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Toward a Family-Centered Approach: Families Coping with Parental Mental Illness

Family-centered approaches have emerged from the child mental health arena. The family-centered model stems from the recognition that children and adults live and function in families and that children are best served when their families are supported. Historically, there has been much silence about the parenting role among adults with mental illness. Traditional mental health services have largely ignored this central reality in the lives of adult clients who are parents and their children. As issues of parenting are typically not included in mental health service planning, the needs of parents with mental illness and their children remain unknown and/or unaddressed.

Families impacted by mental illness may be best supported by family-centered approaches. While parents and children live together in families, mental health systems typically focus only on an “identified client” and serve adults and children in separate systems. This often results in fragmented and/or inadequate services. That is, traditional, categorical services result in a lack of parenting support within the adult mental health system and a lack of services in the child welfare system for parents who do not abuse their children. A family-centered strategy allows adults with mental illness to work on their mental health, the health and well being of their children, and their health as a family.

Parental mental illness is a reality for millions of adults. Individuals with mental illness become pregnant and bear children at rates similar to those of the general population (Apfel & Handel, 1993). While most state mental health systems are unaware of the parental status of their clients, this “invisible” population of men and women makes up a growing portion of persons receiving mental health services (Nicholson, Geller, Fisher, & Dion, 1993; Nicholson, Nason, Calabresi, & Yando, 1999). Parents with mental illness are often assumed to be incapable of caring for their children simply because of their mental illness. Family members and providers may perpetuate this stigma by discouraging adults with mental illness from having intimate relationships and bearing children (Nicholson, Sweeney & Geller, 1998).

Stigma is a significant barrier to service utilization for parents with mental illness. In many states, the diagnosis of mental illness alone justifies the removal of children from their parents’ care and the termination of parental rights. High proportions of parents with psychiatric disabilities lose custody of their children (Mowbray, Oyserman, Zemenchuk, & Ross, 1995). However, there is no research indicating the percentage of parents diagnosed with serious psychiatric disorders who are abusive or neglectful of their children.

The challenges faced by parents with mental illness are, in many ways, not unique to having a mental illness—they are the challenges of parenting. Like any other parents, parents with mental illness worry about having health care, managing their money, finding child care, managing children’s behavior, and having safe and adequate housing. Parents also have concerns that are specific to living with mental illness. Parents think about how their medication effects their ability to parent, worry about how to manage hospitalizations and child care, and wonder about ways to communicate with their children about their illnesses.

A 1999 survey of State Mental Health Authorities (SMHAs) (Nicholson, Biebel, Hinden, & Henry, 1999) found that most states do not recognize or respond to their mental health clients’ role as parents. Less than 25% of SMHAs ask if their clients are parents, while only 8% have policies specific to parents with mental illness (e.g., visitation policies in hospitals). Case-

managed adult clients’ services are somewhat integrated with children’s services, with 65% of SMHAs providing co-location of adult and children’s services, while 45% facilitate flexible funding between the adult and children’s systems. When coordination occurs with outside agencies, it frequently involves the Child Welfare and/or Education/Early Intervention systems.

Research on parents with mental illness grew out of an interest in examining the risks for psychiatric problems among the children of these parents. Numerous cross-sectional and longitudinal studies have examined the impact of parental mental illness on child adjustment (Canino, Bird, Rubio-Stipec, Bravo & Alegria, 1990; Rutter & Quinton, 1984). The findings across these studies offer two truths: (1) Children of parents with a mental illness are at greater risk for a variety of emotional and behavioral problems than children whose parents do not have mental illness (Weissman, Warner, Wickramaratne, Moreau, & Olfson, 1997) and (2) many (30% to 50%) of these children do just fine (Masten, Best, & Garmezy, 1990). Thus, although parental mental illness is a risk factor, it does not *necessarily* predict poor outcomes.

Studies have revealed that child outcomes are related to multiple factors. These factors include illness characteristics, such as severity and chronicity; parenting factors, such as emotional responsiveness; family factors, such as communication; environmental factors, such as stress and support; and child factors, such as temperament and coping (Downey & Coyne, 1990; Seifer et al., 1996). In addition, the relationship between parental mental illness and child outcomes is bi-directional. Parents impact children, and children impact parents. A child’s temperament or behavior can influence certain parenting behaviors, which in turn impact the child (Hammen, Burge, & Satasbury, 1990). Finally, there is some evidence that family outcomes can be improved by supporting both parents and children (Beardslee et al., 1997).

What services are available for families in which a parent has a mental illness? A recent national (United States) survey of program directors conducted by Nicholson and colleagues (Nicholson, Hinden, Biebel, & Henry, 1999), indicated that there were approximately 65 programs working with parents with a

mental illness. Many of these programs, however, were not designed specifically for families impacted by parent mental illness but were programs designed for other groups (e.g., at-risk children, adults with mental illness) in which families with parental mental illness participated. Approximately 25 programs were identified as having “high-specificity” and had designed programs intended to serve this defined population.

Programs for families in which a parent has a mental illness were characterized as much by their differences as their similarities. All programs emphasized empowerment of parents to manage their own lives and focused on parenting and parenting skills with respect to child development. However, programs varied greatly in regard to what services were provided, the modality of service provision (e.g., case management vs. home-based therapy), theoretical orientation, and funding sources. For example, programs across the country reflected a range of comprehensiveness and intensity of services and supports. Several programs emphasized case-management models with a focus on coordinating an array of services and supports, including housing. Other programs provided a single service, such as dyadic parent-child therapy or parent support groups. Programs also reflected a range of orientations including traditional clinical approaches, adult rehabilitation models, and family-centered approaches. Some programs focused primarily on child development and offered specialized child services, such as a therapeutic nursery. Many programs combined approaches, and reports from the highest-specificity programs indicated that flexibility and

eclecticism were necessary to meet the multiple and diverse needs of these families.

Respondents to the survey uniformly reported that their programs and services benefited the families with whom they worked. Satisfaction surveys reflect high levels of satisfaction across programs. However, very few programs had any formal evaluation data with respect to measurable outcomes for parents or children. Program staff identified numerous barriers to building effective programs and providing services. Among the greatest of these barriers were the stigma surrounding the role of parenting among adults with mental illness and the difficulty in gaining reliable funding from categorical service systems that define parenting as a child welfare and not as a mental health issue and that are designed to serve adults and children separately.

Adult mental health systems appear to need to “catch up” to children’s mental health, which long ago realized that adults and children live and function in families. Family-centered approaches developed within children’s mental health that support and empower parents to parent as best as they can appear particularly well-suited to the needs of families in which a parent has a mental illness. It is clear that the needs of families with parental mental illness cannot be served by fragmented and categorized adult mental health and child welfare systems. These systems will only be able to serve those that they are mandated to serve by moving away from rigid, individual-based systems to family-centered, strengths-based values and practices.

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