An extended family for life for children affected by parental substance dependence

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The scale of the problem of parental alcohol abuse alone is such that it cannot be solved solely by services (Scott, 2009, p. 38).

Parental substance use features among 50–80% of families involved with child welfare services in Australia (Battams & Roche, 2011), and has, unsurprisingly, been referred to as the most critical issue facing the Australian child protection system (Ainsworth, 2004; McGlade, Ware, & Crawford, 2012). Children for whom parental drug use is problematic are not only more likely to be brought to the attention of child protection services but also to be repeatedly reported. This group of children tends to be placed in out-of home-care earlier and to remain longer; reunification is often delayed while parents undergo assessment and treatment (Jeffreys, Hirte, Rogers, & Wilson, 2009). The resulting "bottle-neck" effect, coupled with difficulty in the recruitment and retention of foster carers (McHugh, 2005), has led to an unsustainable out-of-home care system and an urgent need to reduce the number of children entering state care.

This article briefly describes the effects of problematic parental substance use on children; it discusses the provision of support to substance-dependent parents and their children, and briefly reviews policy directions in child protection in Australia. The article then presents the conceptual outline for a new model for working with families affected by parental substance use, one that is less reliant on the service sector to address children's long-term needs. The Odyssey House Victoria Mirror Families program, a professionally led, time-limited, intervention in the informal network of substance-dependent parents and their children is presented.

The relationship between parental substance use and outcomes for children is complex and involves an array of risk and protective factors; assumptions should therefore not be made that parental substance use is invariably detrimental to children's wellbeing. Negative effects can be avoided or mitigated by providing support to parents and/or children, or through direct actions being made by parents to protect

children (Richter & Bammer, 2000). With the exception of children with foetal alcohol spectrum disorder, who may have suffered irreparable brain damage (Riley & McGee, 2005), there is evidence to suggest that the caregiving environment is the key factor in individual children's long-term outcomes (Berger & Waldfogel, 2000).

This article addresses problematic parental alcohol or other drug use, particularly the use of illicit substances, which often results in financial strain, child neglect, poor school attendance and social isolation (Fraser, McIntyre, & Manby, 2009; Gruenert, Ratnam, & Tsantefski, 2004). Many children in such families are exposed to family violence; some are exposed to crime, including drug dealing; and a smaller number witness their parents overdosing or lose them to overdose (Gruenert et al., 2004). Harm can be cumulative and may result in complex trauma that predisposes children to a range of additional long-term problems; for example, their own addictive behaviours, psychiatric disorders, chronic illnesses, legal issues, unemployment, and family and other relationship difficulties (Cook et al., 2005). Outcomes are particularly bleak for children who remain with parents whose substance use is problematic and who become isolated from the wider family (Bancroft, Wilson, Cunningham-Burley, Backet-Milburn, & Masters, 2004; Gruenert et al., 2004).

Supporting the children of substance-dependent parents through formal and informal intervention

Child protection in Australia is considered "everybody's business" (Council of Australian Governments, 2009). The policy of Australian Governments is to exhort the alcohol and other drug sector to attend to the needs of clients' children (Council of Australian Governments, 2009); however, unlike the child and family welfare sector, the potential of the alcohol and other drug sector as a site of primary prevention and secondary intervention for children at risk of abuse and neglect has been largely under-developed (Battams & Roche, 2011). The public health model has been proposed as a means of integrating these two sectors (Higgins & Katz, 2008). In addition to population-based measures, such as taxing alcohol and placing restrictions on its advertising and availability, the public health approach requires building the capacity of adult-focused services, including the alcohol and other drug sector, to be "child and parent sensitive" in order to reduce the incidence of child maltreatment and, by implication, demand on the out-of-home care system. It also requires child-focused services to be more responsive to adult problems (Scott, 2009).

In a UK review of the evidence base for working with substance-using parents and their children, Asmussen and Weizel (2009) highlighted the importance of addressing multiple risk and protective factors for children, parents, families and communities, and the need for intensive, long-term interventions for parents. At the same time, they suggested being cautious regarding the involvement of extended family members in treatment plans and alternative care of children on the grounds that those family members may themselves have substance use or parenting problems.

In the Australian context, kinship care—which is almost synonymous with grandparent care (Horner, Downie, Hay & Wichmann, 2007)—is the preferred policy option for children unable to live with their biological parents, as these placements tend to be more stable and therefore better for children (Baldock, 2007). Indeed, most grandparents who are caring for their grandchildren are doing so due to alcohol and other drug use by parents (Baldock, 2007). Rather than drawing upon the informal network of kith and kin after child maltreatment has occurred, or when placement in out-of-home care is imminent, an alternative approach would be to build a protective network of adults around children while they remain in parental care.

Gilligan (2006) argued that helping children involves understanding them within their social context, and that reliance on formal services may be both a cause and a consequence of reduced access to informal social support. He stated, "helping a child is not about delivering *services*. It is about a stance and a mindset" and goes on to say, "our role in professional helping services may need to be less about doing things *for* and *to* people, and more about restoring and reinvigorating their own capacity, and recharging the solidarity of the natural social systems that surround them" (p. 41, emphasis in original).

Research with substance-using parents and their children indicates that informal support plays a key role in promoting children's safety and wellbeing and that, while the network may contain a significant number of problematic substance users, it is nevertheless possible to identify supportive individuals (Bancroft et al., 2004; Fraser et al., 2009; Moore, Noble-Carr, & McArthur, 2010). For example, Fraser et al.'s (2009) qualitative study with substance-

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using parents and young children (4–14 years) established that grandparents provided essential support over a protracted period and that other family members and non-using adults also provided valuable support. Similarly, Bancroft et al.'s (2004) UK study of 38 young people affected by parental substance use found that most had support from at least one extended family member, usually a grandmother or aunt—a relationship often formalised in fostering. These relationships, while important, were often fragile due to intra-family conflict over substance-using parents. Most young people expressed a need and desire for family-type relationships and felt embarrassment at the absence of family ties. Relationships with service providers varied significantly in intensity and duration and were rarely described as unanimously positive.

Australian young people who have lived with parental substance use describe the need to feel safe, have someone trusted to confide in, and receive emotional and other support, including assistance with education, reducing caregiving responsibilities for parents and siblings, and ameliorating the negative effects of parental substance use on the family. Importantly, they have expressed the need to reconnect with family, friends and community (Moore et al., 2010). They have also suggested that services intervene only when the informal network is unable to ensure their safety and wellbeing (Colverson, 2009).

While it has been reasonably argued that the best way to help children is to help their parents (Bokony et al., 2010), children also have interests separate from those of their parents. Network intervention may increase support for parents and help to buffer children from

adult problems by building their resilience—greater numbers of enduring, reciprocal relationships have been shown to enhance human development and to reinforce coping (Garbarino, 1983). The following section introduces Mirror Families, an innovative, early intervention approach originally devised in the out-of-home care sector to avoid unnecessary disruption to children's care and adapted by Odyssey House Victoria for use with substance-dependent parents and their children. Theoretical and practice frameworks underpinning the model are presented prior to a description of the program and reflections upon implementation to date, with consideration for further development and diffusion to other sectors and services.

Mirror Families: Supporting vulnerable children and their families through network intervention

The original concept for Mirror Families was devised by Claire Brunner and premised on the assumptions that lack of a robust extended family or kinship network is a significant feature of vulnerable families and that in well-functioning, naturally occurring extended families, there are a number of adults who play a significant role in contributing to children's development while simultaneously supporting parents (Brunner & O'Neill, 2009). Rather than ending when the child turns 17 or 18 years of age, as is the case for many children exiting the out-of-home care system (Mendes, Johnson, & Moslehuddin, 2011), children's family relationships tend to endure throughout the lifespan. In Mirror Families, the objective is to create, together with the child or young person and their parents, a functional "extended family" that reflects what happens in naturally occurring extended family structures (hence, the term "mirror families"). Mirror Families "is *not* a care team, a therapeutic placement, nor a care circle" (Brunner & O'Neill, 2009, p. 9, emphasis in original), nor is it a mentoring program. Instead, the aim is to create an extended family for life by recruiting and supporting those with an existing connection to the child and/or others who can commit to the child's future (Brunner & O'Neill, 2009).

Each mirror family comprises members who commit to a role in the life of a child or young person. These roles are divided into three broad groupings, depending on the level and frequency of engagement and current or potential role. The "A" family, who may be the child's birth family or alternative carers,

provides daily care; the "B" family provides respite or emergency care for the child and has potential to become the "A" family, if required; and the "C" family comprises individuals who offer a diversity of supporting roles, such as baby-sitting, attending family celebrations, accompanying the child or young person to sporting events or other functions, sending birthday cards, mentoring, advocacy and/or educational support.

Each family defines its own social network composition, which may include kin, fictive kin (i.e., individuals considered "family" but who are not related by biology or marriage), and/or friends. The number of members in the B or C families is not limited; that is, more than one individual or family member may be able to provide the type of support required by these roles. Should the child's living arrangements deteriorate, and removal from the home prove necessary, a nominated B family member assumes the A position and provides for the child's daily care, either on a continuous basis, or until the child's parents or regular carers are able to resume care. This not only spares the child the additional trauma of placement with unknown carers, it helps maintain the child's attachment relationships, as network members remain in contact with the child until the child reaches adulthood and, ideally, beyond.

The intended outcome is to reduce the likelihood of a breakdown in care arrangements and for children to have enduring relationships, receive responsive support and experience a sense of belonging. The overall goal is for each mirror family to become self-managing and to function like a natural family, thereby helping to break intergenerational disconnection by supporting children until they become adults and perhaps parents themselves. Theoretically, supportive, self-sustaining networks reduce the need for professional intervention, including child protection services and out-of-home care (Brunner & O'Neill, 2009).

Mirror Families at Odyssey House Victoria

Mirror Families was introduced to Odyssey House Victoria, an alcohol and other drug treatment provider, as a pilot program adapted from the original concept outlined by Brunner and O'Neill (2009). The Mirror Families program at Odyssey House Victoria is informed by a number of theoretical approaches that place children in the context of family and community. The program is also underpinned by international, national and state practice frameworks, as discussed below.

Theoretical framework

Attachment theory (Bowlby, 1971), which considers how early experiences in infancy and childhood shape the way relationships are formed and helps to explain adult attitudes and behaviours, is central to the Mirror Families model. As substance dependence, particularly among women, is associated with a history of physical and sexual abuse and other types of traumatic experiences (Heffner, Blom & Anthenelli, 2011), the trauma perspective, closely related to attachment theory, largely informs practice (Cook et al., 2005).

To facilitate the interventions necessary to work with families when forming their network, workers need knowledge of child development across physical, social, emotional, cognitive, spiritual and cultural dimensions. While it is vital to know what milestones need to be achieved at different stages of a child's life to enable workers to assess child development, safety and wellbeing, workers also need to explore the effects of relationships between the child and their immediate family, their educational setting and other significant social groups. Understanding the significance of these multiple contexts requires familiarity with Bronfenbrenner's (1979, as cited in Bowes & Hayes, 2004) Social Ecology Model. The strengths-based perspective ensures that workers help individuals and families draw on existing strengths, resources and capacities to foster change and positive development (Saleeby, 2005). Resilience is developed by building children's own social networks (Gilligan, 1999, 2006).

International practice framework

Mirror Families upholds children's rights under the United Nations Convention on the Rights of the Child (UNCRC) across all three principles: the right to protection, the right to participation and the right to provision. While *all* the rights expressed in the UNCRC are interdependent and indivisible, and children's safety and wellbeing is promoted in their convergence (Reading et al., 2009), the Mirror Families program strongly supports the following articles:

- Article 3: the child's best interests as a primary consideration in matters concerning children;
- Article 5: the need to respect the responsibilities, rights and duties of parents and, where applicable, members of the extended family and community, to provide direction and guidance in the exercise of the child's rights;
- Article 8: the right of the child to preserve his or her identity and family relations;

The aim is to create an extended family for life by recruiting and supporting those with an existing connection to the child and/or others who can commit to the child's future.

- Article 9: children should not be separated from parents without their approval, except when such removal is necessary in order to uphold the child's best interests;

- Article 18: both parents and legal guardians hold responsibility for bringing up children; the state is required to provide appropriate assistance, including institutions, facilities and services, to parents and legal guardians in the discharging of their child-rearing responsibilities; and

- Article 19: appropriate measures are to be taken to protect children from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parents or legal guardians; this includes the provision of social programs to support the child, parents and legal guardians, and for services to identify, report, refer, investigate and treat child maltreatment, with judicial involvement, if necessary.

State and federal policy frameworks

At the national level, the policy of harm minimisation informs the alcohol and other drug sector. In acknowledgement of the fact that, in the short-term, drug use frequently is an ongoing issue, harm minimisation seeks to ameliorate the adverse consequences of substance use for the individual user, their extended family and the broader community (Commonwealth of Australia, 2011). The child and family welfare sector is informed by the National Framework for Protecting Australia's Children 2010–2020 (the National Framework), which requires adult-focused services— including, but not limited to, alcohol and other drug treatment—to be more responsive to children's needs (Council of Australian Governments, 2009). Traditionally, the alcohol and other drug sector and child welfare services have operated within very different paradigms, each with its own (and frequently conflicting) policies, values and assumptions. For example, relapse is normative from the perspective of the alcohol and other drug sector, but can be seen as parental "failure" in child welfare practice. The sectors also have different timelines for practice: the alcohol and other drug sector accepts that problematic substance use is a chronic condition, whereas child protection services can impose timelines for the cessation of alcohol and other drug use so that reunification of children to parental care can occur and permanent care avoided.

At the state level, best interests principles in the *Children, Youth and Families Act 2005* (Vic.) underpin practice in family support

services, Child Protection, placement services and the Children's Court. Odyssey House Victoria's Mirror Families model is consistent with the three themes of the best interests principles: supporting and assisting families to keep children safe and meet their needs; promoting children's stability; and promoting children's cultural identity and connectedness (Victorian Department of Human Services, 2007). The program works within the cycle of recovery, recognising that lapses may occur and implementing strategies to reduce the risk, severity or occurrence of harm. In accordance with the UNCRC, the National Framework and the *Children, Youth and Families Act 2005*, it also keeps the child's best interests at the forefront of all interactions with children and families. This focus on children's interests by an agency primarily funded to provide substance abuse treatment to parents is an example of practising a child aware approach (Scott, 2009).

Implementation of the Odyssey House Victoria Mirror Families program

Odyssey House Victoria's Mirror Families program began its pilot operation within Kids in Focus, a specialist child-centred early intervention service for families affected by parental alcohol and other drug use, funded through the Australian Government's Family Support Program and administered by the Department of Social Services. Most referrals to Kids in Focus are received directly from the statutory Child Protection service or from Child FIRST agencies. A substantial number come from within Odyssey House Victoria. The Women's Alcohol and Drug Service at the Royal Women's Hospital, the State of Victoria's major provider of obstetric services to substance-dependent pregnant women, also regularly refers to the program. The program complies with the agency's Child Protection Reporting Policy, which reflects requirements of service providers specified in the *Children, Youth and Families Act 2005*.

The Mirror Families pilot program was delivered by a caseworker with qualifications in community development, and who came with extensive experience in family support and out-of-home care services.

Six families self-elected to participate in the pilot program, which operated for 18 months from the beginning of 2011. Five families were exiting Odyssey House Victoria's residential Therapeutic Community, where they had been resident with their children, and the sixth was referred to the program from the agency's Supported Accommodation program. Five

families were sole female-headed families; the sixth was headed by a sole-parent father. The gender bias was not unexpected: most children whose parents receive services from the alcohol and other drug sector live in sole-parent households, typically with their mothers (Gruenert et al., 2006; Jones, 2004). The sole-parent father was unable to be meaningfully engaged in the formation of a mirror family and the process was not pursued beyond initial assessment. Five women and a total of seven children participated in the program. Children's ages ranged from 2 to 12 years. All families were historically known to Child Protection. Two were involved with the service at the commencement of the program; of these, one case was closed following successful family reunification of the child, and the remaining family's case was closed and subsequently re-opened following a family violence incident.

As part of the Mirror Families program, the five women and their children received home visits, mostly on a weekly basis. Visits tended to be of two hours' duration, but could last up to several hours depending on each family's needs. Visits became less frequent as reliance on the informal network increased, reducing from weekly to fortnightly and finally to monthly until mothers considered they no longer needed the program. The women's participation in Mirror Families ranged from seven to 22 months, with an average of 14 months (median 7.5).

A number of criteria were important for admission to the program:

- the family self-identified as being isolated, dislocated or estranged from extended family and/or community networks;

- agreement was reached that work would focus on the needs of a child or children up to 13 years of age;

- the child was in parental care and the parent had the capacity to provide continuous care, or a reunification plan to parental care had been made;

- the parent or carer was committed to establishing and maintaining a mirror family for the child; and

- Mirror Families was assessed as being the most beneficial option for the child.

The aim was to reduce the likelihood of parental relapse and to break often intergenerational disconnection from extended family and community, while improving children's safety and wellbeing.

Unlike the original Mirror Families model (Brunner & O'Neill, 2009), the Odyssey House Victoria Mirror Families model did not use the terms A, B or C family to describe roles within networks. Some of the women participating in the program had experienced past removal of their children and found reference to an "alternative" family to be threatening. Instead, a "layered" level of support and connection was referred to, in which network members provided more or less support to the child and parent, depending on their role within the network. The process involved family progression through sequential stages, from relative isolation to engagement, development, connection and, ultimately, to sustainability.

After receiving a referral, a follow-up conversation was held with the referrer to establish appropriateness, following which the caseworker undertook the dual task of assessment and engagement. Engagement was the most important step in the process: this was where the client's investment in Mirror Families commenced, and in the intense dialogue, a working relationship developed. Timing was of the essence as the pace was set by the client's comfort with the process. After initial conversations, in which the family's "story" was elicited and respected, practice tools were administered, including:

- the genogram;

- the eco-map;

- the Norbeck Social Support Questionnaire (NSSQ) (Norbeck, Lindsey, & Carrieri, 1983); and

- the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997, 2001).

The genogram was used to obtain a historic picture of the individual child/family and the links across and between generations. The eco-map provided a graphic representation of the child and family's connection to other people and/or systems and located the individual and/or family in their current social context. The genogram and the eco-map were also used to explore the strength of relationships, whether relationships were conflicted or positive, and where there were gaps or areas of isolation or disconnection where resources needed to be

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augmented or strengthened. Additionally, the tools provided an invaluable foundation for often difficult, but necessary, conversations while building a supportive network. The NSSQ measured emotional and tangible support, as well as overall functional support, and network properties including network size, category of relationship (e.g., family, friends or professionals), the duration of relationships, and frequency of contact. Loss of support was also measured. The SDQ is a widely used measure of children's social and emotional wellbeing. The NSSQ and the SDQ, along with scoring instructions for each instrument, are available free online.

During development, the most intensive stage of the process, the caseworker facilitated the nexus between initial discoveries made during engagement and the establishment of relationships in the connection phase. As the relationship between caseworker and family developed, more information was made available. It became evident that some of the women participating in the program had experienced childhood trauma, including sexual abuse, and that it was therefore necessary to enlist support from beyond the family. As children's participation in social and recreational activities or family events was unlikely to occur or be maintained without support, parents were empowered to connect with significant others, to form new friendships and to engage more fully in civic life.

In the connection phase, the caseworker supported parents to rebuild relationships with "safe" family members, to reconnect with and to reactivate dormant, but formerly positive, friendships, as well as establishing connections with the wider community by recognising social settings that had possibilities for new links. The caseworker accompanied women as they ventured into the community, modelling appropriate social behaviours and demonstrating it was possible for them to overcome fears of stigma and rejection. As a result, mothers who previously avoided entering the school ground subsequently volunteered for children's reading groups in the classroom, while others attended recreational and sporting events with their children, activities they had not engaged in prior to the program. Throughout, the caseworker remained "in the background, valuing and affirming what others are doing" (Gilligan, 2006, p. 41). This "walking" alongside women also allowed for "understanding of risk" and intervention in the "everyday actions of practice" (Ferguson, 2010, p. 1101).

While still essential, at this stage the caseworker's role began to diminish. This was mostly a very positive time, with children and families forming connections and establishing reconnections; it did, however, elicit difficult emotions and realisations among some parents, who found creating an extended family heightened feelings of grief and loss regarding their own family-of-origin experiences. These issues were addressed through counselling as part of the program. As women came to understand the risks of social isolation, and the importance of obtaining support for parenting, they negotiated "back-up" from their B and C supports. Typically, this involved a phone call to organise a social event when mothers required emotional support or to request child-minding. Only one of the five women lapsed during the program. To ensure her child's safety and to hold herself "accountable" for her actions, the mother in question informed her network members, who were then able to provide timely and appropriate support.

At completion of the program, a further eco-map was constructed and the NSSQ and SDQ were re-administered. Results were compared with those from the assessment phase to assess any gains made during the program. Evaluation was an important step in the process, both for the specific family and for the program. A follow-up call was made to the family a few months after the last session. Evaluation

provided an opportunity for families to reflect on their experiences and achievements and to consider areas they may still have needed to work on. It also encouraged them to focus on the future for their child and family. Evaluation also assisted individual caseworkers to reflect on their practice, contributed to continuous program improvement and quality assurance, and provided information for administrative purposes, such as when reporting to funding bodies.

Reflections on implementation and considerations for further development or diffusion

Families needed a level of stability to fully benefit from the model. In some instances, intensive case management may need to be conducted prior to attempting a mirror family when serious problems or child maltreatment have been identified. There may be times during the process when suspension of the program may prove necessary due to illness, relapse, incarceration or other crisis, including family violence, which was the case for one family. In that instance, the process was suspended until the children's safety was ensured by temporary placement with extended family with whom the mother had reconnected during the Mirror Families program. If serious problems occur during the sustainability phase, the child and family should, ideally, be supported by a well-functioning social network. If the family is yet to perform the necessary functions of a safe mirror family, referrals may need to be made to other services, including child protection, until problems are addressed. When parenting capacity is compromised by acquired brain injury, mental illness or intellectual disability, promotion of children's safety and wellbeing may require more direct and frequent contact with network members and the caseworker, and when professional involvement in the mirror family has concluded, between network members.

Ideally, termination of practitioner involvement occurs when the caseworker and the family assess that the mirror family is safe, self-managing and sustainable. In some instances, mirror families may prove to be an inappropriate model for working with families; for example, when the child's safety and wellbeing is compromised and the family is unable to prioritise the child's needs. Scott (2009) noted that several key questions need to be answered prior to further replication or diffusion of any model:

- Is it effective?

- How is it effective?
- Is it cost-effective?
- Is it sustainable?
- Is it transferable?

In regard to efficacy, all children in the program were safely in maternal care at the end of the intervention. Efficacy was largely due to empowering mothers to improve naturally occurring networks by developing a more sophisticated understanding of networks and their risks and resources. Together with the caseworker, mothers considered the risks associated with the presence of substance users or family members, friends and partners who had perpetrated abuse, and identified individuals able to provide instrumental and/or tangible support. New relationships were forged as mothers gained confidence in approaching other parents at their children's schools and community groups, and dormant, but safe, relationships were reactivated. Increased network involvement improved risk and protective factors for children: children, and their home environments, became more visible to a larger number of protective adults while their mothers simultaneously received assistance with child care—key factors in prevention of child maltreatment (Dubowitz & Bennett, 2007; Seng & Prinz, 2008).

Children's own networks also improved. Social contacts, including friendships with peers, increased as they participated in more social and recreational activities, with and without their parents' presence.

The program was formally evaluated, and results based on the NSSQ and the SDQ at baseline and after twelve months of intervention, together with qualitative data from interviews with participating mothers, are being prepared for publication.[1]

Building and sustaining informal social networks required the development of trust between caseworker and families, which was time-consuming and consequently expensive. The model also required a highly experienced caseworker who was able to identify when clients were receptive to "teachable moments" and was open to having difficult conversations, including on parental drug use and its effects on children. Despite the expense, the potential for improved outcomes for children, the reduction in child protection investigation and intervention, including use of the Children's Court, and the prevention of avoidable placement in out-of-home care, make Mirror Families a worthwhile model for further development and implementation.

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The naturally occurring networks with which Mirror Families works are more likely to be sustained than constructed social support, such as attendance at groups for socially isolated parents. The Mirror Families model has been integrated with practice in the Kids in Focus program, and staff members deliver training on network intervention to other service providers to facilitate practice change.

Mirror Families may prove particularly useful as an after-care component for families exiting residential alcohol and other drug treatment services or at the conclusion of intensive family preservation or other family support programs. The model is also likely to sit well with Indigenous Australian families. Elders can be respectfully involved and acknowledged as being pivotal for children's wellbeing and to their connection to culture. Mirror Families could be used with newly arrived and refugee groups to build social networks for parents and children.

The model may also prove highly beneficial in a range of practice settings beyond child welfare. For example, positive family social support is associated with a reduction in recidivism in the resettlement of offenders with mental illness and substance use problems (Spjeldnes, Jung, Maguire, & Yamatani, 2012). Mirror Families could also help to avoid premature or unnecessary placement of disabled or elderly people in institutional care.

More rigorous testing of the model will need to be conducted to determine if it is effective and financially feasible prior to further disseminating and transplanting the program (Scott, 2005, as cited in Salveron, Arney, & Scott, 2006). This is particularly important considering that all women who received the program were referred from within the same agency.

Conclusion

The public health approach to child protection provides a foundation for prevention and early intervention efforts (for an in-depth discussion, see Higgins & Katz, 2008). Yet, stemming the flow of children entering the tertiary child protection and out-of-home care system remains a stubborn challenge. Clearly, "a different type of engagement between frontline caseworkers and the children and families who come into contact with the child protection/ child welfare systems" is needed (Higgins & Katz, 2008, p. 49).

The Mirror Families program helps shift child protection closer to a community-building approach by working directly with vulnerable families alongside "natural or potential allies of the child and parent in their everyday domains" (Gilligan, 2006, p. 43). The highlight of the program was the self-construction of positive informal networks and integration into the community by formerly socially isolated women, and the benefits this conferred for their children. The low point was the need to suspend the program with one family following an incident of intimate partner violence and placement of the children with extended family. However, even if removal of children from parental care, either temporarily or permanently, is ultimately warranted, the model provides some continuity of relationships, the importance of which cannot be understated.

Endnotes

1 Please contact the first author for publications details.

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The highlight of the program was the self-construction of positive informal networks and integration into the community by formerly socially isolated women, and the benefits this conferred for their children.