

Family Options: Supporting Parents with Mental Illness and their Children

The heat rushed out around the loose windows in Ann's sparse, but immaculately kept apartment. February's heating bill would be more than her disability check, and her phone had been disconnected for a month. Her depression and anxiety prevented her from getting to the grocery store without a companion. She was preoccupied by her 12-year-old son, Billy, who had recently transitioned to day school from his residential program, but was missing a lot of school and getting suspended. Years before, when Ann's illness was severe and there was domestic violence in the home, Ann's two other children had been placed in foster care. These experiences left Ann distrustful and intensely fearful that Billy would also have to go away. With all of these stressors present in her life, Ann found it very hard to talk at meetings with the service providers. Billy's therapist felt ineffective, and when wraparound and intensive, home-based services were attempted, the team reported that Billy would not engage and that Ann did not seem to be able to learn new parenting strategies.

Parents with Mental Illness

Like other parents, parents in re-



covery from mental illness report that the parenting role is a primary and positive life role, and that they want to be the best parents they can be. They express the same joys and concerns about parenting and their children as parents without psychiatric diagnoses.³ Families in which parents have mental illness are often the same families in which children have severe emotional or behavioral challenges. These families represent a substantial subgroup of families participating in children's systems of care, and tend to have poorer child functioning and

greater caregiver strain at intake, and over time.^{1,2}

Many forms of intensive support, such as home-based services and wraparound, are predicated on active parent involvement. Active parenting is particularly difficult for parents struggling with psychiatric symptoms and the social and environmental conditions (e.g., stigma and poverty) that accompany mental illness. Effective service delivery for these families requires modification and enhancement of currently existing wraparound processes to reflect and respond to these families' unique experiences and complex needs. The *Family Options* program is an innovative effort to fill this gap and to advocate for systems change with respect to the needs of parents with mental illness and their children.

Family Options

Family Options is founded upon the belief that recovery from mental illness is a family process, and that parenting and family relationships are a critical part of recovery. *Fam-*

ily Options is organized in accordance with two mutually reinforcing mental health care delivery approaches: one typically used with adults, and one used with children and their families. The first approach, psychiatric rehabilitation, is a strength-based, recovery-focused approach that emphasizes empowerment of adults with mental illness to manage life tasks successfully through resource and skills development.⁴ The second approach, wraparound, is a conceptually allied approach used with children and their families. This blending of models with parallel values and principles from child and adult service sectors allows *Family Options* to provide effective strengths- and community-based care that identifies and responds to the needs of parents who are recovering from mental illness, and to the needs of their children.

Families, Staffing and Components

Referrals to *Family Options* come from both the child- and adult-focused service sectors, with the majority from child welfare. Parents report a range of primary diagnoses, with 69% reporting a history of trauma co-existing with other psychiatric diagnoses. A family is eligible for the program if the parent has a diagnosis of major mental illness, is receiving mental health treatment, and has a child between the ages of 18 months and 17 years living at home. Fifty-six percent of the children involved with *Family Options* meet criteria for a range of mental health diagnoses, and 58% are involved with special education services. Seventy-five percent of the children have Medicaid as their primary health insurance.

Family Options is currently staffed by a director with extensive wraparound experience; three family coaches, each of whom works with a maximum of eight families at a time; a parent peer coordinator; and a consulting research and clinical psychologist. *Family Options* has developed a model in which the family coach has three central functions: 1) to identify and prioritize, with the parent, the needs and strengths of each family member; 2) to work with the parent



to build a trusting partnership that supports learning and skill-building related to identified family strengths, needs, and recovery goals; and 3) to provide a wraparound team process that is enhanced by the parent–family coach relationship and by procedural modifications that provide a safe, manageable, and highly supported role for the parent. *Family Options* also has a 24-hour, 7-day-a-week support line; a parent support group; and flexible funding to support activities essential to successful outcomes for each family.

Family Coaching

Parents recovering from mental illness often feel deeply betrayed by and suspicious of providers, and this is particularly true for parents for whom child custody loss is, or has been, a threat. To overcome this distrust, the family coach meets weekly with the parent to focus on parent-driven learning, behavioral modeling, direct support, and skill-building experiences. Trust and partnership develop as parents and children learn that they can rely on their coach to be available when needed—to listen, to respond, and to support. Sometimes the coach responds by “doing for” families, but more often the coach helps families develop strategies and skills, or supports them to make connections to community resources so they can “do for themselves.”

Initially, Ann’s family coach needed to understand and respond to Ann’s anxiety about paying utility bills and rent, going to the supermarket, and getting Billy off to school. This required the coach to access flexible funds, accompany Ann to the market, and provide last-minute transportation on school mornings. As the partnership developed, Ann was able to work with her coach on longer-term, sustaining goals, such as finding affordable housing and finding ways for Ann to get Billy off to school without outside help.

Family Teams

In order to be effective with this population, the *Family Options* program has modified the “traditional” wraparound team planning process. While preserving wraparound’s commitment to a strengths-based, need-focused, parent-driven, collaborative team process, the *Family Options* model requires that coaches have additional areas of knowledge and skill. Parents with mental illness are often socially and personally isolated due to their histories and mental functioning, as well as social stigmatization and the system’s unresponsiveness. The coach’s efforts to establish a trusting partnership—through supportive, parent-driven learning and skill building—creates a critical bridge for the parent’s participation in the family team process. In addition

to doing careful team preparation and debriefing with the parent, the family coach must be knowledgeable about the process of recovery, understand and support the symptomatic and environmental challenges that can compromise parenting in general and parent participation on the team in particular, address the real life needs of the parent and her children, and structure the meetings to maximize parent participation.

Another modification includes the family coach's role in educating team members about mental illness and its relationship to parenting, and advocating for strengths-based strategies that appreciate and respond to these needs. In spite of the need to overcome Ann's distrust of Billy's school, her coach was unsuccessful in getting the school to understand and respond differently to Ann's trauma-based trust issues. Instead, Ann and the family coach worked with the local school district to transfer Billy to a different school where the staff was able to engage Ann, and this resulted in her agreement to bring the school into the team process.

In addition, for families affected by mental illness, family teams must have the capacity to give equal focus to the needs of parent and child recovery. Family coaches must, therefore, work to engage both the adult's and the child's formal and informal resources in the team process. Family coaches' access to adult team resources is facilitated by *Family Options'* location in an adult clubhouse, a self-help program in which staff and members who have a mental illness work collaboratively to achieve members' employment, educational, housing, and social goals.

Transition Planning

Since recovery for both parent and child is not a linear process, *Family Options* provides careful post-program transition planning. Acknowledging the mutual importance of the parent-family coach relationship, and recognizing and celebrating the skills and accomplishments of the parents and children, are important transition activities. As Ann remarked, for a long time there were only two people she

could talk to: her coach and God.

Secure housing, public sector case management, effective treatment, and strengthened informal supports have been some of the important components of transition planning. Ann's and Billy's transition planning will focus on solidifying the relationship between parent and school, and securing affordable, safe housing and effective mental health treatment. *Family Options* offers post-program supports that can include continued participation in the parents' group and less intensive access to family coaching.

Families in which parents have a mental illness and children experience emotional or behavioral difficulties/disorders pose challenges to children's systems of care, requiring modification and enhancement of service delivery processes to meet their complex needs. *Family Options* advocates for systemic expansion of programming for this population and for the re-alignment of child and adult mental health services to reflect a family recovery approach to care delivery.

References

1. Center for Mental Health Services. (2003). *The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation findings—Annual Report to Congress, 2002–2003*. Atlanta, GA: ORC Macro.
2. Hinden, B. R., Nicholson, J., Williams, V., Fernandes, B., & Banks, S. (2005). *Supporting all families in systems of care: Examination of families with a history of mental illness and substance abuse*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
3. Nicholson, J., Sweeney, E. M., & Geller, J. L. (1998). Mothers with mental illness: The competing demands of parenting and living with mental illness. *Psychiatric Services, 49*, 635-642.
4. Salzer, M. (Ed.) (2006). *Psychiatric rehabilitation skills in practice: A CPRP preparation and skills workbook*. Columbia, MD: United States Psychiatric Rehabilitation Association.

Authors

Betsy Hinden is Program Consultant for *Family Options*.

Chip Wilder is Director of *Family Options*.

