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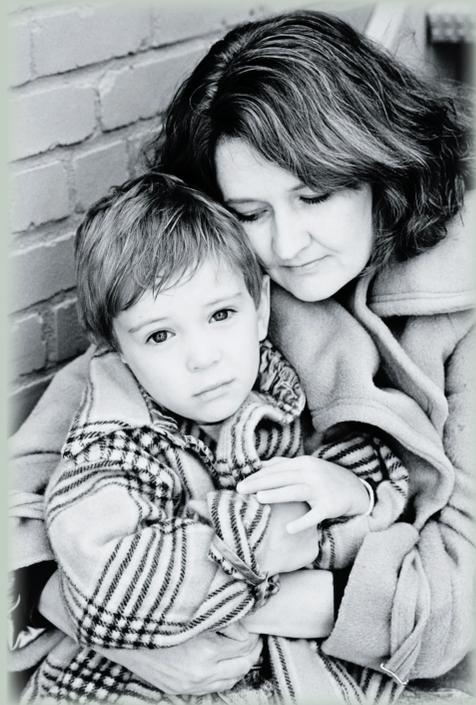
Family Members with Overlapping Mental Health Needs Require the Transformation of Systems and Services

Joanne Nicholson, Ph.D., Kathleen Biebel, Ph.D., Betsy Hinden, Ph.D., Valerie Williams, M.A., M.S., and Bernice Fernandes, B.A. with Judith Katz-Leavy, M.Ed.

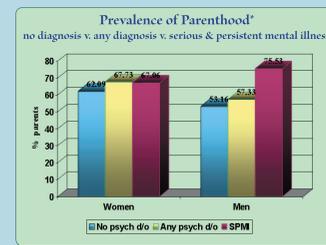
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How many parents with mental illness are there?

millions



Women and men with a lifetime prevalence of psychiatric disorder are at least as likely to be parents as are adults without psychiatric disorder.



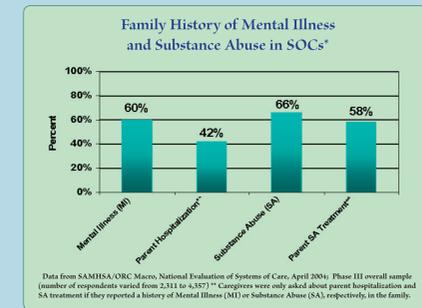
*National Comorbidity Survey (e.g., Kessler et al., 1997)
 • Nationally representative sample of U.S.
 • Prevalence, incidence and risk factor study
 • Administered between 9/90 and 9/92
 • Research diagnostic interview (DSM-III-R)
 • 8,098 non-institutionalized civilian respondents age 15-54 in Part I; 5,877 in Part II

The majority of adults in all diagnostic categories are parents, including those meeting criteria for affective and anxiety disorders, PTSD, and non-affective psychosis

(Nicholson et al., 2004)

Children with Serious Emotional Disturbance (SED) receiving services in Systems of Care (SOCs) programs may have multiple family risk factors.

Secondary analyses of the SOC National Evaluation Data collected and managed by ORC Macro, Atlanta, Georgia, with thanks to Wayne Holden, Ph.D., and Brigette Manteuffel, Ph.D. (Hinden, et al., in progress)



Data from SAMHSA/ORC Macro, National Evaluation of Systems of Care, April 2004. Phase III overall sample (number of respondents varied from 2,311 to 4,357)* Caregivers were only asked about parent hospitalization and SA treatment if they reported a history of Mental Illness (MI) or Substance Abuse (SA), respectively, in the family.

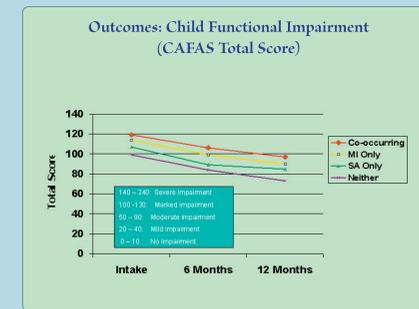
Family Risk Factor Study Groups

- **Neither:** no family history of MI or SA (N= 1,359)
- **MI only:** family history of MI; no SA (N=859)
- **SA only:** family history of SA; no MI (N=1,147)
- **Co-occurring:** family history of both MI & SA (N=2,088)

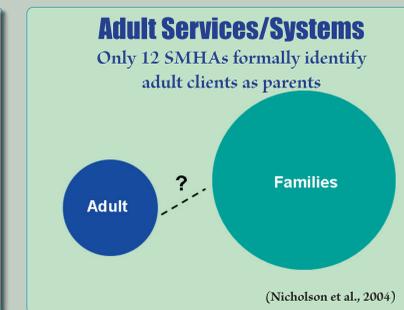
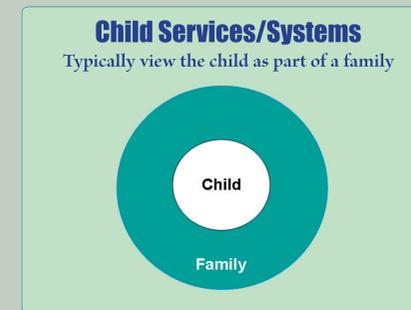
Children with SED in SOCs with more family risk factors function less well at enrollment and, though they do make improvements, do not achieve the levels of functioning of children with fewer risk factors at 12 months.

Within the group of children with SED whose parents have co-occurring psychiatric and substance use disorders:

- 30% report child physical abuse
- 25% report child sexual abuse
- 68% report domestic violence
- 31% of parents have been found guilty of a crime



Family-centered, strengths-based practices require a paradigm shift in the way administrators and providers view and intervene with children and adults.



Developing the Evidence Base: What "works" for these families? Innovative Programs for Parents with Mental Illness and their Families

UMMS Site Visit Project (2001)

- Invisible Children's Program: Goshen, NY
- Emerson Davis Center: Brooklyn, NY
- Children & Parents Together: Commack, NY
- Family Support Services: Iowa City, IA
- San Francisco General Hospital Programs
- Women's Inpatient Unit
- Outpatient OB-Psych Clinic
- Infant-Parent Program

Common Core Program Components Identified:

- Family case management
 - Comprehensive array of services
 - Coordination of multiple services
 - Communication among providers
- Parenting skills, parent-child relationship, education re: child development
- 24-hr. crisis intervention & support services
- Flexible funds to meet unique needs

What contributes to change? Key Program Ingredients:

- Family-centered:
 - integration of adult and child services
 - interagency collaboration
 - funding to meet family's needs
- Strengths-based:
 - non-judgmental approach
 - support of positive adult role model
 - trusting provider-family relationship
- Trauma-sensitive: safe, dependable (Hinden et al., in press)

Systems & Services Transformation Require:

- True "family-centered" care that recognizes the strengths, needs & goals of both parents & children.
- Integration/collaboration of adult & child systems & providers (and development of mechanisms to support this) both within mental health & across service sectors, e.g., child welfare, public health.
- Cross-training of providers re: experiences, needs & goals of family members with multi-generational issues, especially re: co-occurring disorders & the impact of trauma on families.
- Technical assistance to programs & providers regarding state-of-the-science models for addressing the needs of both parents & children.
- Funding mechanisms consistent with family needs & co-occurring disorders.
 - Flex funds to insure service access across child & adult sectors.
 - Expansion of public & private insurance to cover co-occurring disorders.

What Administrators & Policy Makers Can Do:

- Review routine policies & practices
- Consider eligibility & reimbursement requirements
- Review contract language & performance criteria
- Identify & support existing resources, e.g., exemplary programs, providers
- Support prevention efforts & the development of resiliency, i.e., mental health over the life span
- Build & nurture relationships with traditional & new partners, e.g., primary care, early intervention
- Identify, designate, & support "champions" within & outside the agency
- Partner with parents & families

Why are we committed to this topic?

- Parenthood is prevalent among adults with mental illness.
- Parenting is a meaningful life role.
- If parents do better, children do better.
- Effective treatment & rehabilitation strategies exist for mental illness.
- There are opportunities for prevention, & the promotion of resilience.
- Inattention or inappropriate attention has negative and, at worst, life-threatening consequences for children and parents.

How many children have parents with mental illness?

many millions



"My children give me strength, they give me hope, they give me the will to survive..."

a mother with mental illness

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Visit our web site: www.parentingwell.org