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## Improving family functioning and child outcome in methadone maintained families: the Parents Under Pressure programme

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### Abstract

Twelve families responded to posters displayed in a methadone clinic for inclusion in a pilot study assessing the viability and potential utility of an intensive, multi-component family-focused intervention, the Parents Under Pressure programme. The programme was designed to improve child behaviour, decrease parental stress and improve family functioning in methadone-maintained families by targeting affect regulation, mood, views of self as a parent, drug use and parenting skills. Nine of the families completed the programme delivered in their homes; eight were recontacted at 3 months. Each family reported significant improvements in three domains: parental functioning, parent-child relationship and parental substance use and risk behaviour. In addition to the changes in family functioning, the majority of families reported a decrease in concurrent alcohol use, HIV risk-taking behaviour and maintenance dose of methadone. The families reported high levels of satisfaction with the programme. It is recommended that future studies include independent measures (e.g. behavioural observations) of child outcome and parental functioning. The results were optimistic and provided the impetus to evaluate the treatment programme using a randomized controlled trial. [Dawe S, Harnett PH, Rendalls V, Staiger P. Improving family functioning and child outcome in methadone maintained families: the Parents Under Pressure programme. *Drug Alcohol Rev* 2003;22:299–307]

**Key words:** addiction, children, families, methadone, parenting.

### Introduction

The outcome for children raised in families in which either or both parents' use illicit substances is generally poor. Such children are at high risk of child abuse and neglect [1–4] and early conduct and behavioural problems, school failure and adolescent substance use [5–7]. Many of their families are headed by single parents [8], experience social isolation, financial difficulties, and high levels of (maternal) depression and anxiety [9–11]. Parenting practices are often characterized by inconsistency, emotional neglect and an authoritarian style [12].

Intervening to alter the trajectory leading to these poor outcomes poses considerable difficulties. While there is little dispute about the effectiveness of methadone maintenance (MM) in decreasing illicit drug use, criminal activity and other high-risk beha-

viours in people with an opioid dependence [13], MM does little to change family dynamics or child behaviour problems [14]. Importantly, as we have argued elsewhere [5], MM may provide a window of opportunity to deliver family-based interventions that are aimed at helping parents use consistent, non-punitive parenting practices to manage child behaviour, improve family relationships and employ problem-solving strategies. Two relevant studies have been reported in the literature to date. The first, from Catalano and colleagues [15], compared an intensive group-based treatment programme to standard care in families on methadone maintenance. The intervention combined parent skills training with home-based management and included a structured relapse prevention programme to enhance coping skills and decrease non-prescribed substance use. Parents were assessed at pre- and post-intervention with follow-up at 6 and 12

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months. While there were significant reductions in parental drug use at all time-points, improvements in family factors such as domestic conflict and rule definition were evident only at 12 months. Further, there were no significant improvements on child outcome measures and negative peer networks. However, *post hoc* analyses found that there was an age  $\times$  group interaction with younger children in the intensive condition reporting more positive involvement in activities with their parents compared to control children.

More recently Luthar & Suchman [16] compared the effectiveness of a multi-faceted parenting intervention, the Relational Psychotherapy Mothers' Group (RPMG), with standard care in a sample of mothers on a methadone programme with a child under 16 years. In acknowledgement of the high rates of comorbid psychopathology in substance-misusing women and the impact that this has on the ability both to acquire and then implement parenting strategies, over half the RPMG sessions focused directly on maternal functioning. In order to enhance parenting skills, child rearing was discussed within the context of a supportive psychotherapeutic relationship—the mothers' strengths were highlighted and perceived child-rearing "errors" from the past were used to help women develop insight into those aspects of their parenting that should change. Finally, in recognition of the social isolation experienced by many substance-misusing women, a group format was used to enable women to experience a cohesive and mutually supportive environment. The results were, on the whole, positive. Those in the RPMG condition reported significant reductions in child maltreatment risk, improvement in communication and involvement with their child and a reduction in non-prescribed opiate use. There were trends indicating a reduction in maternal psychopathology, in particular depression. However, there was no improvement in either limit setting or autonomy suggesting that a different approach to learning parenting skills may be needed. For example, a more individually tailored approach may be a more effective way of improving parenting skills. Both these treatment studies included a wide age range of children. As parenting interventions are generally most successful with children in the early to middle childhood years [17] and as child maladjustment in substance misusing families increases with children's age [6], more success would also be expected with developmentally appropriate programmes targeting younger children. The development of programmes for older children may need to address a broader range of issues such as peer networks and parental monitoring.

The current programme, Parents Under Pressure (PUP), builds on the findings from these studies as well as the wider research literature on maternal

psychopathology and parenting. First and foremost, it is clear that any parenting intervention for substance-misusing families needs to address multiple ecological domains, including individual child functioning, parental functioning, family relationships, including the marital and parent-child relationships, and the broader social environment, including managing the demands of stressors and the availability of social support. At an individual level, women with substance misuse problems bring with them harsh and often inaccurate perceptions of themselves as failed parents [12]. The experience of multiple traumas both in early childhood and as adults is common. Such trauma has been associated with adult problems including affect regulation and impulsive behaviours [6,10,18], and the use of psychoactive substances to alleviate distress [19]. Thus, in order to improve child outcome via improvements in maternal psychological functioning and the acquisition of parenting skills, treatments need to ensure that the core schema of a "failed parent" is replaced with a more adaptive view of self; that both affect regulation and coping skills are acquired within the context of a supportive, validating therapeutic relationship, and that relapse prevention principles are included [12].

At the level of family relationships, poor developmental outcomes are more likely in families where there is marital conflict and authoritarian parenting practices that include aggression, hostility and a lack of acceptance, warmth or support [18,20,21]. It follows that parenting programmes should encourage an authoritative parenting style that provides a warm, nurturing and supportive relationship and effective non-punitive discipline [18]. Finally, as many families are socially isolated [e.g. 22] and also lack the skills and confidence to develop social networks, an intervention needs to address the wider social context linking families with resources such as child care and adequate housing and ensuring that some reconnection with main stream society is made, e.g. attendance at school and childcare social functions, allowing children to attend birthday parties. Thus, the PUP programme targets problems at the level of the individual parent, family relationships and the social context and lifestyle of the family. The PUP programme was developed for families with children aged between 2 and 6 years, as the greatest gains are found working with families with children in this age group.

The aim of the present study was to ascertain the feasibility and short-term effectiveness of the PUP programme. Specifically, the study aimed to investigate the recruitment and retention of parents into the programme and the impact of the programme on measures of parental functioning, child behaviour and lifestyle factors, including drug-taking at 3 months.

## Method

### Participants

Twelve parents enquired about the programme in response to posters displayed in a methadone clinic by contacting their key worker or by calling the PUP programme directly. Nine parents took part in the programme. Seven of the nine families were single-parent families with the mother as primary carer, one family consisted of both biological parents and the other family consisted of the biological mother and a stepfather. The mean age of the primary parent was 28.2 years ( $SD = 4.6$ ). The mean age of the target children was 45.6 months ( $SD = 15.4$ ), of whom six were male and three female. The target children spent an average of 23 hours per week ( $SD = 9.4$ ) in child care. Only one child was the subject of a court order. Six of the nine parents were unemployed. Their mean duration on methadone maintenance was 3.3 years ( $SD = 5.5$ ) with a mean dose of 79.4 mg ( $SD = 36.3$ ).

### Treatment intervention: Parents Under Pressure programme (PUP)

The PUP programme aims to improve family functioning and child outcome by addressing risk factors, both within the family and in the wider social systems associated with poor child outcome in substance-misusing families. The individual treatment focus is designed to decrease parental psychopathology. This in turn enables parents to put into practise parenting skills (which addresses specifically the parent-child relationship) and relapse prevention techniques. Finally, difficulties that occur between individuals and their social environment are addressed. A strong therapeutic alliance is considered critical and is achieved by ensuring that there is a shared understanding between therapist and client on the nature of the immediate, short-term and medium-term goals [23]. The programme is primarily cognitive behavioural in focus and draws from the literature on the regulation of affect [24-26], decreasing negative mood states [26], preventing lapse and relapse to substance misuse [27] and improving parenting practices using behavioural family therapy approaches [5]. An individual treatment plan is developed in collaboration with the family and priority areas for treatment are identified.

The programme consists of 10 units that may be delivered over 12 sessions of approximately 1.5 hours. The details of each unit, a theoretical overview and a series of potential treatment approaches and exercises are documented in the Therapist Manual and an accompanying Parent's Workbook (see Table 1 for a brief overview of the programme). The exact number of sessions varies slightly from family to family although it

is anticipated that there would be a minimum of eight and a maximum of 12 treatment sessions. Families are able to choose whether treatment took place in the clinic or their home. Additional telephone contact is made as required; e.g. when attempting to find new housing for a family a series of phone calls are made to both housing agencies and to the client themselves. Two therapists were involved in treatment: one (VR) was a registered psychologist, the other was a psychiatric nurse with 6 years' experience in the drug and alcohol field and working as a senior clinical nurse in the participating methadone clinic. Both therapists were trained in the use of the manuals and parent workbook and received weekly supervision.

The early part of the programme addresses the parent's view of themselves as parents, which is typically negative, by encouraging them to acknowledge their strengths as parents and to notice and comment on positive child behaviours such as attending and following parental commands, completion of requested tasks. Daily child-focused playtimes of approximately 10 minutes are scheduled to help build a positive parent-child relationship. In addition to enhancing the parent-child relationship there is a focus on helping the parent improve their affect regulation and negative mood states. As parents shift from viewing themselves and their children in a pervasively negative light to believing that change is both possible and achievable, it becomes possible to address issues of coping including finding alternatives other than drug use as coping strategies. Within the context of a harm minimization approach, the need to plan instances of illicit drug use to ensure the safety and well-being of the children is emphasized. The latter part of the PUP programme focuses on helping parents acquire and consistently employ non-punitive methods for dealing with problem behaviours, including effective limit-setting and non-punitive consequences for unacceptable child behaviour. Finally, parents are encouraged to extend their social supports by recontacting non-drug-using friends and liaison with community agencies such as playgroups and childcare centres. However, as domestic difficulties such as loss of housing or unforeseen stressors such as release of drug dealer from prison often occurs, there is a degree of flexibility that is required to ensure that wider contextual issues are acknowledged and when possible, the therapist and client develop an action plan to help resolve the situation.

### Procedure

The PUP programme was advertised by posters and through word of mouth at a large inner-city methadone maintenance clinic. Potential participants were invited to telephone one of the investigators for information about participation. To be eligible to participate either

Table 1. *Parents under pressure programme: therapist manual unit topics and purpose*

Unit topic	Purpose
Unit 1: Assessment	Obtain quantitative and qualitative information to provide content for the development of a treatment plan
Unit 2: Assessment feedback and checking out	To develop a shared understanding of the major areas of strengths and areas of difficulties, which leads to a treatment plan and shared goals to work towards
Unit 3: Challenging the notion of an ideal parent	To help bring about change in the view of self as an inadequate or hopeless parent
Unit 4: More	To provide parents with skills that will increase parental attending to good behaviour and, in turn, increase their children's good behaviour
Unit 5: Less	To provide parents with skills to decrease their child's undesirable behaviour to an acceptable level, decrease the use of highly punitive discipline or physical punishment procedures
Unit 6: How to cope under pressure	To help parents to become aware of the relationship between their own emotional state and their parenting practices, to learn how to regulate emotions and tolerate distress
Unit 7: Coping with lapse and relapse	To ensure that clients have skills and confidence to minimize lapses to the use of drugs and alcohol, avoid relapse and remain in methadone treatment. Harm minimization approaches incorporated
Unit 8: Social support networks	To help parents extend their support networks by modelling social interactions and helping parent(s) prepare for social events that may have been avoided in the past
Unit 9: Life skills	To develop practical life skills including budgeting, nutrition, health care, obtaining housing etc.
Unit 10: Relationships	To help improve effective communication with current partner and to identify past unproductive relationship patterns

or both parents were required to be on methadone maintenance and to have a child aged between 2 and 6 years of age. All participants received a \$50.00 gift voucher for a local supermarket to compensate for time involved in the assessment session and again at the 3-month follow-up interview. A consent form that outlined the purpose of the study and the nature of the families' involvement was signed at the start of the assessment session.

#### Measures

A semi-structured interview obtained basic demographic history, background history of both parents including history in care, abuse as a child, treatment history, drug and alcohol history and current drug use including methadone dose.

Self-report questionnaires measuring functioning across the following ecological domains were completed: (1) parental functioning; (2) child functioning; (3) family relationships (parent-child and marital); and (4) the social context of the family. The primary caregiver completed all questionnaires during the assessment session.

*The Parenting Stress Index-Short Form (PSI)* The PSI-Short Form [28] is a well-validated self-report ques-

tionnaire that includes three subscales providing measures across ecological domains. The Parental Distress (PD) subscale reflects the parent's functioning in the parenting role, including competence as a parent, social isolation and relationship with partner and life-stress. This measure includes aspects of individual parental functioning and the social context of the family. The cut-off for a high score (defined as scores above the 95th percentile) is 36. The Difficult Child (DC) subscale reflects the parent's perception of their child as difficult to manage. These difficulties arise from temperamental features such as demandingness, moodiness, distractibility and high activity levels. The cut-off for a high score is 36. The Parent-Child Dysfunctional Interaction (P-CDI) subscale reflects a lack of parental satisfaction with parent-child interactions, for example that the child does not meet parental expectations and is not reinforcing to the parent. The cut-off for a high score is 27.

*The Child Abuse Potential Inventory (CAPI)*. The CAPI [29] is a self-report questionnaire found to discriminate physically abusive from non-abusive parents. The instrument is used widely in studies of parents at risk of child abuse or neglect. The scale included an overall abuse measure (abuse scale) as well as scales that tap into each of the ecological domains targeted in this

study. The CAPI abuse scale is a 77-item scale with internal reliability of 0.92–0.96 and good temporal stability of 0.91 and 0.75 for 1-day and 3-month intervals, respectively. When using the abuse score as an outcome measure, the cut-off score that minimizes false positives is 215 and was used in the current study. Aspects of the individual functioning of the parent are measured by three subscales tapping into the psychological distress of the parent, parental unhappiness and rigid attitudes to child-rearing. Family relationships are measured by three subscales focusing on problems in the parent–child relationship, and problems in relationships with family and problems with others.

*The Significant Other Scale (SOS).* The SOS [30] consists of 10 items reflecting the level of practical and emotional support available to the parent. For each of the four items, participants rate the ideal level of support they would like and the actual level of support they receive. Subtracting the actual from ideal rating provides a discrepancy rating indicating the extent to which the actual level of support falls short of the actual level available. While the original scales measures the level of support from different sources (spouse, mother, close friend, etc.) the parents in this study were asked to rate levels of support without reference to specific sources of that support. The scale has acceptable test–retest reliability. Power *et al.* [30] report that the discrepancy between actual and ideal levels of support is higher for depressed compared to non-depressed individuals.

*The Opiate Treatment Index (OTI): HIV Risk Taking Behaviour Scale (HRBS).* The OTI: HRBS [31] consists of 11 items focusing on injecting practices and sexual behaviour that places individuals at risk of either contracting or spreading the human immunodeficiency virus (HIV). Addition of all items scored on a six-point scale (0–5) provides a single overall score; the higher the score the greater the risk of contracting or spreading HIV. This subscale has good internal stability and test–retest reliability [31,32].

*The Alcohol Use Disorders Identification Test (AUDIT).* The AUDIT [33] is a 10-item screening instrument designed to screen for a range of drinking problems and in particular for hazardous and harmful consumption. It is particularly suitable for primary health-care settings and has been used in a number of different countries and with diverse cultural groups [33]. The psychometric properties of the AUDIT have been assessed across a range of populations, including university students, women, psychiatric patients, geriatric popula-

tions and the unemployed. It has strong internal consistency with Cronbach alphas ranging from 0.80 to 0.94 and evidence indicating good temporal stability. A score of 8 or more is associated with harmful or hazardous drinking [34].

*Connors' Rating Scales-Revised (CRS-R).* The CRS-R [35] is a measure of child functioning, including conduct, family, emotional, anger and anxiety problems. The Connors Global Index is reported in the current study, as it is the best short measure of child functioning and is sensitive to change over time. Raw scores are converted to percentiles adjusted for age and gender.

## Results

Of the 12 families who enquired about the programme, nine families commenced treatment. The mean number of sessions attended for the nine families was 12 (range 8–14 sessions), the mean duration of time in treatment was 14 weeks (12–17). Eight of the nine families were contacted successfully at 3 months post-treatment and follow-up data obtained. The majority of sessions were held in the families' homes; all families chose to have the first assessment session in the methadone clinic, one family also had the next two sessions in the clinic before moving to home-based treatment. Children were present for part of the assessment. They were not involved directly with treatment, although home-based sessions required that the therapists spent some time acknowledging the children and interacting with them.

The number of participants whose scores showed a clinically significant decrease from pretreatment to follow-up was calculated using the method proposed by Jacobson & Truax [36]. Specifically, for each individual, pretreatment scores were subtracted from follow-up scores and then divided by the standard error of the difference. An individual score was determined to be clinically significant if the Reliable Change Index derived using this method was greater than 1.96. From Table 2 it can be seen that the majority of families showed statistically reliable improvement on measures that covered parental functioning, child functioning, the parent–child relationship, parental substance use and risk-taking behaviour.

Figure 1 provides a visual representation of the pattern of changes shown by each family on specific subscales tapping into each ecological domain over the three assessment times. Scores above the clinical cut-off are represented by dark shading, scores between the mean and cut-off score by diagonal shading, and scores below the mean by light shading. As there is no clinical cut-off for the SOS, the mean discrepancy scores

Table 2. Means and standard deviations for outcome measures for PUP programme

Measures	Pre-Mean (SD)	Post-Mean (SD)	Follow-up Mean (SD)	Statistically significant change n (%)
Parental functioning				
PSI (PD)	37.8 (10.6)	33.0 (10.4)	17.9 (5.3)	6/8 (75%)
CAPI (abuse)	230.4 (90)	133.6 (32)	106 (30)	6/8 (75%)
AUDIT	4 (1.6)	2.3 (2.5)	0.6 (0.8)	6/7 (86%)*
Methadone dose	79.4 (36.3)	68.3 (42.3)	67.5 (45.7)	3/8 (38%)
Risk-taking behaviour	5.14 (6.4)	0 (0)	0.6 (1.5)	3/7 (43%)*
Child functioning				
PSI (DC)	36.7 (9.4)	26.3 (2.7)	15.0 (4.2)	7/8 (88%)
Connors Global Index (percentiles)	76.8 (22.1)	53.7 (23.6)	16.8 (9.9)	6/8 (75%)
Parent-child functioning				
PSI (P-CDI)	24.3 (7.8)	19.4 (3.7)	15.0 (4.2)	7/8 (88%)

Note: PSI (PD) = Parenting Stress Index (Parental distress; CAPI = Child Abuse Potential Inventory; AUDIT = Alcohol Use Disorders Inventory; PSI (DC) = Parenting Stress Index (difficult child); PSI (P-CDI) = Parenting Stress Index (parent-child dysfunctional interaction). \*Missing data on one case.

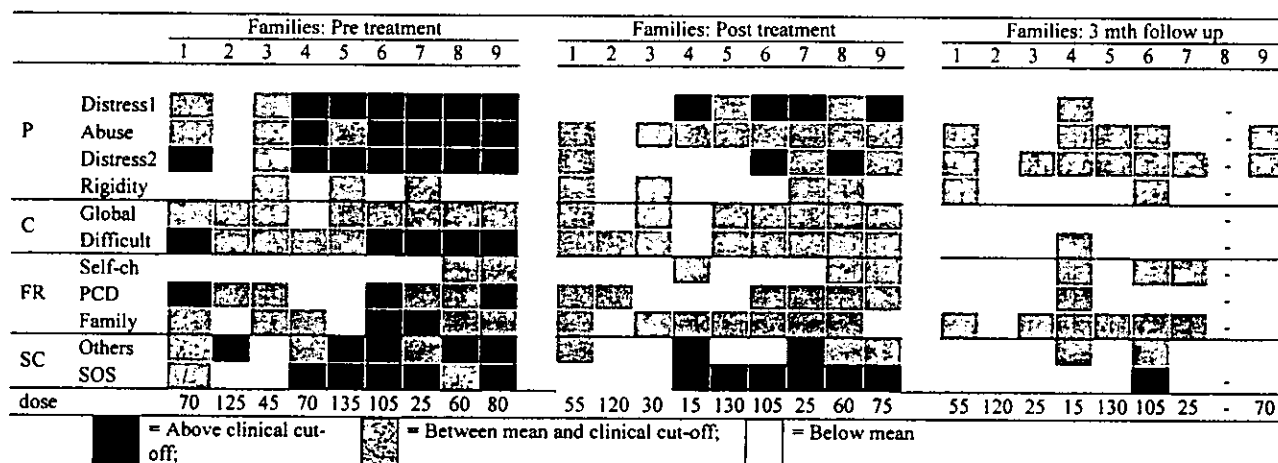


Figure 1. Graphical representation of changes in each family at pre-, post and follow-up assessments. P = parent domain; C = Child Domain; FR = family relationships domain; SC = social context domain; dose = methadone dose (mg). Distress1 = PSI-parent distress; Abuse = CAPI-abuse; Distress2 = CAPI-distress; Rigidity = CAPI-rigidity; Global = Connors Global Index; Difficult = PSI-difficult Child; Self-Ch = CAPI-problems with child and self; PCD = PSI-parent-child dysfunction; Family = CAPI-problems with family; Others = CAPI-problems with others; SOS = Significant others scale.

reported by Power *et al.* for non-depressed (0.95) and depressed individuals (1.4) were used to set the mean and cut-off points in Fig. 1. Rounding to whole numbers, the mean was set at 1 and the cut-off at 2. The measures presented in Fig. 1 are classified by ecological domain—parental functioning, child outcomes, parent-child relationship and social context of the family. From Fig. 1 it can be seen that most families reported scores above the clinical cut-off in each ecological domain at pre-intervention. It can also be seen that four of the nine families reported scores in the clinical range at post-intervention. All scores above the clinical cut-off were in the parental functioning and social context domain, indicating that the problems

were related to the parents' own psychological functioning and less than ideal levels of social supported. Only one parent reported any measure in the clinical range at follow-up. This parent (family 6) reported continued problems in the availability of social support. For all other families, problems fell below the clinical cut-off across all ecological domains.

Discussion

The present study aimed to ascertain the effectiveness of the PUP programme with a sample of parents attending a community methadone clinic. Nine of 12 families who enquired about the programme took part

in the treatment, suggesting that the programme was perceived as accessible and relevant to this client group. All nine families completed the programme and eight were recontacted at 3 months.

Significant improvements were found on all measures of parental functioning. At assessment, all parents were reporting elevated levels of stress in the parenting role as measured by the three scales of the PSI reflecting high levels of stress, dissatisfaction in the parenting role and in their relationship with their child. Scores on all three scales showed significant decreases for the sample as a whole, with the mean post-intervention and follow-up scores falling into the average, non-clinical range. The clinical significance of this result was confirmed, with almost all parents showing clinically significant improvement [36]. There was also a substantial decrease in the abuse score on the CAPI, indicating that the parents in this study shared fewer characteristics in common with abusive parents following participation in the PUP programme. Four of five parents moved from above to below the conservative cut-off score for classifying parents as potentially abusive; six parents showed clinically significant improvement.

The impact on child behaviour was positive, with parents reporting fewer behavioural problems on a self-reporter checklist. These behaviours included temper outbursts, unpredictable behaviour and mood changes, among others [35]. Parental report of decreases in child behaviour problems was clinically significant, with most parents showing a clinically significant improvement. Whether improvement in child behaviour was a reflection of a less negative perception of the children by the parents is uncertain. Similarly, it is unclear whether the decreased distress in the parenting role was responsible for the improvement in child behaviour, whether improved child management techniques led to improvement in child behaviour and, in turn, less parental distress, or an interaction of the two.

In addition to improvements in parental and child functioning, positive changes were noted in the parents' substance use and risk-taking. Three of the eight parents followed-up showed clinically significant improvement on the OTI Risk Taking Behaviour Scale [31] and a clinically significant decrease in methadone dose. Six families showed clinically significant improvement on the AUDIT [33]. Parents reported that many of the high-risk situations that led to drug use were linked to the stress and pressure of being an isolated parent. Excessive drinking or heroin use gave parents some time out from their lives, although periods of drug intoxication were followed typically by feelings of remorse and guilt over their actions. Identifying such patterns and helping parents develop alternative methods of coping was believed to be critical in reducing

alcohol consumption. Acknowledging that parents may use drugs was also a necessary harm reduction strategy and we propose that the reduction in the OTI Risk Taking Behaviour Scale reflected in part a move from impulsive drug use to drug use that involved at least some planning that reduced risk behaviour. Whether this was also accompanied by ensuring that children were supervised in a safe environment while drug use occurred was encouraged but not evaluated in the current set of measures.

Further anecdotal feedback from parents indicated that participants had made some important shifts in thinking. At the start of the programme parents viewed themselves as failed or useless parents. This cognitive schema was explicitly addressed throughout the programme with the aim to replace this core belief with a belief that there were many aspects of their parenting that had been positive for their child. Further, that there were a number of different strategies that could be utilized to build on the parent-child relationship. Attempts were also made to influence the wider social context in which the parents lived to assist in decreasing life stress. For two families this involved contact with Family Services, in one case to arrange temporary respite care 2 days a week, for the other family to arrange emergency day care for the preschool-age children in the family. Families were encouraged to recontact non-drug-using friends and to expand their social network by using community resources such as playgroups.

A substantial proportion of the reduction in parental stress occurred during the follow-up period. It is possible that improvement in family functioning is a cumulative process, particularly when features from the families' wider social environment are changing. Small changes in, for example, social networks initiated during the treatment phase may require a period of time before their full benefits are obtained. It could be argued that the improvements reported were motivated by a desire to present in a favourable light following their participation in the programme. However, it is notable that both the CAPI and the PSI have validity scales to detect faking good or faking bad and at follow-up there were no elevations in either of these measures. Further, it is notable that the methadone dose was extremely stable across the study time period: significantly reduced in three parents and reduced slightly in another three. Methadone dose is generally considered to be an index of stability of drug use and was monitored independently of the PUP team by the physicians in the clinic. Thus, the convergence between methadone dose and the self-report measures further support the effectiveness of the PUP programme. None the less, the findings would be strengthened even further by collateral reports by other professionals involved and/or behavioural observations to provide

further cross-validation of the self-report measures. It is recommended that these additional sources of information are included in future evaluations of family-based interventions.

In conclusion, participation in an intensive, multi-modal family-based treatment was associated with substantial improvements in parental functioning, parent-child relationship and child behaviours. The apparent concurrent reduction in alcohol use and risk-taking behaviours was also encouraging. Future research studies need to ascertain the robustness of these findings by comparison with standard care conditions. Further, attempts to determine whether all families require an intensive 12-session programme compared to a well-structured brief intervention is an important goal given the resource implications of providing such a programme to all families on methadone maintenance.

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