Children in families with multiple problems

Advancing a main challenge

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Abstract

Children in families with multiple problems are from a child and youth care point of view a very vulnerable target group. Yet we still know relatively little about these families and the effectiveness of interventions for them. What we know from research indicates that most types of intervention have up to now not sufficiently succeeded in facilitating sustainable change for the children in these families. In this paper we propose that this might be due to two main reasons: 1. that most interventions durations are too short to deal with complex problems, and 2. that there is not enough direct support for children in home-based family interventions. Based on research related to Pinkerton's model of the care continuum we argue for long-term visions on the effectiveness of child care interventions and the implementation of dual care worker approaches, which offer direct support for children at the same time as for the parents. The care activities and outcomes of such interventions need to be monitored by further research.

Keywords: cumulative risk, child protection, care continuum, dual care worker approach

Introduction

Child and youth care involves different forms of care for children in need and/or for parents experiencing parenting problems. A classic distinction is made between residential care, foster care and home-based care. It is these distinctions and the border areas around them that we wish to highlight in this paper. But we are not concerned with weighing the benefits of different forms of child care against each other as we do not regard "… home-based and non-home-based forms of youth care as opposites, but as complementary types of intervention (…); both are aimed at young people and families who need effective, professional support in problematical childrearing situations" (Knorth, Knot-Dickscheit, & Tausendfreund, 2007, p. 114).

As outlined in this quote, our research interest centres around the child's needs and those types of support that provide greater chances for a healthy development from a pedagogical perspective. From this point of view classical distinctions between forms of care are only of secondary importance, as we will explain in the following.

A child's social environment plays a major role in the development and continuation of problems in childrearing settings. The same holds true for the identification of children's problems and the actual problem-solving process by care and treatment. For young children especially, the family is at the heart of the social environment. It is often the parents who register their child for care, who provide valuable information about the child and its development, and who play a key role when it comes to care fidelity (whether or not appointments are kept), as well as working together on the realisation of care goals (Van der Maas & Albrecht, 2014). From a systematic review of the literature on the parents' role in mental healthcare, Morrisey-Kane and Prinz (1999) conclude that "… parental engagement in the treatment process is influenced by parents' beliefs about the cause of their children's problems, perceptions about their ability to handle such problems, and expectations about the ability of care arrangements to help them." (p. 183).

But what if parents are (temporarily) unable to meet the parental needs of a child, in a way that seriously threatens their child's wellbeing? A temporary or prolonged out-of-home placement may then be appropriate and may offer prospects for the child's wellbeing and a healthy development in a safe childrearing setting. But in an out-of-home placement too, the family can continue to play a valuable role in the child's development. Pinkerton's (2006) continuum of care model offers a conceptual framework for this way of thinking. According to his model, there needs to be family and parenting support, independent of the severity of the problem and the intensity of the care offered. Geurts, Boddy, Noom and Knorth (2012) describe collaboration with families in residential care in their literature review. They conclude that three domains are especially important if parents are to be involved in care within a residential setting:

1. Formal care processes (e.g., helping to develop a treatment plan);
2. Children's everyday lives and activities in the residential setting (e.g., shared mealtimes);
3. Interventions with families to offer support and guidance in the context of their everyday lives. The residential worker must function as a system intervention-

> ist, engaging with the whole family and with individual family members (Geurts et al., 2012, p. 176).

The concept of a care continuum offers a framework for introducing a family perspective into residential care, but can it also serve as a guideline for home-based care? We believe it can, and that this can be achieved by making the child's perspective the central focus, by giving it a distinct place in both the theoretical underpinnings of family support methods and the practical implementation of family support. This idea will be discussed in greater detail below. We will outline a number of professional challenges facing home-based care, as well as the contribution that the care continuum can make as a conceptual framework. Our point of departure here is the phenomenon of families with multiple problems.

Families with multiple problems; not 'multi-problem families'

In the Netherlands, families who by extent, complexity and nature of their problems make high demands on the range and quality of interventions are often referred to as 'multi-problem families' in child and youth care (Tausendfreund, Knot-Dickscheit, Schulze, Knorth, & Grietens, 2015a). From a developmental perspective, it is important to note that the multiple problems of these families lead to a greater risk of neglect, maltreatment or abuse (Denholm, Power, Thomas, & Li, 2013; Fuller-Thomson & Sawyer, 2014; MacKenzie, Kotch, & Lee, 2011) and a greater risk that children will develop severe behavioural and developmental problems (Appleyard, Egeland, Van Dulmen, & Sroufe, 2005; Deater-Deckard, Dodge, Bates, & Pettit, 1998).

However, there is no consensus among researchers on a clear definition or method of identification for these families (Spratt, 2011) who together form a highly diverse group. Nor is the term 'multi-problem family' itself uncontested (Tausendfreund et al., 2015a). The term 'multi-problem family' places the problem one-sidedly with the families and takes no account of the fact that the intervention and care system themselves are partly responsible for the intervention success (Tausendfreund, 2015). The term is also stigmatizing because:

> "… its use as an adjective assumes that certain families are 'multi-problematical' rather than that they have multiple problems. (…) Because of the stigmatizing connotation of the term 'multi-problem' family, it is likely that its use has negative consequences for the care relationship with families and hence for the outcome of family interventions" (Verhallen, 2013, p. 58).

Following the example of the terminology used in the United Kingdom, we will therefore refer below to 'families with multiple problems' (Marsh, Ryan, Choi, & Testa, 2006; Spratt & Devaney, 2009), while avoiding the 'troubled families' rhetoric as it mirrors many of the problems outlined above (Ball, Batty, & Flint, 2015).

Care in families with multiple problems

Many programmes that target families with multiple problems involve interventions in the home setting. As Holwerda, Reijneveld, and Jansen (2014) conclude in a recent re-

view study conducted with Dutch and English studies, we know remarkably little at present about the effectiveness of this form of intervention for families with multiple problems. What we do know from research shows that results are often limited when it comes to improving parenting skills and family functioning (Holwerda et al., 2014, p. 17). Following their study of intensive home-based parenting interventions in the Netherlands, Veerman et al. (2005) say that "the risk that the problem behaviour persists or is exacerbated, including after completion of the vast majority of methods discussed, is so great that follow-up treatment is advised" (p. 186). Research in Germany by Schmidt et al. (2002) showed that in relative terms children and young people benefit least from home-based family support. Why is it that one of the most frequently employed forms of care – home-based care – appears to achieve so little for children in families with multiple problems?

Problems and challenges in home-based care for families with multiple problems

In our view, there are two main hypotheses to explain this phenomenon:

1. Most of the current interventions specifically developed for families with multiple problems are of too short a duration to solve all the problems these families face. The problems some parents and families experience can be so overwhelming – think for example of parents with intellectual disabilities or psychiatric problems – that long-term forms of support can be required if children are to develop and continue to live safely at home.
2. Family coaches find themselves in the complex position of having to work in the interests of the child *and* with the parents. They aim to reduce children's problems by improving the parenting skills of the parents, leaving children at risk of receiving too little direct attention in family-focused interventions.

Programmes are too short to solve complex problems

The vast majority of intensive home-based interventions in the Netherlands are temporary and of fairly short duration – ranging from a few weeks to one year, seldom more (Knot-Dickscheit, Tausendfreund, & Knorth, 2011). The reasoning behind this is that interventions are made during periods of family crisis and that change (as part of the interventions' effectiveness) is mainly achieved in the initial weeks or months of an intervention. But is this true of all kinds of problems, especially complex ones such as child neglect or abuse (cf. Devaney & Spratt, 2009)?

Studies of predictive factors for the neglect or abuse of children (e.g. living in a disadvantaged neighbourhood or having parents with alcohol problems) show that primarily cumulative models – those comprising several risk factors – have a predictive value (Fuller-Thomson & Sawyer, 2014; Jaffee, Caspi, Moffitt, Polo-Tomás, & Taylor, 2007; MacKenzie et al., 2011). The fact that it is a combination of factors that appears to play a role illustrates the complexity that needs to be considered when providing care to families with multiple problems. Because it is not always possible to clearly

differentiate between symptoms and problems in these families, interventions have to target several problems at once (Statham & Holtermann, 2004). One way to take this complexity into account is to provide interventions of flexible, potentially long-term, duration (Moran, Ghate, & Van der Merwe, 2004, p. 118). The benefits of this approach include:

- more opportunities for addressing care avoidance behaviour (e.g., by having the time to build or restore trust between care worker and family);
- greater flexibility in terms of personalizing care (e.g., organising a range of care components of different durations depending on the family's care needs);
- being able to counteract the fragmentation of specialized care (e.g., by coordinating care);
- reducing family stress by preventing the need for a reassessment if crises fluctuate in their course and intensity.

Studies of families with multiple problems reveal that parents often face a combination of internalising and externalising problems (Appleyard et al., 2005), psychiatric problems, an intellectual disability (Mehlkopf, 2008). In her evaluation study of a Dutch family coaching, Schaafsma (2005) suggests making a distinction between 'families that recover' and 'families that stabilize'. Although this distinction needs to be underpinned by further research, it may be helpful as a reminder that some families might benefit more from less intensive but long-term support, for example for parents with intellectual disability (Clarke, 2010). A study by Willems, De Vries, Isarin and Reinders (2007, p. 537) showed that 1.5% of people with an intellectual disability in the Netherlands are parents, with a *mild* intellectual disability being the most common form. Care workers felt that the parenting skills of 51% of parents with an intellectual disability were 'not good enough'; a further 16% had 'doubtful' parenting skills, and for 33% their skills were 'good enough'. Willems and colleagues (2007)

"… were able to isolate some predicting factors, such as the ability and willingness to follow advice, the quality of the social network and the societal acceptance of parenting by persons with ID. But most importantly, this study showed that there is not one decisive predicting factor. Particularly significant is the finding that within the group of persons with mild ID, the IQ has little or no predictive value with regard to success or failure. The overall conclusion from the study therefore is that some kind of balancing model, in which positive and negative factors are weighed, may be useful to predict success and need for support." (p. 543).

Interventions that manage to achieve this balance for varying intensities of care (e.g., before, during and after an out-of-home placement) and adopt a long-term perspective are positioned at the centre of the care continuum referred to at the beginning of this article.

Children in families with multiple problems receive too little direct attention

Finding a lasting solution to complex care needs therefore requires not just time, but also a broad and comprehensive care package. This is because several problem areas need to be addressed at the same time and a number of individuals within the child's social environment are involved. We see

this reflected prominently in the overarching features of intensive home-based care; interventions that have been developed for families with multiple problems or those otherwise requiring intensive forms of support. In addition to shared guiding principles, such as targeting the family as a whole, involving the family in drawing up working objectives, and formulating care goals (Loeffen, Van Butselaar, & Ooms, 2001), these interventions also share similar theoretical underpinnings of their care methods. Systems theory, for example, alongside attachment and loyalty theory, is a theoretical cornerstone of intensive family-based interventions (Veerman et al., 2005). Furthermore, the involvement of the family network is seen as a key component in achieving objectives in families with multiple problems (Berg-le Clercq, Zoon, & Kalsbeek, 2012). This then raises the question of how these intervention theories are actually put into practice. Descriptions of intervention methodology are often too sketchy when it comes to clearly explaining the link between theory and practice (Veerman, Janssens, & Delicat, 2004).

Research is being conducted to gain a better understanding of the care process and of the specific activities, that care workers carry out within families. This type of research is still scarce, but the initial outcomes are somewhat surprising. Exploratory studies of care workers' activities in families with multiple problems (Metselaar, 2011; Tausendfreund et al., 2015b) have shown that interventions expressly designed to work systemically with parents and child as well as their social network, have only to a low degree direct contacts with people from the social network and with the child itself. The underlying idea seems to be that changing the parents' situation and behaviour will improve the situation and behaviour of the child. Although this may well be the case, it does not follow automatically, since achieving the parents' goals does not necessarily eliminate threats to the child's development (Slot, Theunissen, Esmeijer, & Duivenvoorden, 2002; Knot-Dickscheit & Blommert 2009). This inability to translate goals that have been achieved for parents into the achievement of child goals, such as reducing the child's problems, could explain the poor progress of children in families with multiple problems (Holwerda et al., 2014; Kemper, 2004; Tausendfreund, 2015; Veerman et al., 2005). One way to achieve child goals and place children centre stage could be to offer *direct help* to children alongside parenting support. This ties in with Pinkerton's (2006) thinking that, together with the care continuum, the nature and level of the problems should serve as a springboard for identifying care objectives and planning the support needed.

Child coaching

British research has indicated that working with two main care workers – one for the child and one for the family – was associated with more positive outcomes (Thoburn et al., 2013). Thoburn and colleagues concluded that "… the service succeeds in engaging a majority of the referred families who have been hard to reach or hard to change in the past and whose children are either 'on the edge of care' or likely to be significantly harmed without the provision of an intensive service' and that 'improvements were made in the life chances of children in 75% of the families" (p. 228).

Tausendfreund's (2015) doctoral research on the Salvation Army's 'Ten for the Future' (*Tien voor Toekomst*) programme suggests that such an intervention method can also be a significant addition to child and youth care in the Netherlands. 'Ten for the Future' is an intensive home-based intervention developed specifically for families with multiple problems; it is of flexible duration (potentially long-term). For its theoretical underpinnings, the programme adopts a solution-based approach. It is based on learning theory and systems theory, involving the use of directive and contextual approaches. Its central feature is supervision and support for families in ten areas, including parenting, support structure, finances, and mental health. The results show that the programme was associated with a clear reduction in parental stress, especially in the first year. In addition, families with an initial lower level of stress were found to have a greater chance of ending the programme earlier. However, there was a less coherent pattern of change for children's behavioural problems and the functioning of the family as a whole. A possible explanation could be that the main focus of family coaches is on working with parents, and less so on working with children (Tausendfreund, 2015).

In 2010 the 'Ten for the Future' programme introduced the role of child and youth coach. Following an assessment decision, these coaches work in the family alongside the family coach. Their sole focus is to support and supervise children aged 3–18 who have a care need. The help is flexible in terms of both time and duration. The module was rewritten in 2012 and can also be implemented separately from the 'Ten for the Future' programme. The child and youth coaching module has broad criteria for needs assessment. Supervision by the child coach focuses on:

- increasing protective factors for the children;
- encouraging a child's positive development;
- providing a confidential counsellor;
- breaking through transgenerational problems and patterns (Rinsma, 2014, p. 16).

This form of care is unique in the Netherlands. We do not yet know whether child and youth coaching is effective when it comes to preventing or reducing children's emotional and behavioural problems and improving family functioning. We also know nothing yet about how children experience this form of help and whether it meets their needs in the context of their own life story. For this reason we launched a study in 2015 to address these questions (Knot-Dickscheit, Post, & Grietens, 2015).

Conclusion

Families with multiple problems present a care challenge. From a pedagogical perspective we have not yet been able to respond satisfactorily to the care needs of these families, and to those of children in particular. Despite all the efforts made, many children in these families are still not deriving proper benefit from the offered support. In this paper we have proposed several possible explanations for this. There is a need for research that identifies which care arrangements work for which type of family, why and under what circumstances, and how the care needs of the children in these families can best be met. If a temporary out-of-home placement is the best solution, the family of

origin should also receive a form of family support, as part of the care continuum. And if a form of intensive family support is the best solution, the child itself should also receive direct help in families with multiple problems. To ensure that care workers are sufficiently guided in their complex care tasks, explicit attention must be paid to the link between programme theory and programme implementation. In other words, if the theory behind the programme calls for a systemic approach, care workers need to be trained in the skilled translation of this programme requirement into practice. To ensure the programme's integrity, care workers need to be supported through supervision and peer review when monitoring and promoting the quality of the care they provide. There needs to be more research into success factors and care outcomes, which should then be fed back to and utilised in practice.

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