some of the messages that you've given the mothers between sessions. This reinforcement and consistency of message provided an important ongoing activity to assist the mothers in the program translate their new knowledge and skills into the care of their young child. A form of continuity of care is occurring for the women that they may never have experienced in other Drug and Alcohol or Health services.

Yes, and then sometimes they actually reinforce the messages that they've seen from someone else that we'd prefer not to. But that's where it's good, having [staff member] or someone in the house that has got a good basic parenting style. Especially having [case worker] there, she talks to the other workers and then it's carried through.

Tresillian nurse

One mother highlighted the value of her learning about parenting and the insights she has gained as a result of the KYH program.

[Other children] just have no – their behaviours haven't been corrected because their parents aren't present in their life, which is really evident in a couple of people that I know here who are addicts and have gotten clean but haven't done the program like Kathleen York. I see myself as being treated and I see some of my friends as untreated and I see their children and how their children are untreated, where my children are treated through the stuff that I've learnt there.

'Jo'

5. OUTCOMES FOR FAMILIES AND STAFF

The KYH and Tresillian partnership has resulted in many beneficial outcomes for mothers, children and staff. The following subthemes were identified within the data: acting as child and mother advocates; building social networks; changing parenting and other constructs; developing maternal capacity and competence; allowing children to be children; child behaviour outcomes; and developing staff capacity.

ACTING AS CHILD & MOTHER ADVOCATES

A constant thread through the data showed staff acting as advocates for both the mother and the child. This advocacy is crucial, as many of the women have had few positive experiences with government departments, professionals, family and other members of their communities. For instance, the link between having children and access to affordable and appropriate housing is a complex one. If children are removed, mothers find it more difficult to obtain public housing; yet if they lack a secure home, they are unlikely to have their children restored to their care.

These mothers are also more likely to be under the intensive gaze of child protection agencies. One of the mothers during the focus group clearly illustrates her sense of staff as advocates.

I know that the staff started caring about me and advocating for me before I sort of even wanted to for myself. So I think they see a lot and have a great passion for us.

Mother – group discussion

This advocacy required significant effort and very skilled and costly interventions with the legal system to ensure that the mothers were able to either retain or regain custody of their children. The following example illustrates the extensive support and advocacy that was required for one mother who was trying to regain custody after her child had been removed from her care:

When I went in there [KYH] I had no house, I was living out of a car that wasn't registered without a license and it was – I was out here pregnant, and it was terrible.... she was taken at five days old ... Well I got her back within 10 weeks, which is a miracle these days with the system... Because I ticked all my boxes, that I had a great lawyer and because Kathleen York came to every ... court case, they came with me.

'Ruby'

There are frequent changes to the laws around children's services; yet agencies and magistrates are sometimes not equipped with the knowledge about how child protection decisions affect mother and child relationships and attachment.

While the KYH management and staff have a strong commitment to including children into the program, this is not acknowledged formally by the funding bodies. As identified by a KYH staff member, change needs to occur to officially include children as clients to enable adequate funding so appropriate care can be provided.

Well, when children become the consumer or a client or whatever, there's something about that that's really necessary in terms of validating professional and adequate care to the child.

KYH staff member

So that's part of what we're trying to develop in terms of the art therapy program for the children, is that just as the mothers have a transition time out of the program, that the children do as well, because that's a really vulnerable time for them. So at the moment, they'll have six sessions after they move out of the house ... Well, at the moment, although we don't have any funding for it, I'm trying to, I have connections with an art therapist in the community that is interested in continuing the art therapy

sessions with them after. But we don't have funding for that at the moment. So we're looking at how we can organise that...

KYH staff member

The Tresillian nurse provides further insight into one mother's behaviour, linking it with her experience as a child and her later contact with the child protection and/or government systems. The nurse raises the issue of a lack of support for these women and their children.

I guess that now I see why, because of where she's come from. It does tend to make you very focused on children when you see how badly the systems support them.

Tresillian nurse

This comment makes the link between childhood experiences and the intergenerational repetition of such factors as child abuse and neglect, criminal behavior, and drugs and other substance misuse. Given increased identification of children at risk, and constraints in terms of cost and appropriately skilled staff, it is unsurprising that many professionals identify the system as unsupportive. It continues to fail to support and equip those who need the most support, and to punish them by removing their children.

BUILDING SOCIAL NETWORKS

Many of the women have disrupted social networks either as an outcome of their substance misuse and related lifestyle or their life experiences. A significant feature of KYH is the development of a home-like atmosphere and a strong peer support network. The support provided may be as commonplace as sharing childcare to enable the mothers a short period of free time as in the following example:

I watched [fellow resident's] children last night and she's watching my girls tonight

'Lucy'

This mother also noted some of the drawbacks of communal living, as well as its strengths:

So it is a little bit tricky I think here, just in the environment. Not so much because of KYH, but because there's no - they don't have their own bedrooms to go to, things like that. So it does make it a little bit trickier in that aspect. They don't just have a backyard to go run around in. Because I have to supervise all the time.

'Lucy'

One mother noted the significant difference in regard to the behaviour of the other women at KYH:

A couple of girls I knew went there [KYH]. I noticed that they had a really different attitude about their recoveries. They actually cared about each other and the other girls in the rehab. Whereas the other rehabs I had been to, we could've stabbed each other in the back or dobbed each other into the cops. We wouldn't have really cared but they seemed to be more in touch with their emotions.

'Sarah'

This difference could be as an outcome of the atmosphere created by the KYH staff and the expectations and boundaries that are put in place, enabling the women to feel secure in their relationships. In the following extract the mother talks about her experience of staying in hospital with her sick child. During the stay she received supportive visits from KYH and Tresillian staff and the other women. A regular house meeting was held in the child's hospital room to ensure the mother did not miss out:

I think that was part of the family thing. So I know that each of the women is so different and the children are all different, and I think the way that the program here is focused on not us fitting to their program, but they really provide that individualised stuff.

Mother – group discussion

For many of the women this is possibly the first time they have experienced a supportive environment. This mother perceives a concern for her wellbeing, as a form of surrogate family, and experiences bonds starting to develop.

CHANGING PARENTING & OTHER CONSTRUCTS

As the women developed their confidence and skills and started to deal with the issues and challenges related to their ability to remain abstinent, they started to develop new constructs or beliefs and to challenge their pre-existing constructs. This mother repositions herself from taking a victim role to one of being in control. Importantly, the mother recognises her actions have repercussions.

Kathleen York put the confidence in, it put – they put the ball back in my court. Like instead of, because I put the blame game on a lot of my life and a lot of people that were in my life at the time, it was their fault I did this and their fault I did that, and then as soon as I relinquished that and took my responsibility back for [my] own actions I could learn to change what my actions were and think about the repercussions.

‘Ruby’

Having their mothering abilities reinforced as being ‘good enough’ is both affirming and a powerful motivator. The Tresillian nurses use a series of validated parenting assessment tools and other parenting development approaches that facilitate positive feedback to the mothers about their parenting. Nurses use a partnership approach that also creates an atmosphere of trust and respect, allowing the nurse to challenge maternal constructs and behaviours that may not be in the best interests of the infant.

I think the biggest message [Tresillian nurse] had for me was that I only had to be a good enough mother and I was good enough. Nearly every week she would come and she'd say how great I was doing. She'd tell me all the things that I was doing right. She'd do these little evaluations of me – this is a standard test

to check if when you breastfeed you're bonding with them.

‘Sarah’

Another mother explains how what she learnt at KYH helped her to re-interpret and re-define the process of parenting and to understand her influence on her children. The KYH psychologist helped her to acknowledge the impact of her own and her mother's mental health problems. This challenged her previous views and allowed her to recognise her own positive role in her children's future.

When she [psychologist] explained that to me, I knew then that it wasn't my blackness that I'd been carrying around all my life. So I just got this sense of freedom. I got this sense that I wasn't going to inherently pass it onto them. See I had this belief that the girls were doomed because they were my children ... It was just something that I was going to give them without even knowing. So when [KYH staff] helped me around that stuff and helped me identify what my mental issues were, a lot of them were alleviated. So then, when I dealt with the girls, it wasn't as much hard work because I sort of was like trying to make them hard because I sort of had this set belief they were going to be hurt a lot in life.

‘Jo’

The KYH program aims to focus specifically on developing maternal insight into their role in parenting and the importance of attachment with their children, as discussed by one of the KYH staff.

There's a lot more focus on it here than it is at ... other places that I've worked. I think it definitely has allowed them to really focus on and build their attachment with the children. As you said, that opportunity for them to think about it from the children's perspective, how their actions have impacted their

children and how they can begin to make that repair. Also, them looking at themselves as a mirror to their children and the importance of them filling themselves up with strong self esteem and understanding and insights about themselves so that they can then demonstrate that to the children.

KYH staff member

The clinical and relational approaches used by the KYH and Tresillian staff are complementary. In the following statement the mother highlights her need to stay in the moment with the child rather than using more adult abstract thinking that links the child's emotional state to separation rather than to a more immediate concern. This challenges the mother to rethink how she constructs an incident that impacts on her child. Importantly she recognises that others (whom she refers to as 'normal people') may interpret events in a different way.

It was really nice to know how normal [*sic*] people deal with things. That normal people go through all these same things as well. I remember though that [KYH staff member] used to - because when we got to Kathleen York, [my son] was just adjusting to the separation of his father. His father was just suddenly out of his life. So my thinking was if I saw [my son] upset during the day I'd go 'oh you're feeling really sad about your Dad right now aren't you?' [KYH staff member] would go, 'no, he's feeling sad because you took his sandwich away. Don't make it about anything more than a sandwich.' I'd go 'ah'.

'Sarah'

Another mother describes how the Tresillian nurse helped her to understand her children's behaviour as part of a normal process and how to apply this insight to difficult situations:

Yeah. I think it's just really good with [Tresillian nurse]. Like she's showed me the awareness around some things.

When I'm dealing out consequences – we watched this video about the five things that children will do to manipulate the situation. Then like I can see them happening now. I can go, oh look, she's in martyrdom now. Then there's the buttering effect. I'm waiting for [her] growing displays, but I can know that these are coming and think to myself ... This is normal. This is what kids do.

'Lucy'

The following example of the relationship with her Tresillian nurse illustrates how experiencing feelings of being valued without any expectation of getting 'anything out of me' was a very new experience for one mother.

I wanted to say that on my last - when [Tresillian nurse] was booking in my last session with her she said 'let's make our last session a lunch date and I'll take you out to lunch'. I felt really special and I actually cancelled on her because it was a bit overwhelming. But I thought 'oh my god a program like Tresillian thinks I'm important enough to take me out for lunch on our last session'. In my addict mind I was thinking 'they can't get anything out of me, I'm leaving. [Laugh] So what do they want from me [Laugh]'. I couldn't believe that I would be that special. It was just – the whole thing was just great... I felt really valued and I was like - wow.

'Sarah'

The lunch never eventuated as the mother felt overwhelmed by this new experience. However, it was the intent behind the invitation that made this mother feel special. An important experience that may help this mother change the way she positions herself in the world and the value others place on her.

DEVELOPING MATERNAL CAPACITY & COMPETENCE

A significant aim of the program is to develop maternal capacity and competence. Supporting

women to learn childcare tasks is not difficult. The complexity occurs when health professionals focus on developing maternal insight or the ability to understand the experience of the baby, especially if the woman has not experienced these during her own childhood. This first example demonstrates the insight this mother has gained that addressing the child's emotional needs is important and that if this is not done there are potential consequences. Also illustrated is the impact of being drug free and the mother's ability to reflect on the impact of the drugs on her ability to parent.

Awareness... Just more around what their emotional needs are, what they expect, what I need to give to them and how that measures in with their growing, because if I approach things in the wrong way it just - retaliation happens.

'Lucy'

Yeah, but now without any substances it's quite different and I can be present as a mother, I know what's going on, I don't miss a trick. I try to turn off sometimes, but I still don't miss a trick.

'Ruby'

The next example demonstrates that the mother is able to describe a shift in her parenting style from a directive parenting approach to a more collaborative approach with her children. The phrase being 'present in the moment' signals an ability to be emotionally available to her children.

I'm present in the moment probably ... I can actually sit down and have a conversation with them rather than going, 'can you go and do that or can you do this, or sit down and eat your dinner'. It's like 'well what would you like for dinner?' Like it's actually present in the moment stuff. It's not my life, them revolving around in my life. It's my life revolving around them now ...

'Ruby'

For most parents a visit to the shopping centre is frequently a challenging situation. One mother describes an incident where she handles a common parenting situation in a very different way from how she would prior to the program.

Yesterday I took the kids to K-Mart to buy some stuff and they were playing up and I just thought 'I can stand here and look like a raving lunatic in the middle of the shopping centre, or I could buy them everything they wanted to shut them up'. So what I did was I put everything back on the shelf and went 'that's it, we're going'. Both of them just looked at me just really shocked. I said 'that's it, we're going - no more'.

Mother in group discussion

Parenting capacity and competence also requires the ability to integrate tasks and often to learn basic life skills such as cooking. Making connections between the necessary steps to achieve these outcomes is essential. In this example the mother describes her experience and the opportunity to put the elements of cooking a meal in to practice from budgeting and buying the ingredients, through to preparing the meal.

It wasn't just the parenting or the drug and alcohol, it was everything put together. The budgeting, the ... cooking. You had to pick a recipe once or twice a week to cook and you had to ... put that into a budget, which went on the shopping. Like just the smallest of small things that you wouldn't think matter, but they do, and these days I can manage the budget. I can manage my time, manage my housework to a degree.

'Ruby'

Encouraging and supporting the mothers to practise their parenting skills is a crucial component of the learning process as it helps build parenting confidence and competence.

When I was in Kathleen York I spent a lot of time with Tresillian and the staff – practising that routine. So sometimes Tresillian helped teach me how to settle them in bed, at their different ages - at like two and a couple of weeks old. Now they're so used to that routine and I am too, that it's no problem – so that's great.

'Sarah'

Well a long time ago I started practising how to talk to the children in an appropriate way. Talk to them about their emotions and how to explain things to them. So that they would understand for their age. So because I've gotten heaps of practice at that and Tresillian taught me how to do it.

'Sarah'

Not only have the mothers identified enhancements in their parenting capacity and competence but also their ability to reflect on the changes. In response to a question about what has changed since arriving at KYH, this mother responded:

Probably 'what hasn't changed?' would be the simpler question What has changed? My role in my responsibility as a parent, my communication skills with my [older] children as well as my patience level with the young one.

'Ruby'

Another mother describes an occasion dealing with her daughter's behaviour. The child had hit her sister and the mother responded by not allowing her to watch a favourite DVD. The mother recounts the episode with a sense of achievement and expresses how her parenting knowledge and insights allowed her to deal with the incident effectively and consistently, and in a way that contrasted with how her friends responded to their children's behaviour.

But because Molly's four and last night, when she got distressed and I was putting boundaries down and telling her

no she's going to bed and that I'm turning off the light and she needs to get into bed. Because she knows that I have boundaries with her, she can stop, [rather] than continue thinking I'm going to change my decision. So she knows firmly that I'm not changing my decision ... I was in bed with her and I was talking to her and giving her her doggie to cuddle and putting her little music thing on. She knew that I wasn't going to change my mind. So there's no point. So the distress doesn't last very long. Where I have friends that are inconsistent with their kids and the distress lasts a long, long time ... Because they know that sooner or later they're going to get it or get it thrown at them or they're going to get told to get away and get what they want, where I don't, but I don't leave. Because I was lying down with her and patting her and stroking her head, it only lasted three minutes.

'Jo'

This extract demonstrates the growing awareness of the impact of parenting and an ability to view the incident from the child's perspective. It also allows the mother to express her pride in her competence and the growth in her parenting capacity.

Even those mothers whose children are not present at KYH are seen to benefit from the Involvement of the Tresillian nurses. Staff report that they learn skills and insights that they can put into practice on the occasions when they do see their children.

It's often times really difficult in those circumstances [women who do not have custody of their children] but I still see, depending on the mother, I see them taking a lot of the skills still from Mothering at a Distance program and even if they see their own children once a fortnight or once a month, still utilising that space with the Tresillian nurse still practice those skills. So it's still really important for them to have that

connection with Tresillian as well. Because even though, in their future they might not be able to use those skills, down the track they will.

KYH staff member

DEVELOPING MOTHER- AND CHILD-CENTRED CARE

The KYH and Tresillian staff make a concerted effort to ensure the program is mother- and child-centred. This approach acknowledges that when many women become mothers they are motivated to stop their misuse of drugs and other substances. This motivation is not without challenge, as caring for an infant or young child is both physically and mentally demanding. At KYH there is a commitment to capturing this opportunity while providing the support that is required to avoid overwhelming the mother. Crucially for the mothers, completing the program requires the ability to manage the stress of parenting without additional staff support. If this occurs she has the potential to either continue on her rehabilitation pathway. If the stress of parenting becomes overwhelming she is likely to return to her previous lifestyle. The following examples highlights the importance of working with individual differences:

Yeah. I think the staff are so – because it is individual case work, they've really got the time for that person because that's their case. So it was really individualised and personalised because every case is different, every person is different, every parent's different, every child's different.

'Ruby'

... the different skills for [my daughters' different] ages because they have to be handled as two separate cases

'Lucy'

The next example illustrates the importance of a trusting relationship for this mother who continued to tandem feed her toddler after the birth of her second infant.

Because at the hospital they asked for the breastfeeding specialist to come and see me. They didn't actually make it to come and see me but they gave the nurse at the station a message to tell me that it should be fine to keep both of them on the breast. So it was lucky that I had [Tresillian nurse] and I had a trusting relationship with her. Because as soon as she said 'well [my baby] is losing weight so let's just take [my toddler] off because he'll be fine without it'. I went 'yes'.

'Sarah'

Breastfeeding is a significant achievement for this woman and far exceeds the recommendations to fully breastfeed infants until six months of age. By providing information the Tresillian nurse enabled the mother to make a decision based on evidence to wean her 20-month toddler. This incident shows how the mother's relationship with the Tresillian nurse supported her, even when the wider health system did not.

CHANGING CHILD BEHAVIOUR OUTCOMES

Many of the children participating in the KYH program have behaviour problems. Much of the parenting intervention focuses on supporting the mothers in managing these behaviours. However, a whole-of-program approach is essential as environmental factors (especially emotional stability and consistency within KYH) have a strong influence on the children's sense of security and the existence of boundaries to their and other's behaviour. In the next example a mother describes the outcome for her son:

So I learnt a lot there. I think it really helped me because when we first moved into Kathleen York, he was head banging a bit. Having a tantrum and then slamming his head on the ground. So he's never done that again. He doesn't have a problem with tantrums now - at all - hardly ever tantrums now. He's still only three and a half.

'Sarah'

A positive outcome for all children is the development of language. In this example the boy has developed an ability to express his feelings. The mother interpreted his ability as resulting from the 'practice' she had done with her son and she acknowledges that this was important outcome.

I think it was all that practice. His teachers said that he can name nearly all of his feelings. He's the best one in his class about talking about his feelings. That's all from [Tresillian nurse] and the KYH staff telling me how important it was.

'Sarah'

Another mother reflects on how her two daughters (aged 4 and 10) now respond to difficult situations and compares them with her friends' children, who have not had the opportunity to attend KYH.

I see myself as being treated, and I see some of my friends as untreated and I see their children and how their children are [as] untreated, where my children are treated through the stuff that I've learnt there [KYH]. The way their children are really makes me feel blessed that I went there ... For the transformation in my life, seeing how, yeah, they are. Just being present in my life. My kids don't attention-seek ... Whereas my other friends' kids attention-seek all the time, 24/7, where my kids don't do that because I'm available. So that's interesting.

'Jo'

These mothers talk with great pride about their children and how their experience at KYH (and the mothers' own increasing insight) has helped them learn more appropriate behaviour and enhanced their emotional maturity.

DEVELOPING STAFF CAPACITY

At the core of the KYH and Tresillian partnership has been staff capacity development. This acknowledges that different skills are needed to

work with the mothers to support their involvement in an abstinence program and to provide parenting support, intervention and education. The development of trusting relationships is key to this capacity development:

I can ring a Tresillian worker – I've done this and said 'this is happening, what do you think?' So I've got access to someone, and we do handover when they come. When we send them over, what's been happening with the client - what's been happening throughout - like it's absolutely fantastic, isn't it?

KYH Staff member

Yes. I've been rung up and asked, 'what do you think about this?' Lots of things like on sleep and settling, breastfeeding, even bottle feeding, routines for children, what's playtime, how do people understand playtime and what might be helpful.

Tresillian nurse

Tresillian – the insight that I've gained from them, I was thinking 'shit, where were they when I had little children?' So I've actually learned skills. I thought if I'm ever a grandmother it'll come in really handy, but they actually – I have learned along the way about the boundaries and about what's okay, what's sort of not okay and how children need to feel safe et cetera, et cetera. So it's given me more information and more insight. As I said, that's not my specialty. However, as you can imagine the women with children bring it up in counselling, the struggles that they're going through and how it impacts their life, and being able with knowledge and stuff that's passed from staff members – it flows over. So it is the one-stop-shop.

KYH Staff member

Because I'm not a mother myself, I've learnt a lot about different parenting

skills and the importance of creating boundaries for children, because all of that was really new to me. I'm really familiar with working psycho-dynamically with children and learning about that through them and what they express in their artwork but in terms of real parenting skills, it's all new to me.

KYH staff member

For the Tresillian nurses it has resulted in a greater understanding of working with women with complex and multiple vulnerabilities. For the mothers, it has resulted in a greater trust and ability to express themselves honestly to staff members. As a KYH staff member notes:

What I've noticed since Tresillian has been coming here is they actually are getting that picture. It's becoming more okay for the women to go 'I'm having a really lousy day and the kids are driving me insane' ... being able to express what's really going on without basically lying through their teeth, and for good reason. I'm not knocking the women. I understand where they were coming from. So I think that they learned that underlying fear often drives so much and it's hard to break down and get right underneath that.

KYH staff

For the Tresillian nurse, working in partnership with the KYH staff member has been rewarding.

Inherent in working in partnership is a sharing of knowledge and skills.

Because [KYH staff member] had a really good parenting style and very in tune with mothers that seemed to have this drug and alcohol difficulty – problems – that they had. It was sort of getting alongside; it was certainly working more in a partnership with the mothers

Tresillian nurse

The following example reflects the sense of pride in the KYH program amongst those involved in the integrated program:

What I have noticed from the staff at Kathleen York is they seem to be quite proud of the program and the service. That seems to have very much developed a pride in that work, and I think that's very much directly because they feel they're doing more than just - I actually think it's because they know they're doing more than what a lot of other services are, that they get a sense of real impact here.

KYH Board member

By working together, the KYH and Tresillian staff provide an expanded service and greater opportunities to develop their clinical skills that benefit the mothers, children and their organisations. There is obvious mutual respect and trust between the staff of the two organisations.

6. WHAT HAVE WE LEARNT FROM THE KYH RESEARCH?

CAUTIONARY COMMENTS

In this final section we address two questions. First, what have we learnt from our research engagement with KYH? Second, what can we say about the design and impact of the program at a specific point in time?

Prior to responding to these questions, a note of caution is needed. It is important to emphasise that the study was a small exploratory engagement with a complex, developing and constantly changing program. Our fieldwork with KYH occurred intermittently over seven months and with a number of staff and clients who agreed to participate. Self-selection is frequently associated with positive bias. We did not use psychometric testing to test whether the changes reported by participants were matched by measurable changes in behaviour and perceptions. The study never aimed to pursue these issues. Rather our aim was to provide an account of the development, impact and implications of the program as experienced by those involved: mothers and staff. In doing this we have relied on detailed interviews developed over the period of the fieldwork. We have also relied on our observations. Further, in terms of validity, we were interested to use data to look for common patterns of experience and interpretation across a range of clients and staff from two very different agencies, with different organisational cultures and with different forms of practice and foci for intervention.

One further cautionary comment needs to be made. That is, any complex psycho-social intervention, delivered in a complex psycho-social environment can only ever claim to be indicative in terms of what is occurring and why this is occurring. However, being able to work with and comment on situations that are defined by complexity is, we think, an important and valuable thing to do. Our hope in attempting to address questions about what has been learned and how this might be relevant for other programs is that our conclusions, though

tentative, will be taken up, tested, refined and added to in future studies.

Finally, one of the major challenges faced by all researchers trying to make sense of complex psycho-social interventions is that they are inevitably experienced as 'a whole'. Disentangling and attributing certain properties to specific elements is always difficult. Even when researchers focus on one aspect of a program – a particular kind of support, the length of time they were clients, the culture, case meetings, the role of a counsellor etc – all are part of something larger, the whole program or the program ecology. We have aimed to present issues that seemed to us to be so consistently and strongly experienced that they can be identified as defining characteristics of the program, either positive or negative characteristics. They hang together as a whole rather than as separate individual elements.

CHALLENGES FOR THE PROGRAM

In addition to the often-intense personal challenges experienced by the women participating in the KYH program, the service itself dealt with many complex challenges on a regular basis. Many of these arose from the limited resources available to the program, which impacted on the working and living environment in which it took place. Despite its many positive achievements, the program operated in the real world and dealt daily with inter-personal tensions, unrest, scarcity and disappointments.

It is not uncommon for innovative services such as the Integrated Program to be driven by individuals with a strong commitment to reform. While their input inspires and facilitates innovation, this situation poses a risk for sustainability, if those individuals leave, taking their skills and initiative. It is critical that succession planning takes account of the risk of services being discontinued due to personnel changes.

THE VALUE OF THE KYH INTEGRATED PROGRAM

Our study indicates that for those we interviewed the program worked. Mothers and staff members alike experienced the very positive impact of the

KYH program for the families involved. For some women it was a transformative experience.

The WHO defines health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (World Health Organization 1946). The approach of the KYH program is consistent with this definition, focusing on both the mental and physical needs of mothers and children, with an emphasis on social connection, inter-connection and support in the community.

A number of program elements stand out. They seemed to us to be tied together in a way that was distinguished from participants’ experiences in other programs and in other settings.

Participants consistently commented that the KYH program was very different from other AOD and mental health programs. As we note below, this difference extended far beyond the explicit KYH focus on children and parenting.

SEEING & ENGAGING WITH THE CLIENTS AS ‘WHOLE’ PERSON & AS AN INDIVIDUAL

The comments from the women and staff strongly emphasise the positive impact of two defining characteristics of the KYH program: responding to the women as a ‘whole’ person, not just as a person dealing with addiction; and using this knowledge to adjust interventions to be more individualised or personalised for each woman. This acknowledges the fact that one size fits all health services often contribute to poor health outcomes.

For the women we interviewed, their experience of these two characteristics of the KYH program distinguished it from many other programs. They experienced being identified not only as a person with major AOD problems, but also as a mother and parent, as validating and as offering scope for further personal change and growth. Quite clearly the terms of engagement between the women and the service were affected significantly by this approach. We would speculate that engaging with women in this way is a significant intervention in its own right. It challenges what may frequently and inadvertently be reinforced in AOD and mental health programs, that is, that the individual is

primarily a mental health problem or an AOD problem. Such negative and uni-dimensional representations of self reinforce negative stereotypes and make the work of reclaiming a sense of a ‘good enough’ self much harder to achieve. It contributes to reduced self-esteem and a sense of guilt for issues that are beyond these women’s control. Many staff also identified that recognising each woman as a person whose life and capabilities extend beyond their AOD and/or mental health problem, was a critical part of their approach to their work.

CONGRUENCE BETWEEN INTENT & WHAT OCCURRED

All of the above might mean very little if this was not experienced as congruent with the daily experience for the women in the program. It would exist as policy and rhetoric, not practice. The women regularly commented that this focus on the client as a valued whole person was consistent with their experience on a daily basis. Some women expressed surprise that this occurred and many gave examples of such personalization and consideration of the individual. These examples were not only about what happened within the house, but also about their dealings with external agencies, for example, situations where KYH staff, the women and friends of KYH had been active in supporting a woman whose child was admitted to hospital and in supporting a young mother through a difficult court custody battle.

RESPECTING & INCLUDING CHILDREN – EXPANDING THE INTERVENTION FOCUS & LEARNING FOCUS

Another area in which congruence was experienced was in relation to children being respectfully and actively included in the work of the program. The women discussed this in very positive terms and differentiated what they experienced at KYH from what they had experienced in other programs. This was both validating for the women in their role as mothers and parents and, from what we were told, important for the children involved in the program. As well as being experienced positively, this focus was also experienced as challenging. It confronted the women with their own difficult

histories, their often problematic parenting styles, and the losses they had experienced as both children and parents. They did, however, report that ongoing work in this area enabled positive change, in particular, developing parental confidence and capability, often against a backdrop of little or no confidence in their own capacity as parents.

One staff member noted how the opportunities created by the KYH program (the focus on parenting, the educational input, the length of stay etc) allowed the women to test and integrate different parenting ideas and strategies into all aspects of their daily life. This is not to say that a more limited program on parenting skills would not be helpful, but it would provide far fewer opportunities than a program that integrates parenting into daily life and provides formal education during the six-month period of the residential stay at KYH.

The researchers also observed in case conferences and family-focused discussions the effort made by all staff to develop and maintain a consistent approach to what effective parenting might look like for each different mother. This consistency was identified as important by staff and mothers alike.

CHANGE, CHANGE & CHANGE!

The research gathered many accounts of change, quite frequently described in terms of transformative change. Whilst always difficult to assess whether such experiences will be sustained in the longer term, the mothers and staff consistently identified the positive impact of participation in the KYH program. Importantly, and in line with what the KYH initiative hoped to achieve, participants often referred to an increased ability on the part of the women to understand, respond to and manage their children. It seemed clear that the parenting repertoire of the mothers had expanded and changed. The mothers in the program reported thinking and acting differently, with positive flow-on effects both for themselves and their children.

The significance of the change, and the scale of the work and effort required to produce and

sustain change were all apparent in our discussions with both staff and the women. We often heard accounts in which changes in parenting required substantial and painful work on the part of the women. There was a sense in which building new and more effective ways to parent was closely aligned with building new and more effective ways to live. No small feat!

WHAT STANDS OUT?

What can we take from these accounts of change? Six things stand out.

First, the conditions generated by the KYH experience create the time and focus to engage with and work at significant change. For instance, the mothers discussed the issue of rebuilding trust. 'Good enough parenting' had clearly not existed for many of these mothers. For the women to engage with trusting themselves, trusting others, trusting their parenting and trusting new ways of being with their children, requires significant amounts of time, commitment and learning.

Second, the KYH program recognises parental relationships and parenting as central components of individual identity and functioning (DeGuio, Maddox & Davies 2009). Including children and nurturing parental capability-building as central features and foci of the program has opened up critical areas of development that intersect with what is happening and what will happen for the women and their children. There is a real sense in which the expanded focus of the KYH program – a focus on both mother and child – more strongly engages with the challenge of breaking the intergenerational cycle of dysfunction and difficulty. This view, strongly held by KYH and Tresillian staff, is supported by research that clearly identifies improved parenting as making a significant difference to the physical, emotional and psychological development of the child (Kelly, Slade & Grienenberger 2005). Rather than being identified as the stereotypical uncaring and unfit mother (Kandall 2010), these women experience a program that highlights their maternal strengths, and supports and encourages their ability to develop maternal insight.

Third, extending from a focus on the whole woman and her parenting, is the commitment by staff to personalising and individualising the way in which they work with the women. The women frequently commented on this, and indicated that it was valued and made a significant difference. Also strongly in evidence was the use of a range of therapeutic and enabling strategies – ideas resourcing, modeling, inviting and supporting, challenging, containing, and so on.

Fourth, the women noted the congruence between what KYH said it would do and what it did. Whilst this may seem a surprising comment, the divergence between what organisations say they will provide – the promise – and what in fact is delivered – the reality – is a constant feature of literature addressing health reform and service redesign.

Fifth, it seems to us that the skillful and well-coordinated ways in which KYH and Tresillian staff are able to work with each other and with the women and children made a significant difference. Staff indicated that collaborative working expanded their understanding of the woman and her child, and their relationship. The Tresillian nurses extended their understanding of DOA issues and how these intersect with parenting. For KYH staff, the Integrated Program expanded their understanding of the parent/child relationship and parenting, and how these intersect with AOD issues. One consequence of this was the development of different and more effective ways of engaging with the women and their children around the connections between their AOD issues and their parenting issues. For both staff and women the cross-agency approach was experienced as valuable.

Finally, many participants referred to an important condition existing for most mothers – an increased motivation to change (Hall & van Teijlingen 2006). They valued the opportunity to focus in depth on their parenting (whether or not their children were resident with them at KYH) – an opportunity to reconnect with their children and to rebuild their families. KYH and Tresillian staff saw this as a great source of motivation for

making change. As such, this factor can be seen as one of the many conditions supporting change.

LEARNING IN & FROM PARTNERSHIP

Whilst rarely identified formally, it seems to us that the underpinning dynamic of the KYH model might best be described as a process of continuous 'learning' for both women and staff (DeGuio, Maddox & Davies 2009; Fowler 2009). The commitment of the KYH model to an interprofessional and partnership approach sets the scene for learning – learning between staff, learning between staff and the women, and learning between women. However, what generates growth and change is the preparedness of both the women and staff to engage in learning as part of their daily practice. It appeared to us that this had occurred for both groups of participants.

COSTS & CHALLENGES

Before concluding this section, it is important to recognise the costs and challenges associated with implementing and sustaining the KYH approach. The KYH program was frequently discussed as a resource intense program. KYH is an intensive and long-term residential program with an intervention focus extended significantly beyond the traditional scope of many AOD programs. Challenges were identified in many areas. In terms of financial costs, maintaining such a program over time is costly. Staff capacity is clearly extended not by funding more time but through the preparedness of staff to provide what is required from their own resources – the capacity to 'stretch' so familiar within the human services area. Clearly, the effort necessary to keep family-focused interventions personalised requires a considerable commitment to working together. Whilst not often identified in formal terms, staff learning with and from the women and other staff was in evidence across our interviews and observations. Of course, this does not always go easily. Staff considered that working across disciplines and different areas of expertise offered considerable benefit overall, although it was sometimes experienced with difficulty.

A matter discussed by some participants was the lack of alignment between the standing and pay of many KYH staff and the complexity, intensity and importance of the therapeutic work they carried out. The development and professionalisation of the AOD workforce was identified as an important issue in ensuring programs such as KYH are able to draw on an appropriately educated and remunerated workforce, and, conversely, that staff delivering such services are remunerated for the difficult and highly skilled work being undertaken. This remains an issue for both KYH and other services.

FINAL COMMENTS

How might we describe the KYH model? Defining elements of the KYH model are its commitment to each woman as a whole person, interprofessional working, recognition of the central role and importance of parenting and the parent/child relationship to these families, the application of well-identified change-focused

strategies, developed over time and through a process that was resourced and informed by knowledge from a diverse group of health professionals and case workers. Of particular importance is the length of time over which the program operates, a time frame that supports a reworking of self and the development and testing of new parenting capabilities.

With the cautions and qualifications identified at the front of this section, it is clear that the KYH program as a whole has made a significant difference to the women who participated in this study. Staff involved in delivering and experiencing the program were also extremely positive about the changes for the women and for their own knowledge and practice. From everything that we have heard and observed in this study, it seems to us that the KYH approach (the conceptualisation of the model, the work of staff from both agencies, and the enabling conditions) has made a significant and positive difference for the women, children and staff.

7. WHERE TO FROM HERE?

In 2008, KYH approached Tresillian to assist with the development and implementation of an Integrated Program of parenting support within their AOD rehabilitation program. This report is one outcome of the ensuing collaboration. In presenting this report we are reminded that without research to document the kinds of practice and innovation being developed by agencies like KYH this important work would remain invisible or only locally known. The implications of this are highly problematic. Most importantly what has been learnt – the knowledge garnered from initiatives like the KYH integrated program – would not be available to other service provider organisations, nor would it be available for governments and those involved in health policy development and service design who are charged with funding and supporting the most effective types of service provision.

In this final section, we identify four areas in which we believe research is urgently needed. Within the area of AOD, an area of immense difficulty and challenge for all involved, knowledge development provides one of the most important ways in which service provider organisations, teams and individual practitioners can learn and develop. Each area of research adds a different kind of knowledge and perspective. Each area is critical to inform policy development, service design and decision making in practice. When brought together understandings developed from all four areas provide a comprehensive knowledge or evidence base to inform practice. After briefly outlining the four research areas, we end this section with comments on what could become a developing program of research at KYH.

GETTING CLOSE TO INNOVATION & CHANGE

Whilst the health policy focus on new partnership or integrated models of service provision is well developed and strongly argued, relatively little is known about how such policy directions are successfully translated into new forms of service provision and practice that are both responsive to and sustained in local organisational settings. What is, however, clear and well documented in

the literature is the challenge of this process. We know that well-intentioned reform initiatives frequently produce disappointing results (Bate, Mendel & Robert 2008; Dunston et al. 2009). There is clearly a complex process of translation that involves practitioners, clients and organisations. We know very little about how such processes work – where they work, how they work, when they work for instance. Identifying the organisational conditions associated with successful implementation, often termed key success factors, would be of immense value. Whilst the KYH study is an important step forward in documenting and understanding innovation in the workplace, much more is needed. This is particularly true for studies where ethnographic and qualitative methods are used. What is needed, we suggest, are a number of case studies to focus on how different agencies within the AOD sector are implementing and adapting new partnership, collaborative and integrated approaches. In the context of the KYH program, the investigative focus would be on how agencies are working with clients as parents, as well as individuals with substance abuse problems.

Studies utilising qualitative, ethnographic and case study approaches will tell us much about what is being done, experienced and learned over time by participants and agencies. Such research will also provide powerful narratives and important learnings about the process and experience of change. Adding knowledge gathered from such research, complemented by the findings of studies using other methods, such as randomised control trials or mixed methods approaches, should become an urgent priority on the research agenda.

More specifically, we identify four areas of research focus, the final one referring to KYH.

DETAILED LOCAL ACCOUNTS

First, research is needed to develop detailed and workplace-based accounts of how agencies are implementing and adapting new service models. This research would pay attention to local context, to adaptation, to the experience and learning of all involved. All workplaces are not the

same. Whilst we can learn about what is general and generalisable, the more diverse our knowledge base is, the more it will assist diverse agencies addressing particular sets of issues with particular client groups.

HOW DO PRACTITIONERS LEARN TO PRACTICE DIFFERENTLY?

Second, research is needed that addresses the question of ‘how do practitioners learn to practise in new ways?’ This critical issue has received far less attention that it deserves. What we are learning from small-scale studies is that taking on new forms of practice is not simply a technical issue, or a matter of preparing and disseminating a new guideline. Rather it involves complex processes of learning, unlearning, suitable organisational conditions, quality supervision etc.

IDENTIFYING ‘MECHANISMS OF CHANGE’

Whilst impact and outcome studies tell us much about what occurs at particular points in time across a group or population, such studies rarely tell us about how change occurs and evolves, and whether or not it is sustained. Such studies engage with end points and outputs rather than process. Research that focuses on mechanism of change – what works, for whom, in what setting – is increasingly being identified as essential for our understanding of how complex models or interventions work in relation to complex problems being addressed in complex settings. The work of Pawson and Tilley (1997) is a good example of this thinking.

IDENTIFYING IMPACTS & OUTCOMES

Ultimately, service models, service provision and professional practice are about making the most positive difference for those who engage with

their services. Impact and outcome studies are therefore critical and make up the fourth area of research required. Within the KYH context, we suggest that research into impacts and outcomes of the integrated program would now be timely. A key goal of the KYH integrated program is to increase supportive and appropriate community engagement while reducing both the need for costly government community services involvement with participating families and the placement of children into out-of-home-care or, where this has already occurred, to restore these children to maternal care. Where maternal care is simply not possible, the aim is then to reduce the impact of separation on mothers and children. These outcomes need to be measurable and should therefore assess the impact of the program on the mothers’ parenting skills and confidence and the impact on children in terms of their growth and development. As this report highlights, there are strong indications that participation in the program has impacted on the women’s ability to manage their substance dependence and mental health issues, a critical outcome in supporting mothers to reclaim and rebuild their identity and capacity as parents.

Whilst each of the four areas of research identified above generates important knowledge, we think the time is right for a significant study that investigates the impacts and outcomes of the KYH program. This would require a commitment to research activity over a three to five year period, and a mixed methods approach to engage with the complexity of interventions with families with a range of vulnerabilities. The International Cochrane Collaboration supports the synthesis of qualitative evidence in order to enhance reviews of the effects of such interventions.

8. DISSEMINATION

PARTNERS IN HOPE DVD

In addition to the research activities proposed as part of this study, the Research Team responded to an opportunity to develop and promote an educational DVD.

Members of the Rotary Club of Drummoyne approached the research team with a proposal to fund the production of a DVD in order to raise awareness of the issues facing substance-dependent women and their children, and to encourage corporate and philanthropic donations towards the cost of further research and service development in this area.

The Manager and Board of KYH approved this proposal, and staff and mothers agreed to participate in the production. This process required considerable sensitivity, especially in relation to the filming and presentation of material about specific KYH clients, and the team received valuable support from UTS Legal Services. Three brave women agreed to be interviewed on film about their experiences of the Integrated Program at KYH. In addition, the DVD included interviews with three experts on substance dependence and mental health.

The DVD was filmed at KYH during May and June 2011 by the UTS Digital Media Production team. The production placed considerable pressure on the House, adding disruption to an organisation that already has busy and demanding routines, and that is at times subject to crises arising from vulnerable people living in close proximity.

However, the staff and mothers contributed generously and sincerely to the project, resulting

in material that is instructive and moving for the DVD's audience.

Members of the UTS Digital Media Team were highly committed to the project and were sensitive to the needs of the staff and mothers at KYH. They were able to produce a high quality DVD, with integrity, flexibility and discretion. Once the DVD production process was nearing completion, two of the research team arranged a viewing session for staff and women at KYH. Their discussion afterwards was recorded and constitutes one of the data sources for the study.

The DVD was officially launched in July 2011 at UTS by Deputy Vice Chancellor (Research) Attila Brungs. Over 120 guests attended the launch, including KYH staff and mothers, and their children. The audience also included academics, health professionals, staff of service providers and community agencies. A member of Drummoyne Rotary contributed to the costs of the launch.

Since its launch, members of the research team have used the DVD as an education resource, and have held screenings and discussions with health professionals, policy makers, University students, and members of Rotary.

FEEDBACK TO KATHLEEN YORK HOUSE

Members of the research team plan to present the main findings of the study to members of KYH staff and management. There may also be opportunities to discuss the project with professionals working in the wider AOD sector.

PUBLICATIONS

The first article from the study was published in 2012 (Fowler et al. 2012).

APPENDICES

APPENDIX A RESEARCH TEAM MEMBERS

The original research team consisted of

- Professor Alison Lee, Project Director, Centre for Research in Learning & Change, FASS, UTS (Chief Researcher, until September 2012)
- Dr Amanda Davies, Manager Kathleen York House (until January 2012)
- Associate Professor Carolyn Day, Senior Lecturer in Addiction Medicine, at Sydney Medical School
- Anne-Lyse de Guio, Manager of Education & Research, Tresillian Family Care Centres (until May 2011)
- Associate Professor Roger Dunston, Centre for Research in Learning & Change, FASS, UTS
- Professor Cathrine Fowler, Tresillian Professor of Child & Family Health, Faculty of Health, UTS
- Dr Libby Topp, Senior Lecturer, Kirby Centre (formerly National Centre in HIV Epidemiology & Clinical Research), University of New South Wales (until February 2012)

Additional researchers joined the team in the course of the project

- Chris Rossiter, Research Assistant, Centre for Research in Learning & Change, FASS, UTS (from March 2011)
- Professor Larissa Behrendt, Professor of Research, Jumbunna Indigenous House of Learning, UTS (from August 2011)
- Associate Professor Catherine McMahon, Centre for Emotional Health, Macquarie University (from August 2011)
- Professor Juanita Sherwood, Professor of Australian Indigenous Education, FASS, UTS (from August 2011)
- Dr Lorraine West, Family Therapist, Canterbury Drug Health and Rotary Club of Drummoyne (from August 2011).

APPENDIX B THEMES

Members of the research team analysed the data from the study. In the first instance they identified a number of key themes that arose consistently from the material. These themes were:

- Developing the strategy of the Integrated Program – a program that addresses the full range of mothers' needs, not just AOD treatment, and looks at education, mental health, emotional well-being, employment, legal support and especially parenting.
- Learning between the professions - CFH and AOD professionals learning from each other and from the women, developing new skills, new language, and new ways of working with women and understanding the women as mothers.
- Developing a child and family focus to AOD service provision – identifying children as clients with their own specific needs, distinct from those of their mothers.
- Parenting the parents – helping mothers learn about their children and their needs, and about understanding how they were parented and the impact of this on their own emotional needs.
- Re-inventing the family – developing a small scale, homelike service, safe and supportive, where women can relearn to live in a family with children and deal with conflict, trust, sharing, competing demands and other people's physical and emotional needs.
- Looking to the future – looking beyond the women's immediate rehabilitation needs, towards equipping families to face future challenges eg parenting through developmental stages, with an emphasis on life skills, employment etc.

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