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BC Partners for
Mental Health and
Addictions Information
EMPOWERMENT THROUGH INFORMATION

BC's Mental Health & Addictions Journal Visions

Parenting

artist: Annie Wilkinson

background

experiences & perspectives

alternatives & approaches

bc partners | Seven provincial mental health and addictions agencies are working together in a collective known as the BC Partners for Mental Health and Addictions Information. We represent the Anxiety Disorders Association of BC, Awareness and Networking around Disordered Eating, British Columbia Schizophrenia Society, Canadian Mental Health Association's BC Division, FORCE Society for Kids' Mental Health Care, the Kaiser Foundation and the Mood Disorders Association of BC. Our reason for coming together is that we recognize that a number of groups need to have access to accurate, standard and timely information on mental health, mental disorders and addictions, including information on evidence-based services, supports and self-management.

visions | Published quarterly, *Visions* is a nationally award-winning journal which provides a forum for the voices of people living with a mental disorder or substance use problem, their family and friends, and service providers in BC. *Visions* is written by and for people who have used mental health or addictions services (also known as consumers), family and friends, mental health and addictions service providers, providers from various other sectors, and leaders and decision-makers in the field. It creates a place where many perspectives on mental health and addictions issues can be heard. To that end, we invite readers' comments and concerns regarding the articles and opinions expressed in this journal.

regional programs

editor's message

A public education campaign in the UK is called "Every Family in the Land." The message carried in the title is that mental disorders affect *all* of our families in one way or another. One of the most direct ways this can happen is when a parent has a mental disorder, where the impacts are felt not just by the parent her or himself, but by the extended family, the spouse, and by the offspring.

There's a growing awareness that parental mental illness – the scope of this issue of *Visions* – is fairly common. People with mental illness want to parent, and *do* parent, at about the same rate as the general population; with the right kind of support, they make good parents. As Dr. Rob Lees points out in his guest editorial, we've come a long way from the time when mandatory sterilization was government policy, to when child removal was commonplace, to the more progressive approaches that are starting to spring up in various places today.

To reflect this progress, we're very fortunate to have contributions from some of the international leaders in the field, such as Joanne Nicholson of the US, and Vicki Cowling from Australia, who outline some of the 'best practices' that are developing in their countries. One thing common to the *best* of these approaches is that they are based on a thorough understanding of the experience of parents and offspring – many of whom are grassroots leaders themselves, and whose stories of struggle and recovery appear in this issue of *Visions*.

As we put together this issue on parental mental illness, we realized that we in BC are not alone. In many countries throughout the world, a group of advocates – including community advocates and concerned professionals – have been working hard to make things better for parents with mental illness and for their offspring of all ages. We also realized that this work – produced literally 'off the side of the desk,' or off the side of the kitchen table – has translated into all sorts of programs, resources and information – and also into growing societal awareness of what can be done.

It's no exaggeration to say that taken together, all of these various efforts represent a worldwide *movement* to improve the lives of parents with mental illness and their families: a movement from the side of the desk to centre stage.

Eric Macnaughton

The BC Partners are grateful to the Provincial Health Services Auhority for providing financial support for the production of Visions

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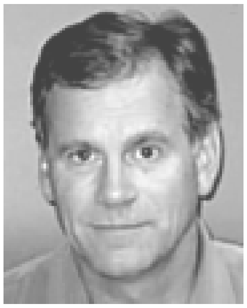
We've Come a Way, But Not Far Enough

Supporting families with parental mental illness

Dr. Rob Lees, RPsyc



Dr. Lees, a registered psychologist, is the Mental Health Service Quality Analyst for Fraser Region, Ministry of Children and Family Development. Rob has served on the provincial working group on families with mental illness for over five years and was involved in developing Kids in Control, a psycho-educational group for children whose parents have mental illness. He is also an instructor for the graduate program in counselling psychology at Trinity Western University where he teaches marriage and family therapy

There was a time when people with mental illness were considered lunatics. Although we may think of this as ancient history, within my lifetime we have come from seeing mental illness only being depicted in the setting of huge institutions in movies like *One Flew Over the Cuckoos' Nest,* to an appreciation that mental illness lives among us in many forms. Think for example of Jack Nicholson's portrayal of a reclusive sufferer of obsessive-compulsive disorder in *As Good As It Gets*.

Friends and colleagues in child protection tell me there was a time when a parent's mental illness would mean automatic removal of the children. In a recent survey I conducted of child protection staff, they expressed unanimous desire to understand how to avoid removal and support parents in their fulfillment of their parenting obligation. Between 1940 and 1960, people with mental illness were sterilized because it was believed that they should not be able to generate offspring.

> A good part of the distance has to do with how we think about mental illness and how we've moved from seeing mental illness as something that is 'within' an individual to viewing it as something that affects the whole family.

In 2001, the government of BC through its Ministries of Health and Children and Family Development (MCFD) and other social agencies published *Supporting Families with Parental Mental Illness*, a manual built on the assumption that persons with mental illness can parent if the necessary supports are in place.[1] As we'll see later in this edition of *Visions*, the manual is a guide to community planning, offering basic information on mental illness and material aimed at fostering dialogue about the experience of parental illness from both the parent and offspring perspective. In addition, there is information on how to do 'advanced planning' for specific families, and a self-assessment checklist that communities can use to set goals in relation to their sensitivity and response to this issue. That's a good distance to have come.

A good part of the distance has to do with how we think about mental illness and how we've moved from seeing mental illness as something that is 'within' an individual to viewing it as something that affects the whole family. As an instructor in a graduate program teaching marriage and family therapy, I find it difficult to convey to fresh, young helpers how revolutionary this is. To them, it just makes sense. But if it makes so much sense, why is it so hard to do? Why doesn't it happen more often?

The story of families and mental illness is contained within the broader cultural story of the development of our modern institutions. In many ways, these modern institutions – for dealing with crime as well as mental illness – took responsibility away from families and communities and rested it with the state (i.e., the government). The state, however, with its equalizing potential can never rival the altruism and care found in close communities and families. Slowly we are learning the function the state can play while allowing communities and families to fulfill the roles they play best in addressing social problems.

While the family role was partly sidelined by institutions, the family was also seen as part of the problem by researchers. Perhaps a special opposition was spawned in the treatment of mental illness when early family therapists were associated with 'blaming' families for causing mental illness. For example, the schizophrenia research of Gregory Bateson in the 1950s sought a connection between family communication and mental illness. Then of course, studies in other jurisdictions and locally have demonstrated that the majority of parents with serious, persistent mental illness have had their children placed in foster care at some time. The separation of offspring from their parents with mental illness has been the ultimate reflection of past approaches that sought to separate the person with mental illness from their family unit, and saw a parent with mental illness always as 'a problem.' The gulf between the individual illness perspective and the family-centred view has done much harm to the natural aspirations of persons with mental illness to parent effectively.

Concerns of parents

When you speak with parents with a mental illness, you quickly learn how desperately they want to fulfill their roles as parents. Similar to any other ill parents, they are beset by a 'false guilt' because of the limitations imposed by their illness. Then there is the extra stigma associated with *mental* illness. If it was cancer or multiple sclerosis, the parent could count on societal sympathy. This isn't the case when a mental illness prevents someone from fulfilling their parenting as they would wish. In a qualitative study of mothers with mental illness, one wrote: "Thank you very much for letting me participate in this survey. It has helped me lose some of the shame and guilt I carry for being ill and at times unable to cope."[2]

There is great promise in initiatives that bring together all of those involved – professionals and parents, community resources and neighbours – to build a community of care around a family with parental mental illness. When they meet regularly enough they begin to anticipate problems, building in the necessary supports for both parents and children. Astute caregivers and neighbours can then know when the family system requires intervention because the parent's illness is flaring up. Preplanning helps them know what to do, with the 'ill' parent contributing and directing this process when they are well.

While initiatives such as this – which in their various forms are known as advanced planning, representation agreements (Ulysses type-agreements), and collaborative integrated case management (ICM) – have helped some parents to feel dignified and supported in their roles as parents, these practices are not widely available.[3] Further, where they are, there is often a slippage in treatment integrity, so that the interventions are not implemented as effectively as they should be. Past evidence suggests that parents coping with mental illness, besides having their symptoms to manage, must also contend with stigma, self blame, and the pronounced fear of losing contact with their children if others are let into their family lives. They do not tend to see agents of the government as friendly or sharing their goals. This promotes secrecy, aggravates isolation, and worsens other harmful family dynamics.

Concerns of protection workers

I recently surveyed child protection social workers in BC's Fraser Region MCFD and learned that many agonize over the needs of families with parental mental illness. Although sometimes seen as being overly focused on needs of the child, this group (and clearly those in our survey) struggles to view the problem systemically and from a family focus. Child protection workers in their written responses reported they want to support the bonds between parent and child. Yet they fear harmful effects on children left in the care of a sick parent. They are acutely aware of problems with medication compliance and the variable nature of the mental illnesses. They want to understand the impacts of illness on the short and long term functioning of family and child outcomes. They consistently mentioned their desire for greater collaboration with mental health professions to assist them in playing an informed role with families. They are often frustrated by the issue of confidentiality and the limited communication they receive from the adult mental health system.

As one wrote: "We are hardly ever called by mental health professionals." Protection workers are aware of the suffering of both parent and child, but often don't know how to build trust with families to reduce the fears about apprehension. A respondent wrote: "I have never received a call from the child of a mentally ill client (because) the children have always lived with the mentally ill parents, so do not find the corresponding behaviour of the unstable, out of the ordinary."

Not only do they want more education on mental illness, but they wish the mental health system was better educated about child welfare. They want to know which psychotropic medications can be sold on the street, and what is the course of bipolar disorder and borderline personality compared to schizophrenia. They don't want to make life-changing decisions for families without the best information and the support of that family's community. They want adult mental health professionals to place the same priority on ICM as they do.

Concerns of offspring

Although stories of offspring vary, they are often filled with a feeling of loss. Small wonder they have been called "the invisible children."[4] One adult told me that the most powerful memory of his childhood was seeing his mother taken from the home when he was a little boy by men in white coats. The feeling of destitution and helplessness has haunted him since. There was no one there to comfort or explain.

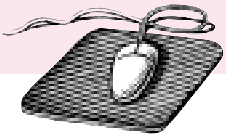
Things are beginning to change for offspring of parents with mental illness. As described later on in this issue, Kids in Control, a psychoeducational program for children sponsored by the BC Schizophrenia Society, equips kids with correct information and the experience of knowing they are not alone. Other psychoeducational programs with whole families have shown some success. 'Adult survivor' groups are another promising initiative that can help offspring heal later in life. Unfortunately, to date these initiatives are mostly small-scale and isolated from each other.

The adult mental health system

The introduction of new psychotropic medications and initiatives such as those around early interventions for psychotic illnesses (i.e. schizophrenia, bipolar illness) have instilled a new air of hope. A better understanding of the prevalence and long-term impacts of depression and anxiety have brought mental illness towards the mainstream. Women's health initiatives have highlighted the importance of parenting among women with mental illness. Natural partnerships with prenatal carers have fostered a focus on the role of patients who parent. There is a growing awareness that much of mental illness, or its effects, can be mitigated. A recent

web resource

The *Supporting Families with Parental Mental Illness: A Community Education and Development Workshop* is available online at www.mcf.gov.bc.ca/mental_health/mh_publications/



The Experiences of Parents with Mental Illness

Background issues for consideration

Adapted from the Supporting Families with Parental Mental Illness Manual, Chapter Two: "The Experience of Parents"

Parenting is an important life role that is valued highly by most people in our society, and people with mental illness are no exception. Not surprisingly, they are also highly motivated to become parents, and as shown by one recent study done at the University of Massachusetts, people with mental illness do parent at the same rate as the general population.

Having a serious mental illness – as with any other serious illness – impacts the ability to parent, but does not prevent a person from doing so. With the right kind of support, people with mental illness can be good parents. The following article provides some background as to the kinds of issues that should be addressed when considering the support needs of a parent with mental illness. ▶

We've Come a Long Way | *continued from previous page*

article in the American Psychological Association's journal, *Prevention & Treatment,* declared, "Treatment is not Enough: We Must Prevent Major Depression in Women." Exemplary demonstration projects such as The Invisible Children's Project in Upper New York State indicate the value of family-focused case management. Treatment of eating disorders, with its strong multi-factored approach, has brought the family to greater prominence in the treatment of mental disorders.

Unfortunately, the mental health system continues to remain the poor cousin among health services. In many places, medical and psychosocial models remain in tension. Trained family therapists are seldom employed in the formal mental health service. This is despite a growing evidence base for relationship therapies (e.g. interpersonal therapy) as a robust treatment for depression, particularly with women. My survey of child protection workers reflects the ongoing gap between health and social service providers. Issues such as confidentiality continue to be a barrier to expanded integrated care. As well, communicating takes time, a precious resource in a system with limited capacity.

Public policy considerations

Policy makers need to truly understand that at least two thirds of persons with psychiatric illness will be parents[5] and that the costs to children, parents and the mental health system of not addressing their need from a systemic and family-oriented perspective are enormous. A major problem has been the practice of funding programs based on individual, not family needs.

There are promising initiatives such as the training and community building through the *Supporting Families With Parental Mental Illness* initiative, but they need to move from the corner to the centre of someone's desk. Prevention groups such as Kids in Control and specialized parenting programs need to move from pilot projects to core priorities. It is heartening to see in the articles contained herein by Dr. Joanne Nicholson (USA) and Vicki Cowling (Australia) that other jurisdictions are wrestling with similar concerns. A comprehensive environmental scan including European and other industrialized countries will no doubt reveal there are some wheels we do not need to re-invent. It would no doubt also reveal that British Columbia can be proud of its initiatives to date.

A hopeful way of seeing

It is fitting that family therapy, which once so alienated those affected by mental disorders, could now provide a new paradigm for more helpful actions. The writings of narrative family therapist Michael White and others remind us that persons are more than the predominant stories about them. They say the story of mental illness is a 'thick' story that may smother other important stories about family competency.

Here lies the invitation to look for strengths and to tell the stories of mothers and fathers who despite their illness continue to parent effectively. It is the opportunity to clearly see our own societal journey, painfully slow perhaps, from individual illness stories to a broader picture of family and system functioning. Psycho-educational programs for families have demonstrated that with the right information, families can accomplish a great deal. Communities working together with advanced planning, ICM, family support, family therapy and a range of other services can keep parents out of the hospital and help children stay with their own families. We've come a long way, but there is a distance yet to go.

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footnotes

[1] Ministries of Health and Children and Family Development. (2001). *Supporting families with parental mental illness.*

[2] Benjamin, Lynn R. et.al. (1998). The parenting experiences of mothers with dissociative disorders. *Journal of Marital and Family Therapy, 24(3*), 337-354.

[3] Representation Agreement Resource Centre. (2004). *What it a representation agreement?* See www.rarc.ca

[4] Hinden, Beth et.al. (2002). *The invisible children's project: A family-centered intervention for parents with mental illness.* Center for Mental Health Services, Office of Policy, Planning and Administration. See www.Paretingwell.org/ resources.htm

[5] Nicholson, Joanne et.al. (2002). *The prevalence of parenthood in adults with mental illness: Implications for state and federal policy makers, programs and providers.* See www.parentingwell.org/ resources.htm

The socioeconomic context of parenting with mental illness

When we think of the kinds of issues faced by parents with mental illness, many of them relate not to the illness, but to the fact that many of these parents are dealing with struggles related to poverty, isolation, and in some cases, gender.

Many parents with mental illness are single mothers who live on limited incomes. And because they are poor, they face difficulties with meeting basic needs such as decent, affordable housing, adequate transportation, proper nutrition for their family, finding child care that they can afford, and paying for recreational activities that support the healthy development of their children (outings, lessons, etc.).

Since mental illness often causes conflict within a person's social network, parents may become isolated from family and other potential sources of emotional and practical support that most people access through their informal networks.

A final point relates to gender: more women with mental illness than men are parents. For people with schizophrenia, for example, this is partly because the illness often strikes later in women, after they have had children. One issue that may be relevant is protecting themselves and their families from domestic abuse.

The impact of parenting on mental illness

The relationship between mental illness itself and the parenting role goes both ways. That is, having an illness impacts on the ability to parent, and being a parent can have an impact on the way an individual experiences her or his illness.

First of all, for some people, the birth of a child can actually trigger the onset of the illness. For others with a vulnerability, the stress of child-rearing may be what triggers the illness. For a person with a pre-existing illness, the day-to-day demands of parenting, on top of the demands of managing the illness – keeping appointments, taking regular medications, etc. – can be a major stressor that can worsen the course of the illness. Parents might also feel guilt or resentment related to the sometimes-conflicting demands of parenting and managing their own illness.

There may also be added stress since people with mental illness feel pressure to 'measure up' or prove themselves as parents, sometimes to unrealistic standards. For example, they may lose sight of the fact that some of their struggles are typical for all parents, and judge themselves negatively.

It's important to remember that being a parent is not just a source of stress. It can also become a major contributor to a person's recovery, by providing:

- a source of motivation to manage one's illness (some people will say that they didn't follow through on their treatment in the past, but that they decided that it was important to take responsibility for their health so they could be there for another person.)
- a source of structure that helps them be organized enough to 'make it through the day'
- a sense of identity and status apart from being 'only' a person with a mental illness.

The impact of mental illness on parenting

The other side of the two-sided relationship between parenting and mental illness is the impact that the illness has on the parenting role. First of all to consider are the effects that symptoms related to certain illnesses can have: for example, depression – either in and of itself, or co-occurring in other illnesses such as schizophrenia – can have negative effects, as it can reduce an individual's motivation and energy level to parent. For people with schizophrenia, *negative symptoms* (i.e., lethargy, emotional 'flatness') can have similar effects, especially if their medications are not adjusted properly. *Positive symptoms* of schizophrenia (i.e., delusions) that are not properly managed can also have an impact if they distract the parent from attending to real-world concerns and if their children are drawn in to a delusional worldview – especially if the offspring have not been given any education about the illness.

The illness may also have an impact on the parent's ability to form relationships and attachments. One consequence is to reinforce the tendency for the parent – and therefore the family – to be socially isolated. The other relates to the difficulties that the individual may have with forming healthy attachments with their small children. Research shows that they may either be overly detached or overly involved. This may translate, for example, into having difficulty understanding how to play or interact. The impact of this may be that the parent may be either overly directive and brusque, or on the other hand, may appear not to show any interest at all in what the child is doing, or in the needs that the child is indicating. As time goes on, these difficulties in knowing how to parent may be compounded if the individual's own parent had a mental illness and was not a positive role model that can be drawn upon for strength.

A final point for consideration is how the issues of familial mental illness cause concerns for the parent in relation to the healthy development of their children. These can cause further negative impacts on the parent's own mental health. Mothers with mental illness tend to have more difficult pregnancies and their offspring tend to have more physical health complications over time. Chronologically, the next issue that comes up is the concern over attachment and style of interaction with their children and the impacts this can have on the healthy socialization and mental health of the offspring. As the children get older, the parent may then have to cope with mental health problems or behavioural difficulties in the children themselves. And as the offspring approach the age of

When a Parent is Hospitalized for Treatment of a Mental Illness

A research project examining a child's perspective

Hylda Gryba

Hylda is a nurse clinician currently working as a therapist with the Abbotsford Child and Youth Mental Health Team for the Ministry for Children and Family Development. She developed a children's psychoeducational support program for children who have a parent with a mental illness, known as Kids in Control, and is a current member of the provincial working group on Supporting Families with Parental Mental Illness. She is presently completing her research for her MA in counselling psychology

I'm currently working on a research project which examines a child's experience of the hospitalization of a parent who suffers from a mental illness. Face-to-face, semi-structured interviews were held with ten children between the ages of 8 and 18. The interviews focused on major themes such as the memories of the event, the child's understanding of mental illness, what changes resulted (e.g., living arrangements), advice for professionals, what helped, what didn't help, and coping strategies. The audio transcripts of the interviews were then analysed and the emerging themes identified.

As this is research that is currently being conducted and the analysis is in process, it is too early to arrive at definite conclusions. However, in the preliminary findings, some very definite themes are emerging. Comments like, "When I saw her face, I felt okay," or descriptions of how it felt to be "torn apart" flowed throughout the interviews, identifying the themes of grief and loss, and the child's need to stay connected to the parent.

Another theme that is apparent is that of caretaking and shared family burden. Children often made comments such as, "We noticed that he was. . ." or "I called the police." The child's role in caretaking is seen on many different levels. The child may learn to take care of his/her own basic needs such as making meals, getting to school, doing laundry, etc. There were also instances in which very young children commented on their active participation in treatment and illness management. Comments such as "I always give her the medication because she forgets to take it," or "I do it for her because Dad gets too frustrated," point out the very active role that children are very likely to play, and the tremendous burden of responsibility they shoulder. Combined with those tangible burdens are the emotional and psychological burdens the children spoke of. They often "worried," were "afraid," and "suffered," in various situations, suggesting that the family burden of mental illness has very definite impact on the child's daily life.

The children also gave good insights into things that they found helpful. Being given information about what was happening and about the mental illness were foremost. "When I learned it was a chemical imbalance, somehow it didn't seem so bad," was one comment. Advice to professionals included:

1. **be nurturing:** "give them an ice-cream and a big family hug"
2. **provide reassurance and support:** "tell them it's going to be okay"
3. **provide opportunities to have fun and to act 'normally':** going to school, playing games, and maintaining daily routines were identified as helpful activities.

Being ignored or dismissed and excluded were the behaviours seen as unhelpful or harmful. One child emphasized, "They couldn't stop me, I was going to see her!"

In regards to coping strategies, children identified several strategies such as pretending and fantasies; talking to counsellors, friends, or family members; and joining support groups. Hope and meaning were also valued by the children who stated that they "had to believe things would get better" or that they would "find a way to make things work for the best."

This research project was designed to provide an opportunity for children to speak up and to inform us about their experience living with a parent who has a mental illness, particularly around the circumstance of the parent's hospitalization. The initial findings suggest that children, by virtue of being a family member, are full participants in the course and treatment of a parent's illness, and that they are impacted in very real ways. The collective voices of these children identified the wish to have that participation acknowledged by being nurtured, supported, informed and included when the family experiences a traumatic event.

Experiences | continued from previous page

risk for major mental illness, the parents face the worry over whether their child will develop the same illness they have. As the adolescent approaches adulthood, parents often have difficulties in fostering a healthy degree of separation as the adolescent moves into adulthood. Often, the offspring is the parent's primary source of self-esteem, so the eventuality of the child moving on represents a threat to the parent. Both the parent and the offspring may need support to negotiate this transition.

Discrimination Against Parents with Mental Illness and their Families

Changing attitudes, opening minds

Sarah Hamid-Balma

Sarah is Director of Public Education and Communications at the Canadian Mental Health Association BC Division and Visions' Production Editor

> “Just as people were to some extent freed from the view that their genes meant that they should not breed, they were confronted by the view that they could not make good enough parents … Childbearing by people with mental health problems no longer simply spelt bad nature: it spelt *bad nurture*”[1]

Children, youth and adults all around us are ample evidence that most people with mental illness can parent successfully, though some need support at times to do so; however, getting others to believe that has been the tricky part and, historically, an uphill battle. What the quotation featured to the right speaks to is the eugenics-based programs of the twentieth century that tried to weed out ‘undesirables’ like criminals, prostitutes, people with addictions, mental illness and other assorted disabilities which were all thought to be hereditary. As a result, the legacy of parenting-rights discrimination for people with mental illness began with the complete elimination of those rights through forced sterilization in men and women, boys and girls, in Western nations like Canada and the US. In the US, for instance, from 1907 onwards, at least 60,000 people who had either epilepsy or a mental disability were sterilized.[2] Closer to home, 2000 residents of provincial mental institutions were sterilized without their permission between 1928 and 1972 under the Alberta Sterilization Act.[3] Though the days of legalized sterilization programs in the Western world are over, discrimination around parenting rights for mental health consumers exists all the same, just in altered form:

- Of those consumers with children who responded to a British survey, 48% of women and 16% of men believed that their parenting abilities had been unfairly questioned because of their service-user status.[4]
- It is frequently implied or even stated that people diagnosed with severe mental illness should not marry or have children because they are too psychologically fragile, carry a genetic predisposition, or are incapable of providing a stable home environment.[5] One consumer describes such an encounter: “In an icy and imperious voice that I can hear to this day, he [the physician] stated – as though it were God's truth, which he no doubt felt that it was – ‘You shouldn't have children. You have manic-depressive illness.’ I felt sick, unbelievably and utterly sick, and deeply humiliated. Determined to resist being provoked into what would, without question be interpreted as irrational behaviour, I asked him if his concerns about my having children stemmed from the fact that, because of my illness, he thought I would be an inadequate mother or simply that he thought it was best to avoid bringing another manic-depressive into the world. Ignoring or missing my sarcasm, he replied ‘Both.’ I asked him to leave the room, put on the rest of my clothes, knocked on his office door, told him to go to hell, and left. I walked across the street to my car, sat down, shaking, and sobbed until I was exhausted.”[6]
- Despite a lack of evidence suggesting that people diagnosed with mental illness are unable to parent (like everyone else, they have an equal shot at being good, bad, or indifferent parents), research has shown that parents so diagnosed lose custody for reasons “that would rarely constitute grounds for termination with ‘normal’ parents, such as bad attitude or sexual promiscuity.”[7,8]
- Consumers struggle to reconnect with children who get placed in foster

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footnotes

[1] Sayce, L. (1999). *From psychiatric patient to citizen: Overcoming discrimination and social exclusion.* New York: St. Martin's Press.

[2] Lombardo, P. (1983). Involuntary sterilisation in Virginia: from Buck v. Bell to Poe v. Lynchburg. *Developments in Mental Health Law, 2(3),* 17-21.

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[4] Read, J & Baker, S. (1996). *Not just sticks and stones: A survey of the stigma, taboos and discrimination experienced by people with mental health problems.* London: MIND.

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Mothering Under Duress

In/visibility of mothers with mental illness

Marina Morrow, PhD

Marina is a research associate with The BC Centre of Excellence for Women's Health. Marina is currently working with a team of researchers investigating first generation South Asian and Chinese immigrant women's experiences of postpartum depression in a project funded by the BC Medical Services Foundation

The BC Centre of Excellence for Women's Health has been engaged in women and mental health research since 1998, when it launched its first mental health research project, *Hearing Women's Voices: Mental Health Care for Women*. The centre employs a unique involvement model that brings together researchers, health providers, policy makers and community stakeholders, to develop action-oriented, policy-relevant, feminist research in women's health. The Women and Mental Health discussion group is one such network at the centre, which has focused its attention on projects that examine the ways that mental illness and mental health are experienced differently by men and women. As such, issues related to mothering, substance use and mental illness have been a focus of a number of the centre's research projects. What follows is a description of one of these projects, and its implications for policy development and service provision in mental health as it relates to mothering.

The Mothering Under Duress project was funded by Status of Women Canada's Policy Research fund and was published in 2002 as *A Motherhood Issue: Discourses on Mothering Under Duress*. This project took as its starting point a growing concern that the specific experiences of women, especially those of mothers in crisis, are not being taken into account in service delivery and policy decision-making. Indeed, mothers are often obscured by a public focus on the rights and safety of children and in gender-neutral policy language that talks about 'parents.' What this ignores is that women are still overwhelmingly the primary caregivers of children, and that the needs of children are intimately tied to the needs of mothers.

The project explored three situations of mothering where women are most likely to be scrutinized by the mental health and child welfare systems and to lose their children to apprehension: women who are using substances while pregnant or as mothers, women who are mothers and experience intimate violence from their male partners, and mothers with mental illness. This project examined women's experiences with systems of supports and looked at the prevailing attitudes about mothers embedded in key policy documents and in the media. The discussion below highlights the findings with respect to mothers with mental illness.

Women with mental illness face a variety of challenges during pregnancy and in their role as parents. While some women may experience remission of their symptoms during pregnancy, others will experience worsened symptoms. Psychotropic medications may pose a risk to the fetus, making decisions about medication difficult. Many of the challenges that the women in this study mentioned were those that are echoed by single mothers more generally: for example, struggles ▶

Discrimination

continued from previous page

care during a parent's extended hospitalization: "My worst fear was of losing my children. I think it actually prolonged the mental illness because I was so scared and there was no one to help with the kids. If only there had been someone there to help."[1] This fear is worsened by some hospital rules not permitting children visiting privileges inside secure hospital units.[10]

- Consumers are sometimes not permitted contact with children after adoptive parents have taken custody, presumably out of a perceived fear for the child's safety.
- Vocational rehabilitation tends to ignore parenting, probably because it has had a greater focus on male conceptions of work above the 'work' of parenting.[1] Also, as one author points out, "women may be given little recognition for the fact that they may desire the valued role of 'mother' compared with that of 'mental patient,' especially since other roles, such as worker, are often not available."[10]
- Finally, eugenics may rear its head again if, while tackling the human genome project, genes for mental illnesses are discovered that reopen the age-old debate on the ethics of eliminating human frailties or 'defects' in the population before birth.

Yet, although studies continue to investigate the degree of hereditary connections of mental illness – for example, the majority of people with schizophrenia have neither a parent nor a first- or second-degree relative affected by the illness – little commentary is made on the value, comfort and support a parent with a mental illness can provide for a child dealing with their first experience of mental illness.[11] The arguments are always framed as 'We can parent just as well despite our illness' instead of occasionally saying, 'We might just be able to parent better because of our illness.'

Excerpted from Discrimination against people with mental illness and their families: A Report of the British Columbia Minister of Health's Advisory Council on Mental Health *(2002). Unpublished comprehensive report. Executive summary available at www.healthservices.gov.bc.ca/mhd/advisory/publications.html*

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with poverty; finding affordable, safe housing; and the need for child care assistance and respite services. However, women in this study indicated that they often faced discrimination and/or difficulties in accessing existing resources for single mothers, such as those set up to reduce the isolation of women and children. Additionally, women with serious mental illness often have interrupted education and work histories, which makes it even more difficult for them to obtain full employment and maintain relationships with partners, family and their children. Each of these factors brings this group of women into contact with the mental health and child welfare systems.

Although mothering, no matter what form it takes, is always under public and professional scrutiny, it is even more so for women with mental disorders. That women with diagnoses of mental illness are seen as a risk to their children is evident in some professional literature and in practices related to child protection, where women are often scrutinized and monitored to ensure they do not physically harm or neglect their children. Media representations of women with mental illness frequently invoke stereotypes about mental illness and emphasize women's danger to their children over stories about successful mothering. In contrast, research suggests that women with mental illness often place a high value on parenting, and that a woman's ability to maintain a relationship with her children is often critical to her recovery. For example, experts in the field suggest that assisting mentally ill mothers in maintaining contact with their children increases their self-esteem, provides them with a sense of normalcy, and promotes personal growth.

The cyclical nature of mental illness – with periods of wellness and periods of illness – means that in order to mother successfully, women require different kinds of supports throughout their pregnancies and after their children are born. Some professionals have begun using advance care plans ('Ulysses Agreements') to assist women in planning for their children during periods of illness (see *Visions* article on p.32, by Sharon Van Volkingburgh). Such advance planning gives women more control over who will take care of their children and allows them to provide specific instructions about their children's care needs. Most importantly, this kind of careful care plan relieves much of the trauma that women and children often experience during a mental health crisis, when children are sometimes removed from the home. To this end, women felt that better recognition was needed of the kind of grieving that women and children experience when they have been permanently separated due to a mother's mental illness. They also identified a need for grief counselling and mechanisms for assisting women to have an ongoing relationship with their children after separation.

There was evidence in all three of the case studies that mental illness, substance use, and experiences of violence and trauma frequently overlap in women's lives. Despite this, systems of support, especially those in mental health, are currently not set up to assist women who face all these complex issues at once. Recognizing these intersections is critical for delivery of care and treatment planning.

Mental health reforms involve an increased awareness of how the stigma and discrimination surrounding mental illness affect people's abilities to recover and reintegrate into their communities. Reforms throughout the mental health and social welfare system are also closely connected to cost cutting and the implementation of efficiency models, which save time and money. This raises concerns that punitive and coercive policy and legislation will be used instead of better and more comprehensive service delivery for both mothers and their children.

The Mothering Under Duress research suggests that the biomedical focus of mental health treatment planning – together with the fragmentation of services for women and their children – functions to reinforce the 'invisibility' of the day-to-day struggles of women with mental illness who are mothers and creates a context where women's needs are not seen as integrally connected to those of their children. Further, the negative attention paid to mothers diagnosed with mental illness renders the strengths that women may bring to their mothering invisible. This reinforces a reactive policy stance that has serious implications with respect to the kinds of supports available to assist women with mental illness in maintaining caring relationships with their children.

Although a number of important initiatives have been undertaken in BC with respect to developing support systems for parents with mental illness and their children (e.g., *Supporting Families with Parental Mental Illness: A Community Education and Development Workshop*) the needs and concerns specific to mothers are frequently overlooked. That women with mental illness are visible only in times of stress or duress is problematic, with respect to the ultimate goal of supporting women in their parenting roles and in supporting the needs of their children. Instead, what is needed is a proactive policy and service provision approach, which, instead of focusing on women's deficits, builds on their positive capacities to mother.


artist: Cathy Reimer

selected relevant publications

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Women with Mental Illness are Still Losing their Children

Jirina Judas

Jirina works for the Mental Patients' Association

Mental health systems are guilty of not paying attention to mentally ill mothers in terms of needed research, treatment and support. Due to the complexity of their situations, many families led by these women cease to function.

Women diagnosed with mental illnesses do not lose their need for sexual fulfillment and reproduction. They even have more children than on average. It is tragic that 62 % of these women lose custody of some of their children during their parenting years.

Mental Patients' Association (MPA) conducted a study about the experiences of mentally ill mothers who live in Vancouver in order to design a program that would address their needs and help to reduce the incidence of child apprehension, if not eliminate it altogether. Hospitalization, divorce proceedings and difficulties in raising the children on one's own were found to be the main causes of the child's removal.

Some of the women in our study never even saw their children. Often, a child was put up for adoption immediately after birth when the mother was hospitalized with acute psychosis. In 1997, for example, a mentally ill woman sued Chilliwack Hospital for inducing labour and for putting her newborn into protective custody "due to disability of the parent" without her consultation or consent. The mother claimed that the circumstances of the apprehension violated her rights under the Charter of Rights and Freedoms to security of person, privacy, equality and fairness. She lost her case and may be still in a process of appeal.

Hospitalization is the major reason for removing the child from an ill mother's care. Once placed in foster care, the chances of a prompt return of the child are very slim. Most women said that they did not have the mental stamina and lacked important information and the support of the legal system. Many gave up the fight for the return of their children.

In divorce proceedings, the surveyed women reported that their mental condition was used as a ground for divorce and for giving the custody of children to their husbands.

The most difficult situations that single, mentally ill mothers have to deal with are common to most women who are the sole providers for their families: lack of financial resources; lack of social, medical and emotional support; and loneliness. Women with mental illness have to cope with added stresses that are unique and a result of the nature of their specific mental illness and society's perception of it.

When asked about satisfaction with available supports, the mental health system – represented by social workers, psychiatrists and therapists – was assigned the lowest level of satisfaction with available support. The reason for this finding might be the singular approach of mental health professionals to their clients. Dealing only with the diagnosis as the primary focus does very little to enhance the capabilities of mothers to address critical issues of successful parenting. The focus has to be on the whole person and must include recognition that a woman's life changes dramatically when she becomes a parent.

The fact that 31 % of the children stayed with their biological mother until adulthood is an indicator of the strength, ability, parenting skills, dedication and sound symptom management on the mothers' part. It is recognized that children are best cared for by their own families and mental health services have to assist temporarily hospitalized and sick women with the selection of substitute care of their choice before it is imposed ▶

thoughts of the participants:

what is really difficult?

"Complications with child care when hospitalized"
"Lack of education"
"Abuse from relatives and mental health professionals"

"Signing my babies off to their father when hospitalized"
"The only support was through religious means"
"Being judged by the child (when older)"

"Lack of access to children when not well in hospital and in recovery period"
"Helping the children come to an understanding about my illness and time spent away from them"

"Estrangement from my children and my family"
"Trying to keep my house in order"
"How to cope with my emotional difficulties and with those of my child, especially around puberty"

"Constant pressure from hallucinations, work, lawyers (custody battle)"
"I fell into pieces when my daughter was taken away. Now she is a drug addict, in detox."

Life in the Pressure Cooker

Parenting while coping with a disability

Virginia J. Ross

Virginia is a writer, parent and mental health consumer who lives in Vancouver

For the last two years, it feels like I've been living in a pressure cooker in which someone has forgotten to turn off the heat. During this time, my family – my child and I – has suffered enormously as a result of economic and social restructuring in the Ministries of Health, Human Resources, Education, and Children & Family Development. As each ministry implements graduated system-wide reductions, we lose one after another of the essential resources that allowed us to cope with the pressures of poverty and mental illness.

Physically, I am exhausted and in pain. My stress-related symptoms include migraines, an enlarged thyroid, stomach problems, and muscle tension causing joint pain . . . the list goes on. The doctors can find no other cause – it's all due to accumulated stressors. Primarily, this is the result of trying to mitigate the impact of the cuts so my child has as happy and healthy a childhood as can be under the circumstances. The government may be achieving their financial goals; however, they come at great personal cost to families coping with a disability. Like many others, I am unable to alter my financial situation and so am forced into a desperate struggle to cope with one stressor after another.

For example, in 2002, we lost 10% of our already marginal income, along with other health and social benefits. I now have only limited access to massage, physiotherapy or a chiropractor to help me cope with the increased muscle tension I have due to stress. I have lost access to the respite care funds that allowed me to take breaks and parent better as a result of feeling rested and able to cope better.

The Ministry of Children and Family Development (MCFD) talks about providing community and family resources. Realistically, however, they have *cut* funding to community resources, and few people coping with mental illness have family support. I have an average, dysfunctional family, with other members coping with mental illness and addiction, and who do not have the physical or emotional resources to assist us. The stigma and challenge of coping with a mental disorder make it difficult to develop and sustain relationships. The few friends I have are also living in poverty and are coping with their own issues: two different friends each have family members coping with cancer. We are all subject to the stress of service cuts and poverty and are all functioning at the limit of our own resources. Over the long term, this is debilitating and inhibits our ability to participate in our community.

The cuts that are occurring across all four ministries affect every area of our family life and our entire community on the east side of Vancouver. Our school-aged children are constantly under threat of losing Ministry of Education and MCFD-funded resource people and other things such as hot lunches and after-school programs. I have no idea what the long-term impact of the current cuts will be and I am very concerned about the upcoming cuts in welfare benefits to single parents. Many of the parents who have not yet found work suffer from undiagnosed mental health issues including depression, addiction and post-traumatic stress, or other barriers which have prevented them from working. As programs close and our resources become limited, so do our options. People are and will continue to become more and more desperate.

Personally, I have access to all the resources currently available, am well educated, have strong personal resources, and a network of fairly healthy people. If I am feeling overwhelmed, I often wonder how others are coping and what will happen to families not connected to any resources. My gut feeling tells me that just like the untended pressure cooker, this situation is not going to improve on its own.

I realize that people working in mental health and many other social services know what is required to restore services and reduce the pressure. Unfortunately, we are all subject to this bizarre experiment that prioritizes the economy over the well-being of the people the economy serves. Sadly, I also know what happens to the contents of an untended pressure cooker, and I wish someone would have the courage to do something before someone else gets hurt as a result of the desperation and despair that has been created by the current lack of funding and services – and by the apparent lack of concern to do anything about it.

Losing their Children | *cont'd from previous page*

upon them. Women, themselves, can control this option by drafting a 'Ulysses Agreement,' where their choice of action to be taken in case of hospitalization is spelled out.

In the past few years more attention has been given to the problems of mentally ill parents and their children than ever before. We only hope that this trend will continue.

Elizabeth Ando's Nightmare

One mother's obsessive cleaning almost cost her everything

Mark Hume

Reprinted with permission from the National Post, *B1, B3 – May 12, 1999*

At first she seemed like an ultra-domestic housewife. Everything was in its place, the floors were polished, the counters scrubbed. But like the broom that went berserk in Walt Disney's story about the magician's apprentice, Elizabeth Ando simply didn't know how to stop cleaning. She cleaned and re-cleaned her house with a compulsion that often left her exhausted.

At first she explained away her household obsession as simply a means of escaping from an unhappy (first) marriage and the discomfort of living in the woods, in an isolated old house that desperately needed cleaning. But she realized things had gone wrong in her head when she moved into a new house – and immediately began to clean . . . and clean . . . and clean. "If anything, it got worse after that move," she says today, as she battles to overcome an anxiety known as obsessive-compulsive disorder (OCD), a condition that afflicts 1 to 3% of the population and in part is caused by a chemical imbalance in the brain.

It is a disorder that seems almost comical at first glance, but which can torment people and, as Ando knows, destroy lives. People with OCD typically feel compelled to perform a ritual or routine over and over again in order to relieve a sense of anxiety. Although they realize their compulsions are senseless, they have great difficulty in stopping. Some people are so worried about contamination that they wash their hands or clean their homes almost constantly. Some check things, looking hundreds of times a day, for example, to see if the stove is turned off. Others ritualize things, like stopping on every step on the front porch for several minutes, even when rushing for an appointment.

For Ando, OCD is not just a troubling medical condition, it is a curse that very nearly cost her the things she holds most precious in life: her marriage and her new baby. "It has been a nightmare," she says in a recent interview, as her one-year-old daughter, Megan, a typically messy baby, gurgles happily nearby. Ando, 34, can speak openly and with a sense of humour about her problems now, but a year ago, when she lost her baby, she was so distraught she couldn't even talk.

On March 1, 1998, two hours after she'd given birth to Megan at 19 minutes after four on a Sunday afternoon, social workers came to her hospital room and told her they were taking the baby. Ministry officials, who'd visited her home during her pregnancy for routine checkups, had taken note of Ando's cleaning compulsion. The smell of bleach in the home was so strong that a visiting doctor developed a headache within 20 minutes. The baby, they said, was being taken away for her own protection.

"It was a pretty horrible experience," says Ando. She recognized that she had a compulsive disorder, and had been taking drugs to counteract it; however, she'd stopped the medication during her pregnancy because she was afraid the drugs would affect her baby's health. Without drugs, her compulsion became stronger. "I tried to enter a hospital at the end of my pregnancy because my symptoms were out of control. But they wouldn't let me," she says.

She knew the social workers were concerned about her medical problem, but they never told her what was at stake. Until the last minute, neither she nor her husband knew that the government might take their child.

When it happened, she was alone at the hospital. Her voice catches with emotion as she recalls the moment. "That was the worst, when they took her from the hospital. We didn't know where she was going or if we'd get her back." She called her husband to tell him what had happened, but was unable to speak. "All I could do was cry into the phone. I was just so overwhelmed, I couldn't talk."

When her 23-year-old husband, Thomas, did learn what had happened, he was shocked and angry, both with the government and his wife. "At first my husband was totally resentful, blaming me. It wasn't my fault, but it was, because I was the one with OCD," she says.

The marriage, her second, has survived, but it has been rough. The crisis they went through with Megan has "done a lot of damage," she says.

Shortly after she was released from hospital, Ando began a campaign to get her baby back. "We didn't know anything. We didn't understand how the government had done this," she says. "I spent nights phoning lawyers trying to get legal aid, trying to figure out how it had happened."

Why couldn't she have kept the baby, with social workers coming to visit every day? Why hadn't her husband been given the chance to care for the baby? Those questions haunted her then, and have never been adequately answered, she says. "I still don't think this had to happen the way it did."

Four weeks after the baby was seized at the hospital, Ando was in court. But a judge ruled that the government had made the right decision. Judge Jeanne Harvey urged Ando to get professional treatment. Only then, she said, could the baby be returned.

Ando began treatment at the University of British Columbia's (UBC) Anxiety Disorder Clinic a short time later. At first, she was only allowed to visit her baby for eight hours at a time. Returning her baby at the end of each day was heart-wrenching. “Every time they took her, I cried over her diapers – because that’s all I had left of her,” says Ando.

Six months ago, after half a year of treatment, she was able to prove to the courts that she had her compulsive cleaning disorder under control. “UBC is amazing,” she says. “They took a totally different approach to treatment. They got to the bottom of it. I’d seen many doctors and they never knew what was driving my problem.”

Dr. Maureen Whittal, at UBC’s Anxiety Disorder Clinic, says the type of problem experienced by Ando is not as rare as it seems. “Contamination/washing is one of the most common [obsessive-compulsive disorders], along with obsessive doubting/checking,” she says. “It’s a lot more common than you think. It’s a hidden problem, because people are ashamed. They know that what they’re doing, the compulsion they’re engaged in, is ridiculous.”

The biggest step for many is to recognize that they have a problem, and to seek help. There is no ‘cure’ for OCD, says Whittal, but treatment can reduce the amount of compulsive behaviour by 60% within a few months. Some people can reduce it by 95%, virtually eradicating it.

But those afflicted with OCD will always feel urges to follow their compulsions. The trick is to learn how to manage the disorder by identifying it and resisting.

With social workers watching her progress, Ando is aware that a relapse could jeopardize her motherhood, and that the baby she describes as “a wonderful joy” could be taken away again. “I’m working at it extremely hard. I’m hopeful,” she says. “Some experts say you will have to live with it forever, but others say it can be beaten. All I can do at this point is fight it and try and get rid of it.

“I’m really hoping I can get over it. I see the changes. I can do some things now that, even two months ago, I never dreamed of. People can walk in the apartment now with shoes on and it doesn’t bother me. I don’t have to go around cleaning up after them.” She laughs, because that seems like such a ridiculously small thing. But to someone with OCD, she says, it is a major accomplishment. “If you can overcome things like that, it lessens the anxiety. And then you can go on to something else.”

As part of her therapy, she has had to return to the old house where, 10 years ago, her compulsion first took hold. “I have had to go there and sleep in that house, and face right up to it,” she says. “It’s rough. But that’s what it takes – and that’s what I’m doing.”

Having Megan at home has helped, she says, because the baby is a daily reminder of what she’s struggling for. “Who knows? Maybe someday I can say, ‘I’ve overcome it.’ That’s what I dream of.”

From Experiences to Actions

My life as a consumer single mom

Dawn Brossard

Dawn is a reasearcher for the ARA Mental Health Advocacy Association of Greater Vancouver

I feel that, in a sense, I’ve made it through. I am entering a new phase in my life: middle age and becoming a willing grandmother of 7-month-old, twin grandsons. I’ve just come back from England where they live with their mom and dad, who are aspiring young adults.

Their mom, my daughter, was a victim of a very rocky childhood. I became a mental patient in 1978 and was diagnosed with schizoaffective disorder the year she was born. Her father didn’t take kindly to my having a mental illness and we were divorced a couple of years later. Both daughters ended up in a foster home for a year, after being apprehended from my custody, where they stayed until their father and his parents gained custody. But for the few visits with me, they grew up in an uneventful, unloving, and uncaring household.

As I recently went over old letters and affidavits from that time, I realized that it was no wonder why Emily, my other daughter, was having problems in school with her reading and arithmetic. My worries and concerns were having an effect not only on me, but also on this small child. As much as the psychiatrists and doctors were trying to help, the situation at home was getting worse and worse. The medication I took left me listless and chronically tired and sleepy. Emily wasn’t staying home and would be gone for hours.

We were on welfare as well, and I was being pressured by them and by my family to go out and find a job to support my little family. With no skills or work history, I managed to find a part-time job at a local market, at a bakery selling carrot muffins to seniors who happened by. However, my frequent hospitalizations, moves, and my desire to be with my daughters while they were growing up prevented me from continuing on with my job or my education.

Finally, my daughters were gone. Every effort had been made to block me from being successful at childrearing. Their father would not send child support, and welfare wouldn't give me a furniture allowance; every step I took was like going around a blockade.

These early years left quite an impression on me. When my life had settled down, and my daughters came back into my life, I began to think that other moms like myself might need some mutual support to deal with the struggles of parenting with a mental illness: hence, Mothers in Transition (a support group for single moms with a mental illness) was born. We met for coffee and socialized on outings. We helped each other with apprehension and loss of custody issues.

Towards the end of the four years that Mothers in Transition met, a movement to discuss and record stories about all oppressed mothering groups was made by various organizations and agencies. Mothering became a very 'hot' issue and I was involved in a number of these initiatives; for instance, I was interviewed as part of the Mothering Under Duress project (see article on p. 10 of *Visions)*.

All the group meetings, publications and other material don't seem to have made much of a difference with government ministries though. Recently, we faced major changes to provisions for single parents through the Ministry of Human Resources review. The capability and sanity of a single mother with mental illness is still being questioned as a matter of course through the Ministry of Children and Family Development in apprehension and custody cases.

I've had a couple of good jobs since 1989. I worked at CMHA BC Division as Consumer Liaison and developed the West Coast Mental Health Network. In 2001, I began more work as a researcher on a project about single moms at ARA Mental Health Action Research and Advocacy Association of Greater Vancouver.

As I look at my daughter's young family, I think how idyllic it may seem to those outside. I wonder just how prepared they are for the inevitable catastrophes that cross our paths. Hopefully, my daughter will not end up as a single parent. She is too far away for me to support her very well. I think about both my daughters frequently, and the life we've had so far. We're all feeling that better days are on the horizon.

The report, Life Experiences of Consumer Single Moms, was produced in 2002, and may be ordered from ARA Mental Health Action Research and Advocacy Association of Greater Vancouver. Call (604)-689-7938 or toll-free at 1-868-689-7938, or email admin.ara-mha@telus.net

A Parent's Point of View

Hazel Gillespie

Hazel lives in Nanaimo and attends the Phoenix Centre Clubhouse. She is the mother of two daughters (20 and 21 years of age), has had multiple personality disorder for ten years and has been getting help for the last six

As the mother of two girls between the ages of 20 and 21, I have found that parenting is very difficult.

I was diagnosed with multiple personality disorder when my children were just 10 and 12 years old. This created havoc in the house. It started with my children doing a little of the work in the house to help out, but soon *they* became the parents, telling me what to do, how to cope and what I should look like.

It got worse. After a year, my 10-year-old thought she was the mum, while my other daughter turned to drugs and boys to cope. We all know this doesn't help the matter. In fact, for a while, this made matters much worse.

So I turned to a place in Sechelt called Arrowhead Clubhouse. Here, they helped me deal with my children and also cope with my illness. The girls also started to go to the clubhouse to get education about my problem; but also they found a support group, as the rest of the house became surrogate parents for a while.

This was great for the first while, but as I withdrew from the house, the girls lost their support, as did I. Thank God for people who care at clubhouses: personally, I wouldn't be here if not for peer support and friends who didn't judge me, or the way I was with my children.

The girls grew older, but my illness remained. There was some success in getting them to understand my illness, but the obstacles were difficult. I moved to a new place where my children felt too old to attend. They also didn't feel a need to participate, or a need for counselling for themselves.

This time I realized I was alone, and there was no help in explaining to them what was going on. To get my youngest child to realize she was the child and not the mother was difficult, and still to this day she believes she has to make the supper, even though I wish there were times when she would let me do it. My older one has changed, as she is confident in herself and sees no reason for the drugs and the wrong type of attention she once received from boys.

Even though for some it would be a blessing to have a child do the cooking, to me it is a reminder of how sick I was – and that I must be getting better if the small things the kids do for me tick me off. I realize my mistake in allowing the girls to become the parents. Control is ours and we need to be careful how we let others take it from us.

Parenting and Social Work

A route to recovery

Kathryn Lestage, BSW

Kathryn lives in Prince George and works for the BC Schizophrenia Society

This article is adapted from Perspectives, *the newsletter of the BC Association of Social Workers, Volume 26, No. 1*

My story begins in 1985. I am 21 years old. Since high school, I have spent two precious years of good mental health attending community college and traveling our country from coast to coast. I am eager to attend UBC to obtain the prerequisites for their school of social work. This endeavour comes to a crashing, screeching, hallucinating halt. Christmas exams are replaced with psychiatric consults and hospitalization. I experience a 'nervous breakdown' (psychotic break). I am told I may develop schizophrenia and will not work or finish school. I am also told that a nervous breakdown may never again be visited upon me; sometimes these symptoms never come back.

I left the hospital in 1985 on tranquilizers, gaining 45 lbs. in four months, feeling paralyzed by failure, body size and stigma. I started my return to 'normal living' with volunteer work in a group home for teens six months later. I returned to school in the fall, and completed another semester at the community college. The symptoms of depression returned after Christmas 1986, and I had to withdraw from school.

In 1987, I gave birth to a boy on my 24th birthday. Pregnancy was a reprieve from my mental illness. During pregnancy and lactation, I enjoyed the most stable of moods. However, when my son was 18 months old, I suffered another depression. I went into a day program at St. Paul's Hospital for six months. My mother and father cared for my son (500 miles separated us), and my son seemed to stay frozen at the developmental age he was at when I went into therapy. For the next decade, I followed a predictable pattern.

During the month of December, I would need hospitalization; I would return home for about six months of recuperation, paralyzed on the couch. I would volunteer at an agency for about three months and return to the workforce within ten months of hospitalization. I would be able to work for about a year, while picking up two more social work course credits, when the symptoms of depression would return and the cycle repeated itself.

As I mentioned, this pattern became predictable, repeating every second year for the next ten years. Imagine having your work and school goals repeatedly interrupted while you wrestle with a chronic, reoccurring health condition. Add to that the social isolation that comes with being hospitalized in *that* ward, coupled with the social stigma of being a single parent. By the end of this decade in my life, I was beginning to feel hopeless – convinced I was no longer marketable in the workforce.

One thing I was still capable of and successful at, was taking a course or two every year towards my social work degree. These courses helped me to overcome the hurdles of the stigma around me and the stigma in my own head. People and individuals are of value not for what they *do* but for simply *being:* we all have intrinsic value; we all have strengths; we all have challenges. Social workers value and work with these strengths in a way that fosters independence, not dependence. This is our shared value for empowerment. We as social workers help clients deconstruct society's inequalities and challenge the status quo; and we try to give a voice to the disenfranchised.

As I learned the values and beliefs of my profession, I was able to advocate for myself. Emerging from yet another depressive episode, I insisted that my hospital records be gathered together and that a psychiatrist make a diagnosis. I was desperate to parent in an effective manner, and in my definition, this did not include the disruptions of having a recurring mental illness. A diagnosis enabled them to prescribe one magical drug for me. They suggested my depressions were linked to manic depression and if I would take lithium daily for the rest of my life, and use a seasonal affective disorder lamp during the winter months, I would stop having these terrible depressions.

I have lived for 12 years now without being hospitalized. I enjoyed a satisfying career as a correctional officer; I finished my degree in May 2003 and switched tracks to the mental health field. I currently work for the BC Schizophrenia Society, working with individuals in the areas of advocacy and support. I deliver a psychosocial educational course to people living with a severe and persistent mental illness (i.e., schizophrenia, manic depression, obsessive-compulsive disorder). I share my story of living with a mental illness in workshops. If from these presentations, one person realizes there is hope and help, then I have done my

job, and public disclosure has been worthwhile. If one professional nurse, social worker or doctor can empathize with the struggles of their individual clients, then I have helped countless people living with a mental illness. When family members say their home lives have improved, that they are renewed in their efforts to get help for their family member with a mental illness, then I feel a renewal in my own efforts to deconstruct and demystify mental illness.

During a social work conference, I took a workshop with Lena Dominelli and within our group work, I was able to entertain the idea that we as social workers oppress our clients. I experienced another layer of growth. I have become conscious that some of the individuals I work with may not be capable due to their symptoms and/or life experiences to reach stability as I have defined it. There is not a magic pill for every diagnosis. My story is linked more to luck than to determination. I have been privileged to grow up in a family that encouraged secondary schooling, a family that was able to support me through my illnesses. Being middle-class and white certainly were factors in my employability. The values of our profession guide us past our own conceptions to a place where the individuals define for themselves the meaning of success. Many factors enabled me to find my way past mental illness and to find a life for myself and my child. The values of our profession have been integrated into my practice, but more importantly, they sustain me and champion me forward in the management of a mental illness.

Isabel's Story

Isabel

In writing this article I wish to express my sincere gratitude to the Simon Fraser Mental Health Region in Burnaby, Vancouver General Hospital Psychiatric Assessment Unit, Venture, Duke Transition House, Downtown Eastside Womens' Centre, Strathcona Mental Health Team, Coast Foundation, Vancouver Police, and all my family members and friends from four distant countries, to my great, positive boyfriend and his great parents

For many years, I was unaware of my mental illness. My life was very busy and fast paced. I faced the strains of adjusting to life as a first generation immigrant to Canada. At the same time, I was carrying out responsibilities as a professional social worker and raising a family. Then, in early 1995 – thanks to the great help of my then-employer and a few friends – I was able to flee the dangerous and abusive relationship I was in.

All of the sudden, I became a single parent of a son then 15 years old and a daughter 13-and-a-half years old. And although my professional life was very engaging, rewarding and challenging, the experience of being a single parent of two teenagers became really overwhelming. However, sometimes life leaves us with no other choice.

Being a resourceful person, I immediately turned for psychiatric and psychological help for the children and me. I also called a massage therapist to help with the frequent paralysis I was experiencing. Subsequently, I contacted family abroad, and thanks to their kindness and generosity, we received additional financial help.

In the meantime, I filed for divorce. High emotions were involved as I wanted the best for my children, and while I felt I was being reasonable with my wishes, the other party, my estranged husband, was of a different opinion. Unfortunately, and for valid reasons, I could no longer trust the lawyers I hired, so I decided to represent myself in court.

My ex-spouse and his lawyer tried very hard to soften my willpower. At the same time, I was exhausted with work, child rearing, and legal paperwork and procedures.

In order to strengthen my resolve at the time I bought a poster with the caption "Determination." which I looked at very frequently. It shows two palm trees hanging over a cliff and the ocean below. I was determined not to give up for the sake of my children and myself.

In addition to my determination, another thing that kept me going was my knowledge that I had a fairly secure job with the federal government. As my court date approached, I also prayed to God that a female judge would hear my trial, believing that in most cases, they understand family matters better than men. I was lucky, as this is what happened, and the judge helped me solve nearly all of my outstanding issues.

Unfortunately, as time went on, my children did not cope well with the situation and started acting out. This took a further toll on my mental and physical health. Eventually, at the suggestion of my sister, I helped connect them with their father, who by this time had had no contact with them for over four years. This took a load off my own very emotional and burned-out state of mind. It also proved to be a very positive move for my children, who, now at the ages 18 and19-and-a-half, needed to develop some responsibility for their own lives.

It was 1999, and after five years of obstacles and struggle, I was now on my own; but the previous extreme and prolonged mental and physical abuse and burden had taken its toll. I suffered from exhaustion and burnout, and I could not continue working due to lack of concentration and memory problems. Finally, in the year 2000, I was assessed with bipolar disorder, which on top of my several physical disabilities, had been developing over the past five years.

Fatherhood, Mental Illness and the River of Humankind

Bruce Saunders

Bruce is 54, a landscape maintenance gardener and the Coordinator of Movie Monday. See www.islandnet.com/mm

Ten years ago, as my young son was grappling with the revelation that his dad struggles with manic depression, things took a surprising twist. As we were putting the best spin possible on the situation – about adversity making us stronger as a family, more sensitive, closer, and more accepting of others – he quickly worked it all through in his 10-year-old mind and came back with a refreshingly naive take on the matter: "Then families that don't have mental illness aren't as lucky as us!" We assured him it was maybe a little more complicated than that.

Over the years though, I'm not sure if he wasn't right. In many ways, it's been good for our family that we've had to deal with mental health issues.

I've been lucky: I wasn't ever incapacitated for long. My illness, though it almost ended my life a couple of times, has not been as severe as it might have been. I've been able to maintain my modest garden maintenance business, and Laurel and I will be celebrating our 30th anniversary this June. I was lucky to have found such a supportive and accommodating life partner who stuck by me through some hard times.

We're not 'The Waltons.' We live in Victoria, in a nice, little stucco house – two cars, two jobs, two kids. We're pretty much like any modern family would like to be. We're also, like any modern family, plagued with too much to keep up with and not enough time. We struggle with all the tedious things that modern families do: with frustrations from both daily life and from our strong wills and egos, generation gaps and miscommunications.

But something special that I appreciate about our family is that we can talk about some of the scary sides of living in an open manner. In my family of origin, my mother suffered with anxiety and depression, but as kids we knew nothing about it. It was consciously stifled: no books, no information, no discussion.

When my sister and I ran into trouble, we were ill-prepared. We didn't know our family history and, like most families, hoped it would just go away. My sister took her life when she was 26, after struggling with mood swings and career and relationship difficulties. I plugged along for a good while longer before I hit the wall. Mental illness didn't feel like an asset in our lives then.

There have been times when, exhausted and sleepless, tormented by foreboding doubts, I've thought, "What have I done, perpetuating this agony into another generation?" But as it turned out, we've produced two brilliant and decent young men, now 24 and 20. Both are thoroughly engaged in their world and well equipped to deal with any of their old man's 'genetic abnormalities.' Probably part of their sparkiness is my gift to them. I've had my scrapes and my family has had their challenges; but it's out there where we can work on it and it feels like a better way.

I've not always been there for my family as much as I'd have liked. I'm a little odd, eccentric and a little detached at times. I don't laugh as much as my family does. I'm sometimes not much fun on holidays, and Christmas can be a bust. One time, I managed to struggle with depression right through a Hawaiian vacation. It always surprises me how little it seemed to bother their enjoyment of these times when, to me, I seemed to be smothering things in my mood. It speaks to the vitality of youth and the filters that depression can put on perception. It wasn't all about me. And again, it speaks of my good wife's ability to cover for me.

Often I've been either scrambling to keep up with schemes or recovering from chasing them. Crea-

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Isabel's Story | *continued from previous page*

From a distance, I can say that being a single parent – and a first generation immigrant with no extended family in Canada – made it more difficult for me to manage my mental and physical health. But despite this, and throughout this time, I was very motivated to provide the best for my children, to carry out my professional duties, to protect my rights in the court system, and to be as independent as soon as possible. All of these things helped see me through difficult times.

I can also clearly admit that the help my children and I received through the mental health system – psychiatry, psychology and counselling – was very good. In my opinion, the public health system was of better quality than the private sessions we initially attended.

In retrospect, I can also say that what would have helped was if the justice system were more user-friendly and more time and cost-effective, especially in cases such as mine, where there was family violence. It is not only straining on victims, but also extremely costly to taxpayers.

tivity is something many people with my condition need. We feed off that energy and the satisfaction it gives back. But sometimes it has a cost. At least in our family, we can now all recognize what the dynamic is. Albeit somewhat chaotic, our household is a very colourful and creative place.

I'm pleased that I can bring friends home whose lives are also affected by mental illness. People who come to Movie Monday and my longtime involvement in our Mood Disorders Association support group have grown this circle, and it includes my favourite people. Almost every Monday it's, "Guess who's coming for dinner!" for our speedy preshow meal.

Both my sons have several friends who have had similar challenges – themselves and their families – and it's been nice to have been able to be supportive and knowledgeable rather than rejecting them because of their problems. They're interesting people.

This parenting role never ends, but it keeps evolving. My parents are in their eighties now. These days, my dad and I can share books like Kay Redfield Jamison's *An Unquiet Mind* and *Night Falls Fast: Understanding Suicide,* and we can talk about these issues at length. It's cathartic for releasing some of the old stuff that never got dealt with all those years ago.

My mum is in long term care now with Alzheimers and a stroke. I'm helping her to take smaller spoonfuls and singing to her some of the familiar songs I'm sure she once sang to me. She's often looking for *her* parents. It's good to be part of the river of humankind. Just as my parents before me, I'm a proud, worried father and in the balance, no question, it's the most wonderful, rich adventure of my life.

Guilt

The mother of all feelings

Victoria Maxwell, BFA/BPP*

Victoria Maxwell is the owner of Crazy for Life Co., a company specializing in keynotes, workshops and performances for corporations and conferences on a range of mental health topics. Her one-person show, Crazy for Life, is her true-life story of overcoming bipolar disorder, and tours throughout North America and Europe. Victoria welcomes inquiries and comments at victoriamaxwell@telus.net

When I was a teenager, I blamed my mother for a lot of things: my big ears, my geeky high school reputation, my lack of fashion sense, to name a few. But my mental illness wasn't one of them. This did not, however, exempt my mom from feeling the mother of all feelings: guilt.

> "I felt guilty. Tremendously guilty," my mother says...

In 1992, I had my first psychotic episode. Over the next three years, I had two further episodes – both landing me in the psych ward – alternating with suicidal depressions and manic highs. The eventual verdict: rapid cycling, mixed state, bipolar disorder with mild temporal lobe epilepsy and generalized anxiety disorder. But even after the fourth and final psychosis (where police found me running gleefully naked in West Point Grey), I refused to accept the label of a mental illness.

My parents were very familiar with the ups and downs of bipolar disorder. In the mid-1970s, after years of yo-yo-ing emotions and chronic anxiety, my mother was diagnosed with what was then called manic depression. When I landed in the hospital, things started to make sense for my parents. The confusing puzzle pieces of my moody adolescence and university years fell into place as they realized what I had been fighting. For me though, I thought my flights into excitement and enthusiasm (a euphemism at best) and spirals into despair were none other than true dramatic charm and talent. After all, I was an actress at the time.

Take medication? For a mental illness? Hell, this was my gift – agree to any label of pathology and my artistic ability would vanish. Or so I thought. What I didn't understand was if I didn't accept the mantle of mental illness, my career and life would quickly crash and burn. And so it did. With techno-coloured detail.

> "Mental illness is partly genetic."

"I felt guilty. Tremendously guilty," my mother says, when asked how she felt when I was first diagnosed. "Mental illness is partly genetic."

Depression and bipolar disorder run on both sides of the family. But I never thought to blame my parents for the affliction. I was furious at them for other reasons: the helping hand they extended I saw as only parental meddling and intrusiveness. Yes, as I was an only child, my folks over-protected me; but after my hospitalizations, when I was living in a rooming house with a hot plate, on welfare, and devastatingly depressed, you can't really say their concern was unwarranted.

"I felt so helpless. I didn't want to leave you alone. And nothing I did seemed to help," my mother tells me, "and you were an adult, so we couldn't force you to do anything."

My family, like most others, was far from perfect. But my mother and father offered me something I know

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**BFA: Bachelor of Fine Arts*
BPP: BiPolar Princess

has been and still is essential to my mental health, and sadly, is lacking for many others in their struggle with psychiatric disorders: compassion, empathy and unconditional support.

I know many people whose families disowned them once they were diagnosed with a mental disorder. "Not in this family" is the motto. Abandonment and rejection can be lethal – literally. When I worked as a mental health worker at the Kettle Friendship Society on the Downtown Eastside, it was not the drugs and alcohol I saw take the most toll, but the lack of support – family or otherwise. I also know people who fought hard to get a family member off the streets but found it impossible. In order to save their own sanity, they were forced to keep a safe distance.

Growing up in a home with a mother not yet diagnosed with manic depression was no easy road. But I was fortunate: my mom was finally properly assessed by the time I was nine years old.

My mom's illness, ironically, played a largely healing role in my life. She knew intimately what I meant when I said that not only did I not *want* to get up in the morning, but that I *could not* get up, that it seemed I no longer had a choice. My mother would listen, nod and say two of the most curative words there are: "I understand." And she did.

"If I hadn't had bipolar disorder myself," my mom explains, "I wouldn't have accepted your diagnosis as easily. My own illness helped me understand what you were going through."

Empathy and validation cannot be underestimated. Phrases such as, "It makes sense you don't want to talk to anyone when you feel this hopeless," or "It must be hard to even take a shower," have implicit acceptance and immeasurable therapeutic power. Hearing the phrase, "Tell me more about what it feels like . . ." is a restorative balm both my mother and father applied to my soul.

My mother went through many depressions and manias. My father went through it with her. Psychosis? That they never went through – until me.

"It was so scary. I was afraid you'd never 'come back'; that we'd lost you forever. You were rambling, making no sense at all. I had never seen anything like it. I didn't know what to do."

Still, she and my father had only love for me. (Okay, and the occasional swear word and slamming door when I pushed them too far.)

When my mom had to be admitted to the hospital for severe depression and I was only eight years old, my dad kindly explained she was very tired and needed help to get healthy again.

We're walking down a hallway. Pale cream painted walls, shadows of nurses and the smell of stale air. It's quiet. Very quiet. Except for the *swoosh-swoosh* of a patient's slippers on the hospital floor outside my mother's room. A woman I don't know is sleeping on her side, curled up in blankets in a nearby bed.

My mother, with a tight smile, is propped up by pillows. She's very thin, pale. Green hospital gowns don't look good on anyone though. I start to cry warm tears and hug her.

I don't regret that my father took me to see her. I think I only went once. My father worried it would upset me too much. But I was happy to see her, no matter how or where she was. At nine years old, it doesn't matter how often someone tells you your mom is okay. I needed to see for myself.

Over the next couple of years, my mother and father worked together to find the right treatment and medication. She never went into the hospital again. I admire her and my dad for accepting her diagnosis so readily. Denial of my mom's disorder would have been far more damaging to me.

"To have a better life, I needed to accept I had a mental illness. I never told anyone, except the immediate family. It was a secret. There was such stigma. There still is, of course," my mother sighs, "When I think back to what I put you through, it must have been awful." My mom smiles a sad smile, then with a laugh adds, "But you got us back good, didn't you?"

"Yeah," I pipe back, "Thank goodness I didn't run naked around the block when I lived with you and Dad, huh?"

"Am I ever glad!"

My father and mother's signature humour is also hereditary.

> My mom's illness, ironically, played a largely healing role in my life.

Quirks and Glitches

Ula-Erin Chauvet

Ula-Erin is the Regional Coordinator for the BC Schizophrenia Society, Thompson Area

Welcome to my world, won't you come on in . . .

My mom is always singing. Say a word or a phrase and she will break into song. This is her *quirk*. Her mental illness, schizoaffective disorder, is the *glitch*. My opinion of mental illness was developed from seeing a parent suffer.

Many people have stories of living with and loving someone with a mental illness. Trust me, I have a few myself: some that would make you cry, some that would make you laugh. Instead, I would rather tell you how my and my mom's situation has shaped me and taught me tolerance. My mom calls it "being able to appreciate the good times."

I have always considered myself a very positive, open-minded person. I was raised this way. Another one of my mom's *quirks* is that she always had little sayings to remind me "to look at the brighter side of life," that "every cloud has a silver lining," and, my favourite, "If wishes were horses, beggars would ride." My mom taught me that regardless of a person's beliefs, traditions or skin colour, he or she is a person first. Then mental illness entered our lives, and I realized that *my glitch* was a lack of tolerance.

Children of parents with mental illness usually never knew their parent before the onset of the illness. There are a few of us, however, who have seen the illness develop. This was my case. I watched a self-sufficient, strong, stubborn woman who didn't care what other people thought of her become a shell of a person who thought everyone was talking about her; it made her feel sick inside with worthlessness and fear. This happened at a time I needed the old mother I knew, not this new one who now needed me. I hated my situation. I thought I caused this situation. I blamed myself for her illness.

Quirk *n.* A personal mannerism. **Glitch** *n.* A minor mishap or malfunction.[1]

This thought process went on way too long. I left home and started doing all the things that 'grown-ups' are supposed to do. I married, had children, worked and still found time to play. My mom's life also moved on. She found love, visited the grandchildren, worked and she too found time to play.

There are wonderful memories in these times. These memories are tainted, however. I remember waiting for the symptoms to show up, never being able to be unguarded enough to enjoy those rare, special moments. I still didn't understand mental illness. Even as an adult, I still thought I was the cause of or the trigger for her stress. I became fearful that if life became too difficult or stressful for me, I would become like her – mentally ill.

My mother always loved me unconditionally. I was the one who put the conditions on our relationship. My life could be falling apart, but I would say, "It's fine mom. I'm okay, honest." I felt guilty that if she worried, this worry turned to stress and she would relapse despite my best efforts.

Then one day it was pointed out to me that I needed to *understand* mental illness. I needed insight to help her; to 'fix' her. My attitude was, "This has gone on long enough; she had suffered too long . . . *we* have suffered too long." So information and support I found. Now forgiveness began.

It wasn't that I had to forgive my mom for being ill. I had to forgive myself for everything that I said or did in my naive state of mind. There is this saying: "You can't know what no one has told you."[2] This is said in hopes of staving off self-blame. But I kept doing it: I blamed myself again but this time for different reasons. I blamed myself for not being more determined earlier instead of coasting along, hoping my mom would 'grow out of it' as she aged. I became embarrassed remembering all the times I yelled at medical professionals who were only doing what they could. I hated myself for not noticing that my mom didn't want a mental illness any more than I wanted her to have one.

I became aware that I needed to go through all these feelings – that as a family member, I needed time to heal. I have learned that my journey through mental illness is just as unclear as it is for the person suffering directly from the symptoms. And it's okay. This is what allows us to become tolerant, or as my mom would say, to appreciate the good times.

Tolerance *n.*
(my definition)

Realizing that family, friends and those who suffer directly with mental illness are just human beings with glitches and quirks.

To my mom: I don't love you despite your illness or because of your illness. I love you because you are an amazing person. This is for you.

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footnotes

[1] definition from Webster Dictionary (1993)

[2] Family to Family education program of the National Alliance for the Mentally Ill (USA) and the BC Schizophrenia Society

Growing Up with Mental Illness

An interview

Monica Alfreds
[interview]

Monica worked in the animation industry for some years and now is the mother of two small children. She has lived in the Okanagan and on the North Shore, where she currently resides. In this interview she relates her experience of having a parent with mental illness

What was it like growing up having a father who had a mental illness?

The first time I remember my father having an episode was when I was eight years old. He was hospitalized for a brief period and I remember going to visit him, but I wasn't really sure why he was there. Shortly thereafter, my mother sold the family home and business, and we moved from the Okanagan to the Lower Mainland. My mom went to work full-time, and my dad worked off and on for different employers while he cooked up his own business schemes on the side.

Needless to say, our financial situation wasn't great, but we had a nice home in a good neighbourhood. Over the next decade (1980s) he cycled between periods of normal, depressed and manic behaviour. It was unpredictable to say the least, and I remember feeling confused, isolated, lonely and fearful at times. I didn't know anyone else who had a parent with a mental illness. I didn't feel that any of my peers could relate. I rarely discussed it with anyone outside of our family. I really didn't understand the illness either. It is still amazing to me that although mental illness affects so many people, it is often not discussed or understood by those who suffer from its effects.

What kinds of support would have been helpful for you and your brother as you grew up?

I feel that growing up with a parent who has a mental illness is very similar to being raised in a home with alcoholism. Denial, isolation, unpredictable and irresponsible behaviour, financial instability, shame, depression are common in both situations. AA and Alanon have meetings all over the world, but I was not aware of any support groups for families who had a relative or loved one who suffered from a mental illness. I think it would have been very helpful to have had a group like Alateen to belong to: providing a community of individuals who could understand what we were going through, and a place where we could find emotional support. My brother and I had to become very responsible at a young age, and it would have been nice to have had a place to go where we could behave more like 'normal' teenagers, and relax and just have fun.

What kinds of issues did your mother face having to provide support to your father while raising a family?

My mom had a very difficult time. She found it almost impossible to find adequate information or support. My father had some severe episodes of mania, but she would have to prove that he was a danger to himself or to others to get him admitted to the hospital. It was terrible to have to see him get that sick to get any help. My mom also found it difficult to find doctors who would discuss his medical condition with her. She really didn't get much assistance from anyone. It was extremely frustrating and exhausting. She worked full-time and raised two children while she dealt with all of the fallout from his illness. It wasn't easy. I admire her strength and courage.

What kinds of support would have been helpful for her?

I think it would have been helpful if there had been more communication between the doctors and our family. We knew when he was starting to show symptoms of either mania or depression long before he was really far gone. We knew when his medication was or wasn't working. We were also very good at figuring out whether he was taking it or not. He would always tell his doctors he felt great no matter what was really happening. Patients have rights, but the emotional health of those who live with and love them should be considered as well. The wishes, needs and concerns of the family should also be given merit.

> "AA and Alanon have meetings all over the world, but I was not aware of any support groups for families who had a relative or loved one who suffered from a mental illness."

Now that you and your brother are older, what kinds of issues do you face?

The concept of allowing a person with a severe mental illness to be completely responsible for his or her own life isn't very realistic. My dad receives income assistance and he is able to live on his own. He hasn't been hospitalized in years, so he's probably taking his medication as prescribed, but my brother and I can't be with him all the time. I have two young children that I love dearly, and I have learned that my emotional and physical health and my personal and financial responsibilities must come first.

I am blessed to have my brother who provides most of the caregiving and emotional support. He talks to my dad on the phone a couple of times a week. He often invites him to watch the hockey game or to go out for a round of golf. He takes care of most of the critical things. I keep in touch and host holiday events and barbeques with the kids.

I do worry about his health, and I often wish I could do more, but there has to be a balance. He is still the parent and we are the children. We are supposed to lead our own lives. I think we are doing the best that we can, considering the circumstances.

What kinds of resources would be helpful to you (and your brother) now?

What I would really like to see would be programs for people like my dad, who are living with a mental illness: day programs, support groups, and community settings where they could share, learn and find hope for successful, more independent living. It would be great if my dad could find ways to learn new skills or rediscover old ones. This might help him regain self-confidence, self-esteem and possibly a small income. It would also be nice if he could participate in organized social and recreational outings.

I also feel that it would be great if doctors could make an effort to work together with concerned family members. Many times people who are sick don't think that they need help or medication.

It would be nice to have more information about mental disorders and their treatments. I know that there are probably some support groups and resources out there, but I don't know about them. Doctors, the general public, patients and their families should be made more aware of the warning signs, symptoms, current treatments, and supports for mental illnesses: education, education, education! Also, family support groups – it would be nice to network with other people who can give first-hand advice or emotional support. It is always good to know that you are not alone.

Any final thoughts?

My dad is still my dad. He has an illness that affects his thinking and behaviour. It's not his fault. As I gain more experience in life and as a mother, I realize what an amazing job my parents did in spite of all the difficulties they faced as a result of his illness. They did their very best. I have been described as being resilient, understanding, loving, headstrong, independent, and most importantly, as a wonderful mother. I learned this from them. It has taken many years, but I am learning to stop wishing things could have been different, and accept my dad as he is. I have never questioned the fact that my parents love me. Not everyone, no matter how 'normal' their upbringing was, can say that.

A Tale of Dysfunctional Child-rearing

Frank G. Sterle, Jr.

Frank lives in White Rock, BC

I always say: too many people who make dysfunctional parents have the most children; meanwhile, many people who might make the best parents decide to live their life childless. The irony is there, and it's bitter.

Take the example of my late father and my mother, who bore four of us children and then saw these children grow into adults with anywhere from minor to severe forms of mental illness: one has schizophrenia and severe anxiety; another has clinical depression and chronic anxiety; a third, me, has a schizo-affective disorder that also manifests itself in the form of obsessive-compulsive disorder(OCD), chronic anxiety and clinical depression. The fourth seems to be the most functional, who experiences manageable depression along with some also-manageable paranoia.

My mother, a sweet soul, always wanted children – in fact, she divorced her first husband because he wished to remain childless. I believe that my mother, with a functional mate, would have reared functional children. However Dad was basically a dysfunctional mess – albeit, he didn't drink, except for the very rare cup of wine, and he didn't take drugs. But that's just it: he should have been taking drugs – psychiatric drugs, that is.

Instead, he chose to use his family as his relief mechanism for his mental dysfunctions. And his dysfunctions were indeed acquired, at least to some extent, by us children. Two of us, including me as but a five-year-old boy, acquired dad's obsessiveness when it came to turning things off and/or making sure doors were locked. I would tighten the tap faucet knob until it required repair, while other times I'd continually press down on the light switches just to make sure they weren't caught in the central position and thus could pop on some time during the night.

Dad also suffered from chronic anxiety; he worried about *everything*. And he shared – or forced – that worry onto Mom and me and would have on the other children if they had allowed it (though for the most part, they didn't). Thus I grew up with the same dysfunctional characteristics as those of Dad. Simply put, I worried about matters that were inappropriate for a child to worry about.

Mom ended up in Riverview Hospital a few times, receiving electroconvulsive therapy, the old way, to treat her nervous breakdowns (for the record, Mom says the electroshocks worked wonders for her).Today I, once that five-year-old boy, am a man who is a dysfunctional mess, suffering from OCD, chronic depression and severe anxiety.

To summarize, Dad, who was too proud to do so, should have acquired psychiatric help – including psychiatric medications – years before he produced offspring. He should have done so for his family's sake and for himself, too.

Caring for the Aged

The patient | The caregiver

Elizabeth

Elizabeth is a member of the Mood Disorders Association of BC

Over the past years, we as a family have experienced the frustration of watching our mother display the signs of what we believed were that of a person growing old. In our situation, it would have been much easier to deal with the medical problems of one parent, without having to deal with the interventions of the other dominant parent, our father.

Our father's interpretations of my mother's behaviour differed from the rest of the family. He requested medical intervention at each and every occasion, believing what was going on to be a physical illness, and always used to say, "It's her heart, you know!" This put him at odds with the rest of the family, but when we confronted him, our father justified his interpretations by the statement, "You don't live it – you don't know what it is like living with her!"

A specialist (psychiatric) diagnosis of our mother identified her condition as the early stages of Alzheimer's/dementia, but mostly severe depression. The family had been present at one of the visits leading up to this diagnosis, and it was an interesting experience. Our mother was overridden during the visit by our father, who described all the symptoms to the doctor on behalf of our mother. Medication was prescribed, and it was left up to our father to administer. Subsequent visits were conducted in the same manner, to the best of our knowledge, with our father always present, with one exception.

Throughout this period, our father sought medical attention from every resource available to find some other diagnosis, as he could not comprehend that 'depression' was an illness. Again, the family discouraged him from this, but we were constantly reminded by him, "You don't live it – you don't know what it is like living with her." Intervention was discouraged by our father unless it conformed with his interpretation of need.

Our father would interpret the actions of our mother as being hereditary. He would constantly describe our mother's actions in ways that were seldom complimentary and unfortunately, at times, in the company of others. We felt that he was repeating these kinds of verbal reports (abuses) constantly and that our mother was being put into a position of believing them as truths.

She would resort to sleeping, at times, for one or two days, but our father would interpret this as being a medical condition not related to the diagnosis of depression. The family intervened and discovered that he would, at times, administer his own 'natural' supplements to assist our mother, and that these substances would create adverse responses. He was also found to be quite capable of mixing up or unintentionally 'over- dosing' our mother. A different prescription process was initiated, but it was found that our father would blame the druggist for the mistake and continue the 'over-dosing.'

I am not relating this story for the purpose of blaming our father, but rather to provide some insight into the difficulties a family may have with a possessive and dictatorial father or head of the family. Our father detests the idea of being old and is possibly afraid of death and of being alone. We feel he does have true feelings for our mother and in his mind believes what is being done is the best under the circumstances. He displays signs of complete frustration with the medical profession, stating that, "they don't care like they used to and they don't tell you anything." Our father has been abusive to the medical practitioners and is not beyond abusing the system.

Separation of our parents has been discussed and offered as an option, but any intervention has been refused each time. The family has sought outside advice, both professional and otherwise, and at each turn has been met with resistance and the same repeated statement. Medical professionals have been advised of the concerns, and they too have expressed frustration with our father.

We do not believe that a situation such as this is uncommon. Any resolution involving separation, which appears to be the only remedy, would be heartbreaking and possibly destructive to the health of our parents. Our mother's physician has indicated that she could be placed in a separate facility. While our father would accept this, our mother refuses. Our mother was hospitalized for a period of time and showed marked improvement in an institutional setting where she was properly medicated. After she was discharged, she fell back into her depression.

The family has attempted to provide as much support as possible with visits, dinners, offers of outings etc., which have been well received but have not helped to resolve the problem. Our father has been the sole caretaker of our mother and has made her totally dependent on him. Sadly, since the onset of this situation, our mother has indicated on numerous occasions that "she is just tired, feels she is a nuisance to everyone and wishes it were all over."

In an effort to look after our aged parents, we have exhausted most avenues and experienced new emotions that leave us somewhat bewildered as to the best course of action to follow. These two people have experienced a fruitful life in their own right, and still demand that they be left in control of their own destiny, for whatever reason. Our father made plans for this period in their lives, to allow for their independence and ensure that they would not be a financial burden on anyone. This, unfortunately, has not been borne out, hence the dilemma. Others may believe that they have or can offer further resolutions, but, to paraphrase our father, "You don't live it – you don't know what it is like to live with her!"

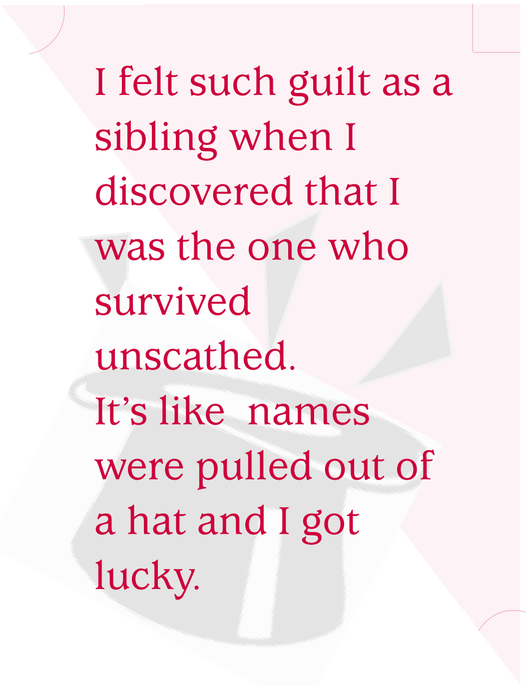
A Sibling's Story

From Grief to Action member

From Grief to Action is a non-profit advocacy society working to improve the lives of drug users, their families and friends

I adore my younger brother. He means the world to me. There isn't anything I wouldn't do for him if it meant that he would be happy.

My brother and I are 14 months apart in age, so we went through the same stages together. We partied together at university, experimenting with alcohol and pot. As siblings, we formed an alliance and shared in our silly and irresponsible behaviour. Together we made an invincible team, popular and busy. When I left home to study law abroad, my brother and I were sadly separated. It was while I was obtaining my degree that my brother's illness surfaced and changed my life forever.



I felt such guilt as a sibling when I discovered that I was the one who survived unscathed. It's like names were pulled out of a hat and I got lucky.

I will never forget the family intervention we held in the kitchen, mid-morning on a sunny summer's day. I was the one who guessed crack cocaine. I felt such guilt as a sibling when I discovered that I was the one who survived the haze of those years unscathed. It's like names were pulled out of a hat and I got lucky. I got to move on with my life while my brother got to enter a treatment centre. We were all so fragile and scared and so ill-equipped. I craved knowledge and understanding and peace. I watched my parents wilt and fade. This was the hardest part of all, to see their sadness and helplessness.

The easiest way I can explain the dynamic of my family is to say that it is like a triangle. In the right-angle corner is me, and I have one kind of relationship with my parents and one with my brother. But it is the relationship between my parents and my brother, the hypotenuse, that is the most difficult to watch. I remember one Mother's Day when I called to wish my mom a wonderful day and to say the flowers were on their way. All my dad could say was that my brother had called from jail in Iowa. Jail in Iowa and I, a thousand miles away. How was I to comfort them and who was there to comfort me?

Discussing an addiction is a difficult thing, especially at a young age and in a peer group and society where overindulgence is socially acceptable. I had had to alter my own beliefs and ideas of addiction and was not yet ready to fight against the stereotypes of others. It was a lonely and confusing time. Every time I called home, the updates grew more and more depressing. The conversations were always about him: my brother, the addict.

During my brother's relapses, our relationship seemed to collapse, and during times of recovery, we made the effort to rebuild what had been lost. This continuous rebuilding is what took the most strength and was the most exhausting. After the tears dried, I spent hours listening and trying to understand and forgive what he had done. The forgiving was always faster for my parents. They carried him endlessly through relapses and recoveries. As time went on, the debates between my parents and I on how to deal with my brother grew sharper and louder. He was taking up so much time, money and energy. I did not have to forgive him as quickly or support him as readily because he was not my child. As a sibling you can keep your distance, but my parents felt that distance and it was hard on them. In the end I would always relent and let my brother know that my love and support would always be there for him. It just took longer sometimes – to tell him, to see him, to hug him again.

This past summer, my brother performed the ceremony at my wedding. He was four months clean and on controlled medication. I was really seeing him for the first time. In his speech, he thanked me for being a key element of support in his rough road to recovery. Little does he know the impact he has made on my recovery. My brother, my hero.

Programs for Families with Parental Mental Illness

Results of a US National Survey

Joanne Nicholson, PhD, with Betsy Hinden, PhD, Kathleen Biebel, PhD, Alexis Henry, ScD, and Lawrence Stier

Dr. Nicholson is an associate professor of psychiatry and family medicine at the Center for Mental Health Services Research, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655 USA

Background

Parenting and Mental Illness

The majority of American men and women who live with mental illness are parents at some point in their lives. Of all parents in the United States, almost one-half of the mothers and almost one-third of the fathers have symptoms of mental illness during their lifetime. Adults with mental illness typically define parenthood as a significant role, and one that gives meaning to their life and motivates them to recover. On the other hand, the potentially negative impact of parental mental illness on the behaviour and development of children is well-known. Given these considerations, it is difficult to understand why or how opportunities for improving the lives of both adults and children living with parental mental illness are missed or ignored, especially when in unfortunate cases like that of Andrea Yates – the mother with mental illness in Texas who drowned her children – the tragedy of these situations is compounded by the fact that they could have been averted or avoided altogether.

Extent and Nature of Programs for Parental Mental Illness

Results of a National Survey

Several years ago, in order to find out more about the responses that do exist, we conducted a national survey. In general, the existing programs have been developed on a small, local scale with limited funding and have remained largely isolated from one another. In total, we discovered 53 programs, which we categorized into three groups: those that were designed and developed specifically for parents with mental illness, we called 'high-specificity' programs; 'medium-specificity' was what we called programs where parents with mental illness participated, but their needs were not the focus (for example, generic parenting programs) and; 'low-specificity' programs were defined as those in which adults with mental illness participated, and that did not have specialized services for parents, but where parenting issues were addressed to some extent.

We were able to study 20 high-specificity programs in greater detail. Five of these were located in New York, four in California, and two in Illinois. Massachusetts, Rhode Island, DC, Michigan, Missouri, Iowa, Colorado, New Mexico, and Alaska each had one program. The newest programs participating in the study had been in operation for four years, while the oldest had been operating for 22 years.

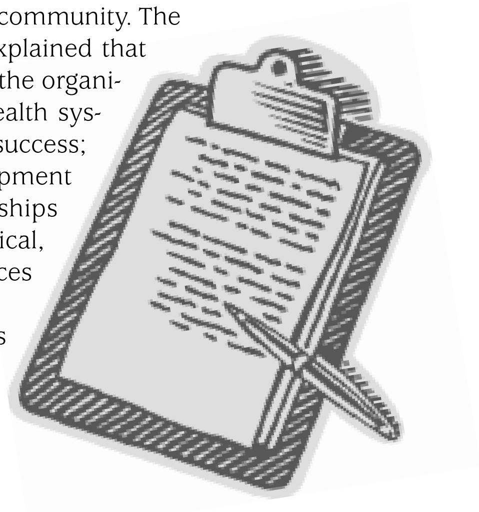
Parents with persistent mental illness who were eligible for state-funded mental health services were the most commonly targeted population in these programs. Key factors often reflected in program design included the child's custody status – that is, whether the child was currently in the parent's custody, or if a reunification was planned – and the age of the child. The majority of programs focused on serving young (0 to 5 years old) or early school-aged children, with a clear decrease in services for children as they aged, and far fewer resources available for adolescent children. Racial and ethnic characteristics of program participants varied greatly by geographic location. The majority of programs focused on mothers only.

Overall, most of the programs discovered by the survey were developed to meet the needs of adults with mental illness who were parents, and were begun by adult mental health providers and policy makers. A second group of programs, however, focused on nurturing child development and resiliency in children whose parents had mental illness.

Factors associated with program development, sustainability and positive client outcomes

When we examined what factors led to programs' development, sustainability and positive client outcomes, we found that success usually depended on the work of one or more committed advocates who were able to engage sufficient political and economic support within an agency and within the larger community. The program directors we surveyed explained that economic resources, politics, and the organization and structure of mental health systems contributed significantly to success; also, the establishment or development of positive inter-agency relationships and open communication was critical, due to the need for multiple services that cross agency lines.

Another factor related to success was agency or program leadership that supported a family-centred approach, and was politically sophisticated and able to advocate for parents with mental illness in



general, and the program in particular.

Most programs were small, though they ranged in capacity from 8–10 families to ‘no limit,’ with the average program capacity being 15 families. Staffing depended on the numbers of clients served, and on the comprehensiveness of the intervention. Case managers from the more comprehensive case management programs worked with between four and ten families each, depending upon the program. Program-level factors that were important to the success of interventions included having flexible, non-judgmental, and clinically knowledgeable staff.

Program funding sources to a large extent depended on the original focus of the intervention. Interventions emphasizing functioning for adults with mental illness were usually started with funding from state or county mental health authorities; interventions targeting children at risk were initially supported by early intervention or prevention funds. Almost all programs had more than one funding source; however, other funding sources such as Medicaid, state mental health authorities, research grants, and other special sources often supplemented the original program start-up funds. Many programs reported difficulties sustaining program efforts given shifts and cuts in funding.

Programs reflected a range of theoretical orientations, with most program directors identifying multiple approaches to treatment, including psychosocial rehabilitation, psychodynamic, feminist and trauma theory. This variety reflected a historical process shared by many programs where an intervention founded upon one particular theoretical orientation borrowed from others as it evolved in response to the complex realities and needs of families. Although interventions reflected a diversity of theoretical underpinnings, *all* programs shared the following commonalities: they embraced the concepts of ‘family-centred,’ and ‘strengths-based.’ Many of the programs also shared these assumptions:

- adults with mental illness have strengths and can be parents with the appropriate supports
- adults with mental illness deserve the opportunity to parent and to receive the supports necessary to function as well as possible in the parenting role
- enhanced parenting goes hand in hand with enhanced child development
- a trusting relationship between provider and participant is central to a successful intervention. As stated by one program participant, “I have a place to live, someone to call, someone who cares about me, someone I trust and someone who respects me”

Two programs that included interventions targeting children shared the additional assumptions that:

- prevention of child problems is possible and imperative
- early intervention to improve parenting can prevent poor child outcomes

Program settings and approaches

Programs fell into three broad categories:

1 **Inpatient programs** tended to be special hospital units with clinically-trained providers who focused on mental and reproductive health for women. These interventions were short-term, and focused on achieving stabilization of the acute phase of the illness; referral was made to community-based services for longer-term follow-up.

2 **Comprehensive community-based interventions** offered an array of essential services to meet the needs of all family members including parent education, skills training and support; case management; residential, housing or supported housing services; individual and family psychotherapy; and therapeutic nursery services. Case management focused to some degree on the needs of all family members and could be appropriately described as family case management.

3 **Circumscribed community-based programs** generally offered a more targeted intervention – e.g., dyadic therapy (an intervention aimed at improving parent-child interaction), or parenting skills training – and did not provide ready access to a continuum of program components.

The central objective of comprehensive programs was improved functioning across multiple domains for all family members. Program directors agreed that the following were essential to successful parenting: stable housing, stable employment or access to entitlements, increased parental self-esteem and self-efficacy, decreased hospitalizations, decreased social isolation, improved access to prenatal and ongoing health care for all family members, the end of child protective service involvement, increased knowledge about child development and improved child behaviour management skills, and the education of parents and children about mental illness and its impact on family life.

In summary, core elements in comprehensive and successful community-based programs in the US include:

- a target population of adults and children living with parental mental illness
- family-centred, strengths-based, working assumptions
- multiple sources of funding
- collaborative inter-agency relationships
- supportive, responsive leadership and advocacy, and skilled, non-judgemental staff
- family case management; and parent support, education, and skills training
- outcomes that reflect the goals, functioning and well-being of all family members

Ongoing Challenges

There are many challenges to working successfully with these families. The stigma of mental illness is ▶

From Little Things, Big Things Grow *

A decade of Australian achievements for children of parents with mental illness and their families

Vicki Cowling

Vicki is a social worker and psychologist who has contributed to research, innovative projects, publications and professional education in Australia and overseas concerning children of parents with mental illness. Her contributions include Children of Parents with Mental Illness *(Ed.) (1999), and* Children of Parents with Mental Illness 2: Personal and Clinical Perspectives *(Ed.) (2004), both published by www.acerpress.com.au. Vicki is the Mental Health Promotion Officer with a child and adolescent mental health service in Melbourne*

Introduction

This article outlines the development of responses to the needs of children of parents with mental illness and their families in Australia, starting with the relevant recommendations of a National Enquiry into the Human Rights of People with Mental Illness, tabled over ten years ago, and leading to the creation of a national project currently in progress. The article also looks at some key developments that happened prior to the release of the Enquiry report, in particular, the Children's Project in Melbourne, Victoria. Though there have been innovations in all Australian states and territories, the focus of the present article is on Victoria, given the author's familiarity and involvement with developments in that state.

Key Developments Prior to the National Enquiry

Prior to the 1992 National Enquiry, recognition of the needs of parents with mental illness and their children was acknowledged in Victoria by concerned individuals through initiatives such as peer support programs for parents and professional education for mental health workers.

Just before the *Human Rights Report* was published, one of the first research projects to be conducted on this topic in Australia began at the Early Psychosis Research Centre in Melbourne, funded by the Victorian Health Promotion Foundation. It became known as the Children's Project.

During the three-year course of the project, a one-day census of adult mental health services in Victoria was conducted, a survey of service providers completed, and focus groups and interviews with parents undertaken. Subsequent research in other states built upon aspects of this early work. As people learned about the research project, a substantial amount of time was soon given to speaking to many ▶

US survey | *continued from previous page*

pervasive, and comes from a number of sources that must be addressed. Providers must educate a number of stakeholders about mental illness – such as school personnel, child welfare workers, lawyers, judges, primary care physicians and landlords – in order to develop important community collaborations and to enhance outcomes for families. Funding is another ongoing challenge: in addition to inadequate and unstable funding, typical adult services and child services funding streams do not support family-centred interventions or ones that are preventive in nature. Services are routinely organized, delivered and paid for with the individual adult or child as the designated client. Family members typically cannot access preventive interventions but have to develop problems of their own to be eligible for treatment.

Common Themes in International Perspective

Work in the area of parents with mental illness and their families in the United States can be put in an international context. Colleagues in the United Kingdom, many of the European countries – including Sweden, the Netherlands and Greece – and particularly in Australia have been active in bringing attention to the issues of these families. When reviewing reports from these countries, there are certain common themes that emerge which are consistent with what we've found to be significant in the United States: the importance of considering *all* family members – adults and children – in situations in which parents have mental illness; the emphasis on resiliency and prevention, as well as problems and treatment; the importance of collaborative relationships that cross organizational boundaries and break down organizational barriers; and the value of the co-location of community services.[1] Another issue that comes up commonly, and must be addressed, is that a primary focus on child protection pits workers against parents living with mental illness.

related resources

Children of Parents with Mental Illness (COPMI) website.
Follow link from Australian Infant, Child, Adolescent and Family Mental Health Association website:
www.aicafmha.net.au

Parenting Well website:
www.parentingwell.org

footnote

[1] Barrett, A. (2004). *Supporting mothers with mental illness: International approaches.* 2002 Edith Cowan Women's Fellowship Report. Western Australia.

This article was adapted from a soon-to-be published piece that was prepared for The Clinician, *John Hunter Hospital, Newcastle, New South Wales, Australia. It appears here with thanks to the author and to* The Clinician, *Adrian Falkov (Ed.). The original article is an edited version of a keynote presentation to a conference organized by the Scandinavian Network for Children of Parents with Mental Illness, "To visualize the invisible children: Preventive work with children of mentally ill parents," given in Stockholm, 13-14 November, 2003*

different groups in a variety of forums locally, and interstate. This process contributed to raising awareness and encouraging participants to think about changes they could make in their workplaces. It also led to the publication of the first Australian book on the topic, *Children of Parents with Mental Illness*.

The Release of the National Enquiry

In 1993, following three years of research, the report of the National Enquiry into the Human Rights of People with Mental Illness was tabled in Australian Parliament.[1]

Chapter 16 of the report focused on children of parents with mental illness, and made several recommendations:

recommendations

- mental health workers should ask clients if they have children, ensure the children's needs are being met and make referrals if necessary
- government departments such as health, education and family services should work together to plan and implement services which provide a range of family and child support services for the children and their families
- agencies must be resourced to meet the varying needs of children: support when a parent is in hospital, support after discharge from hospital, school-based support and community-based support
- education authorities should provide school-based support for children
- governments should allocate money to non-government services to enable them to provide services to families

Following this report, the Commonwealth [Australian federal government] invited submissions for the development of new projects which would improve services for people with mental illness and their families. With this funding, two programs started in Sydney in 1994: a psychosocial intervention program for children which provided education and peer support, and a program to support parents with mental illness who had children up to five years in age.

1995 saw the convening of the first conference held in Australia about children of parents with mental illness. Around 100 people attended, with some travelling to Melbourne from other states. It was so successful that another conference was arranged in 1996.

Subsequently, the media became interested in the subject, leading to major newspaper stories, and to items on current affairs radio and television. In August 1995, an editorial was published in the *Medical Journal of Australia*, accompanied by an interview on the ABC Radio National program, the *Health Report*. This publicity also encouraged interest and enquiry.

The implementation of the Children's Project led to the establishment, around the same time, of what is now well known as the Champs Project, for children of parents with mental illness. This project in of itself has had a number of very positive outcomes, as described below.

Peer support programs for children were started, such as school holiday programs, and weekend camps for children. Two videos were prepared to raise the awareness of workers in adult and child/adolescent mental health services. One of the videos, *Hard Words,* can also be used by workers to help children talk about their own experiences and worries.

Early in 1997, the Victorian child protection service held a series of workshops to increase knowledge and understanding of the issues for children and parents among child protection workers. The workshops, groundbreaking in themselves, were enhanced by the participation of a parent, who described the experience of being a parent and having a mental illness. Since these first workshops, further training for child protection workers in Victoria has included parents as paid presenters.

Also in 1997, a new project began in the eastern part of Melbourne, known as Parents in Partnership, which over a period of twelve months, established two peer support groups for parents, and provided professional education sessions for workers in mental health and welfare agencies. The project continues and now provides regular weekend camps for children, as well as school holiday and after-school programs. Feedback from the children attending the camps – as well as from their parents – was very positive, encouraging the Victorian government to provide funds so that camps could be run in several locations across the state over the following two years.

Around the same time, the Centre for Adolescent Health in Melbourne began providing peer support programs for young people between the ages 13 and 18, known as the Paying Attention to Self program. These groups have contributed to reducing feelings of isolation for these young people, reassuring them that others have similar family situations and also feel angry, alone and confused. The programs have also helped participants to find the confidence to become peer leaders who are responsible for helping run the groups. As one participant said: "Peer support means being there when things are good or bad, talking with other people your own age about the problems that happen at home. Learning from others and telling the truth when it is so easy to cover up what really is going on, by saying, 'It's OK.'"

In 2002, the Victorian government, Victorian Health Promotion Foundation and *beyondblue,* the National Depression Initiative, funded the development of more peer support groups for this age group in five different parts of the state. (See www.rch.org.au/community).

In 2003, the same funding partners once again provided funds, this time to develop a model of best practice to promote the mental health and well-being of children aged 5 to 12 years who have a parent with a mental illness. Known as VicChamps, this project is a partnership between the Eastern Health Mental Health Program in outer eastern Melbourne, and Upper Murray Family Care in northeast Victoria.

The project has three-years of funding to develop a best practices model suitable for both rural and metropolitan areas. Overall, the three aims of the VicChamps project are to increase the resilience and social connection of children who have a parent with mental illness; reduce stigma associated with mental illness; and enhance community capacity to assist these families through partnerships between sectors and services, peer support programs, workforce development services, and through educating the community as a whole. (For more information on VicChamps, and for general information on the topic of children of parents with mental illness, see champsworldwide.com).

National Initiatives

Educational Resources

The development of resources such as books and videos has also been a valuable part of the work taking place across all of Australia. Some examples are *Jakes Dinosaurs* and *Robbie Rose and Monkey,* developed in South Australia and written for younger children. The Association of Relatives and Friends of the Mentally Ill (ARAFMI) in Western Australia developed two books for children and young people: *Handle with Care* is for the younger age group, and *A Book for Young People about Mental Illness* is for youth aged 13 to 16 years old. SANE Australia has published *Joe's Diary* for 10 to 14-year-olds, and *You're Not Alone,* a cartoon-style book designed to build understanding about parental mental illness in young people aged 6–12 years. This book was initiated by Dan Halloran and his family, who were featured on the ABC TV program *Australian Story* in May 2003.

In Queensland, the *Koping Video and Booklet* were prepared to assist workers talking through issues with young people having a family member with mental illness. Children of Mentally Ill Consumers (COMIC) in South Australia has prepared a *Supporting Our Family* kit, which helps children and families plan for a parent's hospitalization and ensure the child's needs are met (see www.angelfire.com/home/comic).

The resources described, and many others, are listed on the Children of Parents with Mental Illness (COPMI) website: www.aicafmha.net.au/copmi

The First National Conference

In April 2002, Australia's first national conference on parental mental illness was held in Melbourne, where many of the initiatives developed over the previous few years were presented. The event was titled, "Holding it All Together: the First National Conference for all Involved in Meeting the Challenges for Children and Families where Parents have Mental Illness." At this event, consumers, carers and young people were well represented among presenters, and Prof. Joanne Nicholson, University of Massachusetts, and Dr. Adrian Falkov, at the time in the UK, accepted the invitation to make keynote addresses.

The COPMI Initiative

Ten years after the *Human Rights Report* was published, we now have an Australia-wide project focusing on children of parents with mental illness and their families: the COPMI initiative.

In 1999, the Commonwealth Department of Health and Aging invited the Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA) to conduct a scoping study to gather information on key projects and services for children of parents with a mental illness, analyze and report on the findings of the study, and make recommendations for future action.

This report was presented in 2001 and, in response, funding was announced for a three-year national initiative known as the COPMI (Children and Parents with Mental Illness) project, which began in late 2001. Administered by AICAFMHA, the project aims to achieve better mental health outcomes for children of parents with mental illness. The draft of a key document arising from the project, *Principles and Actions for Services and People Working with Children of Parents with Mental Illness,* can also be found on the COPMI website (See www.aicafmha.net.au/copmi).

Conclusion

A glance back at the 1993 *Human Rights Report* recommendations shows that we have come a long way. And many opportunities lie ahead yet – for research and evaluation, the development of clinical services, and the further integration of services – so that the needs of children of parents with mental illness, and those of all family members concerned, may be asserted and met.

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footnotes

[1] Human Rights and Equal Opportunity Commission. (1993). *Human rights and mental illness. Report of the National Enquiry into the human rights of people with mental illness.* Canberra, AGPS.

* *From little things, big things grow.* Acknowledgement to Kev Cormody and Paul Kelly for this song

Working Together with Parents with Mental Illness to Maintain their Child's Mental Health

Sharon Van Volkingburgh, MSW

Sharon is a child and family therapist working with Vancouver Community Mental Health Services

I am a child and family therapist working at a community mental health team in Vancouver. At any given time, at least one quarter of my caseload of approximately 30 children has a parent who has, or has had, a serious mental illness. These children present with clinical difficulties including depression, anxiety and serious behaviour problems, as well as other concerns.

Recently, I met with a little boy whose father was in the hospital with a major depression. The child had been referred because he was not sleeping well, not eating, avoiding school, and told his family doctor that he sometimes didn't want to live. The doctor had referred him to our service.

Since his father attended our clinic, I wondered why we hadn't already been aware of this boy and hadn't offered him help before he developed so many symptoms. Why had he not been directly referred by his father, mother, or adult therapist? I can only speculate that our system's preoccupation with helping his father as an individual had somehow not facilitated a family approach that could have provided earlier help to this child. I also wondered whether his mother and father understood the benefit of involving a child therapist to work with the family.

The boy began to improve after the first session. After three sessions – where we talked about 'yucky feelings,' created some expressive art, talked about his own strengths and the strengths in his family, and read a booklet together from the BC Schizophrenia Society about parents with gloomy moods – he was doing much better (sleeping again, eating, going to school, etc.). I also had an opportunity to talk to his mother about the stress she had been under and provide some emotional support.

Parents who have a mental disorder or who suffered from one in the past need to understand that their children are at an increased risk to develop both 'internalizing disorders' such as depression and anxiety and 'externalizing disorders' such as behaviour problems. They will likely need professional help if their children do develop these symptoms and will also benefit from support in developing parenting approaches to lower the risk to their children. Their children also have a higher than average risk of developing illnesses such as schizophrenia and bipolar illness, and parents need to be aware that early identification and treatment of these diseases is important.

> When I talk about these issues with parents, I always promote the idea of advance planning. There are many advantages of making a plan for the care of the child in case of relapse.

What are some of the dynamics that lead to problems? One is 'parentification,' a situation where the child takes a stance that he or she does not need help and resists accepting help from parents or other adult figures. In fact, the child feels that he or she *is* an adult, and actually in charge of their parent – often leading to power struggles, bossiness and unpopularity with peers, and/or a great burden of responsibility for the child to carry. This child often feels that he or she can have control by manipulating others and by not accepting anything for themselves. These children may become 'too good' at dealing with disturbed behaviour in others and are at risk of making poor relationship choices in their teens and not getting the love they deserve in adult intimate relationships.

Other children become dependent and 'enmeshed' with the ill parent to the extent that they are afraid to sleep by themselves, refuse to go to school if they are worried about their parents' health, and may develop symptoms such as stomachaches or headaches.

Both groups of children can become very angry – raging, either by striking out at others or by self-harm – because they have not learned to regulate their emotions. Sometimes their parents have been either distracted by their own needs or too reactive to contain the child's negative emotions at a crucial stage in the child's development. There are, however, ways that these problems can be worked on and corrected.

When I talk about these issues with parents, I always promote the idea of advance planning or 'Ulysses Agreements.' There are many advantages of making a plan for the care of the child in case of relapse.

What is advance planning?

A basic model of advance planning should include the following elements when drawing up a plan:

- **Details:** lists the date, the people named in the agreement and phone numbers; also contains a list of people to inform about the agreement.
- **Statement of Purpose:** the purpose of the agreement is to provide a clear set of guidelines to be taken by members of the individual's support team if the person exhibits illness symptoms that interfere with her or his ability to provide good care for the child.
- **My symptoms:** lists symptoms that the person making the agreement would like others to notice and respond to, and describes the most helpful way to respond.
- **Plan of action:** records how the writer would like to deal with the issue of confidentiality and attaches signed consents if desired. Even with consent, no more information than is necessary for the implementation of the agreement should be shared.
- **Record of writer's wishes for support services:** advance plans can include planning for therapy and support for the child, even if an alternate care arrangement is not needed.
- **Record of writer's wishes for care of the child:** including any information about special needs such as allergies, sleeping routines, etc.
- **Cancellation:** describes the manner in which the agreement can be cancelled. It is wise if cancellation requires a period of time and a set of steps.
- **Periodic review:** describes the manner in which the agreement will be reviewed (e.g., annually.)

This model is not a legal agreement, but an expression of the parent's concerns and intentions made when they were not acutely ill. Parents do have the right to cancel, even if they are acutely ill, but at least expressing their honest desires may help people understand that the illness is causing the problem, and allow for reconciliation afterwards. The Ministry of Children and Family Development is not under an obligation to follow these agreements, but will respect the parent's wishes unless there is a concern about the safety of the child (including concerns about emotional health).

I have found that often there is less motivation to develop these agreements when there are two parents, but it is still a worthwhile project. Working on the advance plan may open up a therapeutic conversation centred on the needs of the children, which can have many positive effects.

What does advance planning do?

By considering a 'worst case scenario,' it is like disaster planning. It promotes putting energy into solutions, breaks down denial, and allows parents to express care and concern for their children.

By inviting others to participate in the advance plan, it opens up opportunity for honest communication and builds a support network for the family. It also allows plans to be made for specific needs, such as interpreters and other community helpers.

Another benefit is that it focuses on the illness and responses to the illness, and avoids blaming the person living with the illness. In addition, it helps to break down stigma about mental illness, which flourishes in silence. Finally, it allows the people named in the advance plan to learn about the illness and to express their love and support to the parent and child by agreeing to participate in the plan.

What problems can advance planning address?

Below is a list of problems that the advance planning process can address:

- **The problem of fear.** It allows parents to discuss and plan for how to manage fears in advance (such as the fear of involving child protection services).
- **The problem of lack of insight.** When ill, parents may deny that a problem exists. This includes not recognizing when one is becoming unwell, the ongoing effects of the illness, and/or the seriousness of the illness; not following treatment; not protecting kids or, for example, involving kids in the psychosis; and allowing kids to be in dangerous situations or around unpredictable people.
- **The problem of confidentiality.** Someone (i.e., principal, counsellor or teacher) at the child's school or daycare needs to know about serious problems that affect the child in order to provide needed support to the child during a crisis. Through this process, parents can agree to create a supportive network for their child, rather than leaving it to the discretion of mental health workers during a crisis.
- **The problem of lack of inter-agency protocols and appropriate family and community supports.** Through the process of developing advance plans, the whole community can get better at supporting families with parents who have a mental disorder.

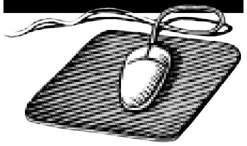
Does it work?

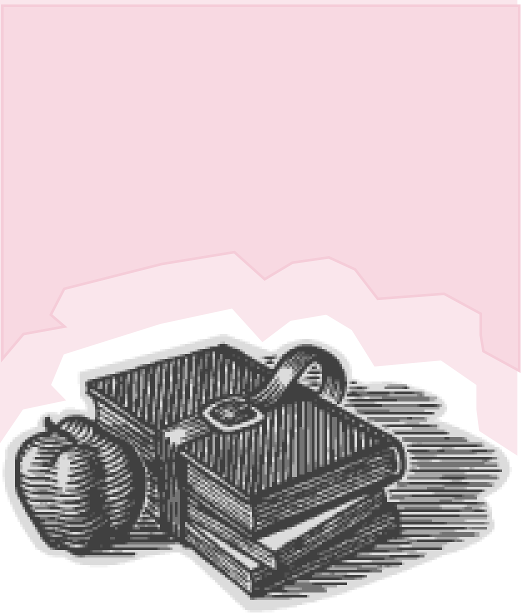
Advance plans do not always work out the way they are intended, often because of the way the illness actually plays out during a relapse. Even with planning, the parent may rescind consents or refuse intervention. Family members and others may still intervene inappropriately.

However, despite these drawbacks, I have seen this type of planning help people develop much needed support networks, with great benefit to children.

web resource

the BC Partners for Mental Health and Addictions Information have developed an interactive template for crisis planning. See Module 4 of our Mental Disorders Toolkit, live May 1st/04 at www.heretohelp.bc.ca





Early Intervention and the Needs of Offspring

I was sitting in a psych class when it all came together for me. The professor had just finished an overview about schizophrenia. "Oh my God!" I gasped to myself, "That's what my father has."...Numbed, I waited for the class to end. There was so much I wanted to ask the professor. Was I in danger of getting it? Would I be doomed to a life of being institutionalized? I was working in nursing school, working part-time as an aide at a psychiatric hospital in New York City, familiar with the pain and horrors of the disease, but never for a moment connecting it to my father's illness, much less to my possible vulnerability to it...

P. Steinert, *Journal of the California Alliance for the Mentally Ill*, Vol.7, No.3

Eric Macnaughton

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Reprinted with permission and adapted from Family Connections Spring 2000: Focus on Children Whose Parents Have Mental Illness, *published by the BC Council for Families. For more information, visit www.bccf.bc.ca, email bccf@bccf.bc.ca or call (604) 660-0675 or 1-800-663-5638*

"*Why didn't you tell me?*" is the title of the article from which this 'moment of truth' is excerpted. The reader might well wonder if this is a common scenario. Surprisingly, and unfortunately, the answer is yes. A recurrent theme running through the writings of offspring of parents with mental illness is this sense of being shut out from the truth about their past family life and unprepared for the effects that the illness might have on their future.

When offspring are kept in the dark, they tend to blame themselves, internalizing responsibility for the otherwise inexplicable upheaval that they often experience. Unaware of 'the facts' of mental illness, they nonetheless pick up the unspoken message that whatever *it* is, it would be a complete catastrophe if it struck their own lives.

The fact is, however, that an offspring of a parent with schizophrenia *is* at increased risk of developing the illness in later life. If one parent has the illness, the chances increase to over 10%, compared to the lifetime risk of 1% for the general population. If both parents have a serious mental illness, the odds increase to around 35%.

Another fact is that with improved medications, and with earlier, more sensitive interventions, developing a mental illness such as schizophrenia is no longer as catastrophic as it was once seen to be.

Part of the early intervention equation relates to the nature of the intervention: using lower medication doses, minimizing the trauma of the care setting, and counselling the person with the illness about how to come to terms with and live with the illness. Supporting the person to resume their life plans is also a key part of the support package.

The other part of the equation relates to the timeliness of the intervention, which in turn relates to the ability of the person in question, and his or her family, to recognize potential early signs and take steps to get help. Unfortunately, offspring are usually uninformed, and incredibly fearful about the possibility of mental illness striking them directly.

What should be done? Since offspring are at higher risk and are often so poorly informed, it makes sense to make them a special focus for any community-wide public education initiatives. Simply providing the facts, though, is not enough. When educating offspring who are moving into their adult years, as much attention should be devoted to undoing the unspoken messages they have already picked up, as to giving them basic information about mental disorders. They need to know that things are different, and that their parent's experience, especially if it was particularly negative or disruptive, does not doom them to the same fate.

A truly preventive approach would be to educate the offspring of parents with mental illness as soon as they are old enough to understand. As the Kids in Control program shows, even young elementary school children can benefit from age-appropriate information and peer support. We must develop more programs of this nature. We must sensitize school counselors to the unique needs of offspring. We should also develop support groups for offspring in elementary and high school settings.

Finally, mental health professionals have to help parents with mental illness themselves engage in direct, healthy dialogue about the illness with their sons and daughters. Mental illness is an extremely sensitive subject, and is very difficult to broach within the family. Nonetheless, offspring *want to be told*. As mental health professionals and advocates, it our responsibility to help them find out the truth, and prepare them to lead healthier lives.

Talking to Children and Youth

When it's time to discuss a family member's mental illness or alcohol/drug problem

Nicole Chovil, PhD

Nicole is Director of Education for the BC Schizophrenia Society

Excerpted from How You Can Help: A resource for families. *Also known as the* Family Toolkit, *this new resource will be available from the BC Partners for Mental Health and Addictions Information. Check the BC Partners website in May/June 2004 to download the toolkit: www.heretohelp.bc.ca*

When mental illness affects a family, the children – including the offspring or siblings of people with mental illness – are just as confused and scared as the adult family members. They know something is wrong. They see that their family member has changed and are aware when there is tension in the home. They need information and explanations to help them understand what is happening. Children often imagine things that are worse than reality.

Parents, older siblings and other family members can help dispel fears and anxieties. Help your child to be supportive of their family member by talking to them about mental illness. Be honest but optimistic.

Talk to your child using language and explanations that are appropriate to their age level and maturity (see 'age-appropriate explanations' box on the next page). Look for books and handouts that are written for children. Movies sometimes offer examples that can be used to help children understand. For example, in *The Lion King,* Simba suffers from depression after the death of his father, Mufasa. Simba's appearance, loss of energy, and lack of interest as he slowly proceeds through the desert provide a concrete example for children to visualize.

Comparing mental illness to other physical illnesses can help normalize the illness. If they have some knowledge of another chronic illness such as asthma, you can use it as an example to help children understand that ongoing care is needed and that people have re-occurrences of symptoms.

It is important to be educated about the particular disorder you're dealing with. If your child asks you a question you don't know how to answer, be honest and tell them you don't know. Let them know you will try to find out.

If a child has seen violent or suicidal behaviour, situations requiring police intervention or any other traumatic incident, don't underestimate how terrifying the experience can be. Help your child to express their feelings.

What you say and do regarding your family member's illness will probably influence your child more than anything you tell them to do.

Suggestions for What to Talk About

Ask your child what they think is the reason for why their family member has been acting differently. Use their response as a way to begin talking about mental illness. Children, especially young children, often believe that if something happens in their world, it is linked to something they did. Ask your child if they somehow feel they are to blame for their family member becoming ill. Reassure your child that their family member's mental illness was not their fault. Mental illness is nobody's fault

Explain that mental illness can make a person act in strange, confusing or sometimes scary ways. Using alcohol or street drugs can make people do things they would not normally do. Ask your child about the way their family member acts and how it makes them feel. Help your child to express their feelings. Let them know that feelings are neither right nor wrong. It's okay and natural for them to have the feelings they're having.

Here are some other suggestions:

- Reassure your child that adults in the family and other people, such as doctors, are trying to help their family member get better.
- Make sure your child knows what to do and who to call if they don't feel safe.
- Explain to your child that many people still don't understand what mental illness is – an illness of the brain. The brain is an organ of the body just like the heart, liver and kidneys. Sometimes it can get sick, just like other organs.
- Help your child to realize that when they try to talk about their family member's illness, their friends (and even adults) may make fun of it. They may say things that aren't true or they may not know what to say. Practice with your child what they might say to their friends and other people.
- If your child witnesses your family member being taken to hospital involuntarily, help them to understand what happened and why it happened. For example, "Your brother suffers from an illness that prevented him from knowing what was best for him. Just like you have had to do things you didn't want to but we knew were good for you. Sometimes when a person is ill, other people

important messages children need to hear

- Mental illness is a medical illness
- With treatment and support, their family member will get better
- They did not cause this illness to happen
- They cannot make the illness better
- Mental illnesses affect the way a person thinks, feels and behaves
- Reminders that it is the illness speaking, not their parent, when they say hurtful or frightening things

Adapted from *Helping Children Cope,* Mood Disorders Society of Canada

related resources

Mental Health Association of Southeastern Pennsylvania. (2001). *Helping children understand mental illness: A resource for parents and guardians.* www.mhasp.org/coping/guardians.html

Pierson, T. (1996). *What to tell children.* Suicide Awareness Voices for Education. www.save.org/coping/children.html

need to decide what is best for them."

- Always remember to let your child know that you are there to listen if they do want to talk.

Here are some questions children commonly ask:

- Why is my [family member] acting this way?
- Is it my fault?
- Can I catch it?
- Will they always be this way?
- Do they still love me?
- Why it this happening to our family?
- Who will take care of me if my mom/dad gets sick?

more related resources

Dumfries and Galloway Mental Health Services Directory. *Helping children to cope: When a parent has a mental illness.* www.show.scot.nhs.uk/dgmhsd/generic/helpchiltocope.htm

National Association for Children of Alcoholics. *What can kids do?* www.nacoa.org/cankids.htm

Children of Alcoholics Foundation. *Coping with substance abuse in your family?* www.coaf.org

Mood Disorders Society of Canada. *Helping children cope.* www.mooddisorderscanada.ca

American Academy of Child and Adolescent Psychiatry. *Talking To kids about mental illness.* (2002). Factsheet #84. www.aacap.org/publications/factsfam/84.htm

age-appropriate explanations

Toddlers and preschool children can understand short, simple sentences that provide concrete information. For example, "Do you remember when you had [cold, chicken pox, measles]? You didn't feel like doing anything and you were sometimes grouchy. It wasn't because you didn't love us or wanted to be that way, but because you didn't feel good. Mommy sometimes doesn't feel well right now and she needs to sleep to help her get better. She still loves you and me, but she can't show it right now." Or "When Daddy is sick, he has difficulty going to work." Abandonment is a major childhood fear, so children need frequent reassurance they will be cared for no matter what happens.

School-aged children can understand more information. They can likely understand the concept of various disorders (e.g., depression, anxiety), but may be overwhelmed by details about medications and other types of treatment. For example, "You know how parts of our bodies get sick sometimes, like when you get a stomach ache or a sore throat. Sometimes a person's brain can get very sick and the sickness can cause a person to feel badly inside. It also makes a person's thoughts get all jumbled and mixed up, so they can't think clearly. These illnesses have names, such as [schizophrenia]."

Teenagers have the ability to understand more complex explanations about mental illness and how it is treated. They are better able to express their own thoughts and feelings. Concerns they may have include: "Will I inherit this illness?" or " What will others think?" (stigma).

Lasting Impressions Program

A partnership program for families

The Lasting Impressions program is a partnership program between the Canadian Mental Health Association (CMHA) Calgary Region and Hull Child and Family Services. The program is designed to strengthen and support families impacted by a parent with mental illness and was formed to meet consumer needs within the city of Calgary – especially in relation to child care and custody issues. One of Lasting Impressions' main objectives, therefore, is to help maintain the family unit and prevent family breakdown.

Towards this end, one of the services offered is trained, in-home 'family mentors' provided by Hull Child and Family Services. Family mentors provide support services, focusing on educating, connecting families with resources, and enhancing family functioning. The family mentor works with all members of the family to establish and attain goals, ensure that needs of the children are sufficiently met, educate the family about mental illness and its effects on family members, and assist in connecting individuals with appropriate community resources.

In addition, the program offers opportunities for family members to connect with one another within a safe community environment. This community portion of the program is provided by CMHA and consists of family network events, youth and teen peer-support groups, a monthly newsletter (*RISK*), information sessions and educational opportunities, as well as the various resources available for distribution.

As part of resource distribution, CMHA currently supplies books on mental illness for families and teachers. Three of the books available are:

For more information about the Lasting Impressions program you can visit www.cmha.calgary.ab.ca or www.wrhull.com

Program partners: Alberta Mental Health Board, Canadian Mental Health Association, and Hull Child and Family Services
Funding Partners: Alberta Mental Health Board, Calgary-Rockyview Child and Family Services, and the United Way

1 Kids Speak Up: Shining Light on Mental Illness

This book was written by a group of children whose parents have mental illnesses. They wanted to share their experiences with others their age: their fears, their joys, their disappointments and their dreams.

Mental illness can be confusing and frightening for children. The fears children commonly express are addressed in this colourful book, designed to open the door to discussion. Parents are encouraged to go through each topic with their kids.

The Canadian Psychiatric Association recently recognized the book as the recipient of their Mental Illness Awareness Week Special Recognition Award. .... *Price: $5*

2 Families Speak Up: Shining Light on Mental Illness

This workbook was developed as a companion piece to the children's book and offers activities and questions to promote individual and family reflection. It helps families talk about some of the challenges and issues they face and promotes healing, understanding and growth. Talking about mental illness openly can be difficult, but it is very important to do. When family members are given the opportunity to share in healthy ways, healing and growth can begin. .... *Price: $5*

3 A Teacher's Guide to Helping Children of Parents with a Mental Illness

The purpose of this guide is to increase understanding about the impact on children and youth of living with a parent who has a mental illness. Teachers can be an important alternative role model for children when parenting may be inconsistent or lacking; especially since it is known that a stable, safe environment outside the home can be enough to protect a child from future emotional problems. The guide outlines recommendations to help teachers and other significant adults be a positive influence on the well-being of affected children. .... *FREE*

Or get all three for $9.

To order, contact Minna Havula at (403) 297-1726, or via email at minna.havula@cmha.calgary.ab.ca

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A Clinic for Women with Schizophrenia

Building skills for life and parenthood

Jennifer Quan

Jennifer is a Communications Co-op Student at the Canadian Mental Health Association (CMHA) BC Division

Written with the assistance of Mary V. Seeman, MD, founder of the Women's Clinic for Schizophrenia at the Centre for Addiction and Mental Health (CAMH) in Toronto, and David Clodman, MSW RSW, a social worker at CAMH

Anxiety about your child's safety is common for any parent, but what do you do when anxiety stems from concerns about the impact that your own mental health might be having on your child? Or from fear that others might see you as an unfit parent? Parenting, or preparing to become a parent, can be doubly stressful for people with schizophrenia. The Women's Clinic for Schizophrenia, operated by the Centre for Addiction and Mental Health in Toronto, Ontario, was designed to help ease that stress, as well as address other concerns particular to women with schizophrenia.

Established in 1995, the Women's Clinic for Schizophrenia is a program that attends, as its name suggests, to the specific needs of women with schizophrenia. Keeping families together is one of the main goals of the clinic, a goal achieved through a focus on helping women gain access to the tools necessary to build themselves happier, healthier households.

These tools include information on controlling symptoms; information on women's issues and mothering issues; and follow-up treatments through therapy groups, parenting groups, psychotherapy and psychopharmacology (the study of drugs that affect the mind). Staffed with psychiatrists, nurses, a social worker and various students and trainees, the clinic also provides clients with connections to community support groups, health professionals and other information and resources to help maximize their financial and emotional support base, as well as the physical and mental health of themselves and their families.

In many ways, the services and information offered at the clinic are not unlike those offered at most other women's clinics; however, most clinics do not welcome women with schizophrenia because they can be incorrectly perceived as disturbed and potentially violent. On the other hand, many schizophrenia rehabilitation clinics are not necessarily equipped to deal specifically with women's issues, and can be intimidating for women who are not comfortable sharing facilities with men with schizophrenia.

As a result, women with schizophrenia are often left in a gap between services. The Women's Clinic effectively fills this gap by providing a place where such women can turn for help in a community and environment in which they feel safe and supported.

Specific issues and questions that are commonly addressed at the clinic include: concerns about the effects of medications on expectant mothers and their babies, fluctuations in symptoms over the menstrual month and with menopause, and the worsening of illness symptoms with age (which is common in women with schizophrenia). In some cases, the women are referred to the clinic from child protective services and other child welfare agencies for help with issues related to parenting capacity and custody disputes.

In the case of children who have been separated from their mothers by child protective services, the support of the parenting group can be quite useful in helping parents understand why their child has been taken away, and what they need to do to see their child's return. "Support is really key," emphasizes Dr. Mary Seeman, founder of the Women's Clinic. "If they have family support and follow through with treatment, the chances of regaining custody of their child are good," she says, adding that the child's age and degree of success with their foster family are also factors.

A constant challenge to reaching women in need of assistance is the reluctance of parents and women desiring to be parents to disclose their illness and to attend the Women's Clinic. Many mothers with schizophrenia fear that disclosing their illness will cause others to view them as unfit mothers, and their children will be taken away. Unfortunately, this often prevents them from getting the help they need until it is too late, and they must come to the clinic for help in regaining custody of their children.

Hoping to break this cycle, the clinic's most recent approach involves focusing on engaging women in their parenting program who are pregnant or seriously considering having a child, to avoid having to intervene once family services has already separated the child from the mother.

In all cases, the clinic emphasizes the benefits of building relationships between their clients and their support figures, whether it

first person account: landing a mars lander

Catherine

Catherine is the pseudonym of a former client of the Women's Clinic for Schizophrenia who has completed her university degree

This article is part of the Schizophrenia Bullletin's *ongoing* First Person *Accounts series. Reprinted with permission from the* Schizophrenia Bulletin, *Vol. 27, No. 4, 2001*

I hear that making friends is a difficult task and that finding a good friend or a best friend is like trying to land a Mars lander on Mars. It requires an exact mix of ingredients to make a friendship happen. Even while all the ingredients seem to be under our control, serendipity often determines the end result. This has often been my experience. This probably has been the case because making friends is pretty much a mystery to me. Even though I have made some friends in my life, I cannot seem to master or understand the skill. Could it be a lack of intelligence? Or is it because I am too quiet? Am I too serious? Is it because I am too distant? Am I chopped liver? This last statement could be true. People just might find me not interesting enough to take notice of me or to want to even be my acquaintance. This is only speculative acrobatics, a form of mental mastication when the mind is left idling. If I knew the answer or had the secret, I think that I would be a happier and more satisfied person. I suspect that the answer lies in deficient social skills and a poor self-concept and lacklustre self-esteem. I do not know.

I have read books on how to improve relationships, and although the books have helped make a few of my relationships more rewarding, I still have relationship woes. Might the answer be in reducing my expectations of the number and quality and intimacy of my relationships? This would be the answer if I were a rock. I feel that the minimum requirements of relationships in my life for my psychological health are not met. Translation: I feel lonely and isolated.

Perhaps I am only looking for a life partner. But how can I achieve this goal when I have trouble making friends? Being friends facilitates forming a bond with a life partner. This I know vicariously from friends who have been in romantic relationships. To these friends, I would never disclose that I have schizophrenia.

Although my first inclination is to tell them about my mental illness and to gain their understanding and sympathy, this would never happen. Schizophrenia is unlike somatic illnesses in that people do not empathize with the person affected. People with schizophrenia are seen as insane, dangerous, deadly and incomprehensible. The stigma attached to mental illness is too great a risk to friendship, and this is why I will now never tell.

However, I consider myself to be normal when I am on medication (and I thank the higher powers that be or just plain luck that I was born at a time when there are methods of successfully managing schizophrenia, with fewer side effects). And I do function normally when I am medicated, except for my inability to make friends. I have friends all right, but they are friends I see a few times a year. I do not have friends that I can go with to a bar regularly, or to see movies with regularly, or to go shopping with be their families of origin, the father of their child, close friends or support groups. Often, housing, income and cultural issues need to be taken into consideration, as they too can impact the health, safety and fair treatment of the clients.

According to Dr. Seeman, the most rewarding part of operating the clinic is seeing the results: watching the women grow and succeed in life by gaining a better understanding of their illness and how to manage their symptoms, building wider social networks and better relationships, gaining access to better housing, and engaging in more meaningful leisure-time activities. The main goals of the clinic – reducing symptoms and reuniting families – are achieved in most cases.

Some more notable success stories include clients who have gone on to complete university education, clients who have found full-time employment, and clients who have regained custody of their children after they were taken out of their care by child protection services. "It's wonderful when you are able to reunite babies with their mothers," remarks Seeman, "They are often very good mothers."

regularly, or to talk with regularly. There is a pattern developing here: however, as I mentioned before, why it exists is a mystery to me.

If I ever found a potential life partner, I would eventually have to divulge my mental illness. I would, however, be in a quandary as to when to reveal that I have schizophrenia. A revelation that came too soon could cause the dissolution of the relationship because of fear and stigma. Would I ever be capable of losing it and endangering other people, especially people I love? The newspapers run stories about [people with schizophrenia] who kill or do harm in other ways. This is a lopsided and misguided view, definitely, considering that the rate of violence and crime within the community of [people with schizophrenia] is the same as the rate of violence and crime within the community at large. A revelation that came too late could also end the relationship because the partner might feel as if I had been lying throughout the relationship. At what point would the revelation of a mental illness not cause the partner in a relationship to leave? In other words, is there a level of intimacy or amount of time passed that would make the person trust me and be comfortable with the schizophrenia that I have? At what point would the person feel like family, not just a boyfriend? And if I did reach this point in a relationship, would I want children? Well, of course, I would want children, but would I want to bring children into the world if they have a chance of developing schizophrenia? Would I be able to raise my children without causing them harm and without forever scarring them?

My immediate family is the greatest asset I have and the most important aspect of my life. They know who I am and accept me every bit. They have supported me throughout the illness, and they are supporting me as I get back on my feet to lead a normal life. Normal is a very subjective word, so I will clarify it by saying that I want to lead a life free of the symptoms of my illness, with a partner, a family and a career. I fear being alone and lonely. I fear that friends will never be enough and that I will never have enough of them. I fear being unable to support myself and having to rely on the social safety net. I fear being homeless and dying homeless, unidentified, and unloved. I fear losing my immediate family to the cycle of life. But all these fears belie how grateful I am for all that I have. I just wish that I had a little more, enough to land the Mars lander.

When Bliss Turns into Blues

Dr. Deirdre Ryan and Doris Bodnar

Dr. Ryan is a psychiatrist at the BC Reproductive Mental Health Program and Doris is Provincial Outreach Coordinator of the program, based at BC Women's and Children's Hospital and St Paul's Hospital

Childbirth is viewed by Western society and in most cultures as a joyous event. However a majority of women will experience the blues, and 12 to 16% of women will go on to experience postpartum depression (PPD) after the birth of a child.

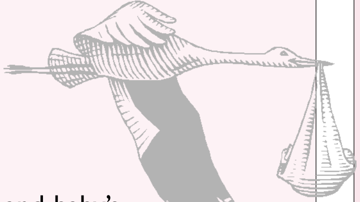
Instead of blissful happiness, these women struggle with sleepless nights, the unexpected demands of a newborn, the loss of order and routine, the loss of their past relationship with their partner, the loss in occupation and income and increased isolation.

They also struggle with guilt, shame and fear of not being happy. This is coupled with the paralyzing fear that if "people only knew how unhappy I am being a mom, how angry I am most of the time, how I resent my baby's constant demands, or the images I have a harming my baby – they would immediately remove the baby from me."

Society's expectations – fuelled by women's cloak of silence – often don't allow women to voice their feelings. Consequently, months usually lapse before a woman finally breaks through the barriers and gets help.

Women who are experiencing postpartum depression may have a range of symptoms that they cannot make sense of and find overwhelming:

symptoms of postpartum depression may include



- Lowered mood, sadness
- Tearfulness or crying
- Feeling worthless
- Anxiety or panic attacks
- Self-blame or guilt
- Worry about own health and baby's
- Lack of energy, feeling tired
- Alternatively, agitation or feeling hyperactive
- Loss of interest in activities, including sex
- Feeling irritable
- Forgetfulness
- Eating too much or too little
- Not being able to concentrate and make decisions
- Not being able to sleep when the baby is sleeping
- Feelings of hopelessness, inadequacy and thinking negative thoughts
- Thoughts about death and, at times, suicide

What typically happens when women are suffering from postpartum depression?

Women may isolate themselves from their families and friends. They typically present a façade that everything is OK, but fall apart once they hang up the telephone or when the visitor leaves.

Women may become preoccupied with physical complaints. For example, they may repeatedly complain to their doctor with their own medical symptoms, or about their baby's difficulty sleeping or poor weight gain.

When the partner becomes aware that his wife is becoming increasingly unable to cope with the demands of the baby, he may call the doctor or bring his wife to an emergency department, asking for help.

Why treatment is important

Women with untreated PPD may develop chronic depression. Women with ongoing depression don't smile or react to their baby's smiles or their cries for comfort, and have difficulty bonding with their babies. The infants of these women either learn to stop smiling and crying, or learn to cry more to gain some attention.

We know that the sooner women who are depressed are treated, the less the depression will effect their infants' behaviour. Identifying women early allows them to access help quickly, begin treatment and get better.

When speaking to women about their depression, they will often say their greatest regret is the *time lost*. This includes time 'lost' being depressed and not being able to remember their interactions with their infant. Women with PPD mourn this loss for years.

> women may say

"The colour has gone from everything."

"I want to cry all the time…"

"I'm no good to my husband the way I am"

"How can I be so unhappy when I have this beautiful healthy baby."

"I've never been this tired."

"I feel like exploding… I get so worked up."

"I'm confused, it seems like I am in a fog…'

"I use to manage an office, now I can't decide what to wear."

"The baby is crying again…I just sat down."

"Sometimes I think my baby would be better off without me."

What help is available to women?

Even if you take good care of yourself – by eating well and getting regular sleep – you may need more help to

related resources

- The Pacific Post Partum Support Society offers information packages for women, their partners and professionals. They have published and sell a book called *Postpartum depression and anxiety: A self-help guide for mothers.* Call (604) 255-7999 or visit www.postpartum.org
- Your family doctor can refer you to the Reproductive Mental Health Program at the BC Women's Health Centre or St. Paul's Hospital. For more information about treatment options and use of medications while pregnant or breastfeeding postpartum, see www.bcrmh.com This site will soon have a *Self-care guide for women with depression or anxiety.*
- BC Partners for Mental Health and Addictions Information fact sheet on postpartum depression. (2003). mentalhealthaddictions.bc.ca
- Sichel, D, & Watson Driscol, J. (2000). *Women's moods: What every woman must know about hormones, the brain and emotional health.* Quill.

treat your depression. This is not a sign of failure but a sign that the depression may be more severe.

Some women benefit from a combination of:

- **Medication:** women experiencing a moderate to severe PPD require treatment with antidepressant medications to help lessen the duration of their mood symptoms. It may take four to six weeks to know if the antidepressant is working.
- **Psychotherapies:** these include supportive therapy, cognitive-behavioural therapy (changing negative thinking patterns), group therapy and marital therapy.
- **Support groups:** ask your community health nurse about groups in your area, or contact the Pacific Post Partum Support Society at (604) 255-7999.

the postpartum blues

Occurs within two to three days of the birth. Women usually experience mild and often rapid mood swings from being very happy to sad, with tearfulness, anxiety, irritability, poor concentration and insomnia. Symptoms get worse with lack of sleep and lack of support. Postpartum blues usually end within two weeks without any help. If symptoms continue, the woman may be developing postpartum depression.

What can partners and families do to help?

- Educate yourself about postpartum depression
- Offer practical supports to new mothers (e.g., make a meal, take care of older children, do the laundry)
- Encourage new mothers to be with other mothers to assist them in adjusting to their new role

If you know a mother who may be depressed, encourage her to talk to her family doctor, community health nurse or a support group.

Postpartum Psychosis

Postpartum psychosis is the most severe and most rare postpartum illness. It occurs in approximately 1 in 1,000 births. It occurs quickly, usually within two weeks of childbirth, but can take up to three months after delivery to appear. Women who have schizophrenia, bipolar disorder or those with a family history of these illnesses are at greater risk of developing postpartum psychosis. Women with psychosis have rapid or disorganized speech, are agitated, distractable, have delusions (false beliefs) or hallucinations (hearing or seeing things that do not exist). They have lost touch with reality and are at increased risk of harming themselves or their infant. These women require immediate hospitalization and treatment.

If you are concerned about a woman or her baby call her family doctor, a crisis line, or take her to the nearest emergency department. ℹ

Supporting Families with Parental Mental Illness Manual

A training tool for communities to organize services to support families

Rob Lees, PhD, Desiree Blume, MEd, Lyne Brindamour, MSW, Nicole Chovil, PhD, Hylda Gryba, MA (candidate), Eric Macnaughton, MA, and Sharon Van Volkingburgh, MSW

The authors are the members of the Supporting Families with Parental Mental Illness Provincial Working Group, chaired by Rob Lees

Background

In British Columbia, the realization of the need to support families with a parental mental illness arose in part out of the 1995 Gove Inquiry, which examined issues relating to child protection including the relationship between custody and parental mental illness.

In the following years, a small group of people came together who were interested in further understanding the needs of children growing up with parents who had a mental illness. This group, now known as the Supporting Families with Parental Mental Illness Provincial Working Group, decided to hold a community forum to talk about parental mental illness and its effect on children.

This forum, the first of two, was held at the Vancouver Public Library in September 1998. Prior to the event, the group wondered if there would be much interest in this topic. As it turned out, over 150 people arrived at the library that day, very much interested and willing to talk.

The success of the first event led to support from the Ministry of Health and from the Ministry for Children and Families, and a second, province-wide forum. Planning for this event reflected a significant shift in the perspective of the working group. Where previously the main interest had been children's needs, the group realized the importance of taking a family-centred focus, which looks at the needs of parents with mental illness and their offspring together.

This time, approximately 300 people from all regions of the province – including stakeholders from both the adult and child/youth mental health fields – met at Vancouver's Roundhouse Community Centre in September 1999.

Keynote speakers included international experts, Diane Marsh and Judith Cook, who discussed the issues of offspring and parents, respectively. In the afternoon, participants heard from a panel of parents and offspring who discussed their experiences, then gathered in groups and spent time discussing what worked and what did not work for families where there is parental mental illness. The comments within the small groups were carefully recorded, categorized by general themes, and later presented to participants as a record of proceedings. This information was then used to prepare the first draft of the *Community Best Practice: Self-Assessment Checklist,* which later formed a key part of the group's next initiative.

Developing the Community Planning Manual

Following this second forum, the working group focused its efforts on developing a tool that would promote integrated community planning to support families where there is parental mental illness. To this end, the committee developed a vision of a guide, grounded in the *Best-Practices Checklist,* that would help interested professionals plan an event where they would discuss the support needs of families, assess their communities' capacity to provide support and develop strategies for moving towards 'best practices.'

In November 2000 and February 2001, two workshops were held to pilot the process and materials developed by the committee. Two different formats of the session were piloted and feedback was obtained from the participants, who reflected a wide range of mental health professionals and others who provide support to families with parental mental illness. These participants included Ministry of Human Resources workers, transition house staff, RCMP, peer support workers, family services agencies, and other community agencies providing support to families with mental illness. From the feedback gathered and group reflection, the materials were reworked into their final form which appear in the current version of the manual.

The manual, called *Supporting Families with Parental Mental Illness,* contains what is needed for anyone with some experience in adult education to hold a community event that will inform participants about the issues involved in supporting families with parental mental illness. This manual is meant as a stand-alone, self-explanatory document that contains all the information needed to hold a successful workshop.

The four main functions of the manual are:

- To educate the community in understanding mental illness and its effects on parenting and child development.

2. To assist communities in critically assessing existing services.
3. To bring service providers together in an effort to encourage collaboration in working with families where there is parental mental illness.
4. To help communities answer the question: "What are we as a community doing to support families with parental mental illness?"

The manual includes six sections, which represent the six major parts of the workshop. The initial sections, covered in the first half of the day-long workshop, offer participants the opportunity to learn about and discuss a number of topics, which then form the basis for the afternoon planning session. These basic topics include:

- an overview of mental illness
- the experiences of parents
- the experiences of children
- the experiences of adult survivors
- an overview of the experiences of offspring

In the afternoon, the participants then have a hands-on opportunity to discuss and plan responses to the needs of families. The first part of the afternoon session looks at the role of Ulysses Agreements as a tool for building a treatment plan and support network around a parent (for more information on Ulysses Agreements see the article by Sharon Von Volkingburgh on p. 32 of this issue of *Visions*). The last session of the day is the *Best Practices Self-Assessment Checklist* which allows the group to discuss and rate their communities' current practices and then to problem-solve ways of increasing the capacity of the community to respond.

Each section of the manual contains:

- a lesson plan
- overheads and handouts for participants
- background information and resources for trainers
- references for further information

The manual also offers a wealth of suggestions on how to set up the day to make it a success.

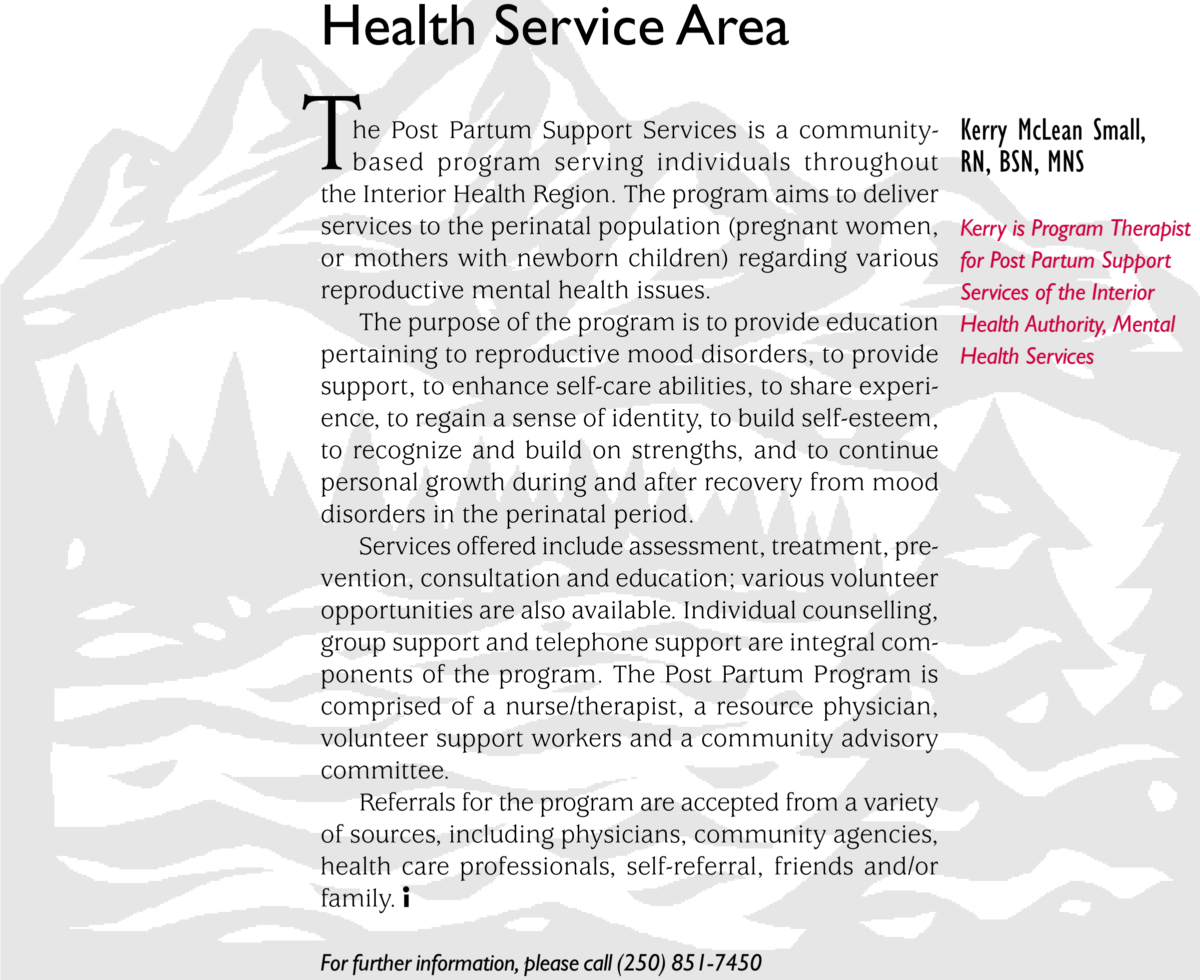
To date, workshops have been run in several communities throughout the province, including North Vancouver, Chilliwack, Delta, Surrey, Maple Ridge, Victoria, and Saltspring Island. Each of the workshops has been facilitated by seed grants, which have been made available through the working group.

To download a copy of the manual, go to www.mcf.gov.bc.ca/mental_health/mh_publications/

For more information about available funding, contact Dr. Lees at 1-800-782-4138

Post Partum Support Services

A mental health services program in the Thompson Cariboo Shuswap Health Service Area



Kerry McLean Small, RN, BSN, MNS

Kerry is Program Therapist for Post Partum Support Services of the Interior Health Authority, Mental Health Services

The Post Partum Support Services is a community-based program serving individuals throughout the Interior Health Region. The program aims to deliver services to the perinatal population (pregnant women, or mothers with newborn children) regarding various reproductive mental health issues.

The purpose of the program is to provide education pertaining to reproductive mood disorders, to provide support, to enhance self-care abilities, to share experience, to regain a sense of identity, to build self-esteem, to recognize and build on strengths, and to continue personal growth during and after recovery from mood disorders in the perinatal period.

Services offered include assessment, treatment, prevention, consultation and education; various volunteer opportunities are also available. Individual counselling, group support and telephone support are integral components of the program. The Post Partum Program is comprised of a nurse/therapist, a resource physician, volunteer support workers and a community advisory committee.

Referrals for the program are accepted from a variety of sources, including physicians, community agencies, health care professionals, self-referral, friends and/or family.

For further information, please call (250) 851-7450

Cross Cultural Perspective and Issues with Families Experiencing Mental Illness

It is important to keep in mind that the perspective described in this article is not founded on any formal research, but is based entirely on my experience helping clients from various ethnocultural backgrounds living in the Kamloops area deal with parental mental illness and its effects on offspring.

H. Picku Multani, MSW, RSW

H. Picku Multani is a Cross Cultural Counselling Services Clinician with Interior Health – Thompson Cariboo Shuswap Health Service Area, Mental Health Services, Kamloops

Kamloops has several ethno-specific groups living in the area and each one is at a different stage of settlement and acculturation. Each individual handles this stress in his or her unique way, and when a mental illness is part of the equation, it often becomes a painful process for the families.

Mental illness is difficult enough for the mainstream population, but additional factors – like language difficulties, social change, role reversals, racism, cultural disintegration, financial strain, religious beliefs and stigma – can cause significant distress for an immigrant parent or other family member who deals with a mental illness.

Along with the known naturalistic causes of disease, many Eastern cultures believe that mental illness is also due to some supernatural powers, which are beyond human control. Illness is sometimes also seen as a character weakness, which goes along with the belief that mental health can be achieved through self-discipline and willpower. For the individual with the illness, these ideas often interfere with following a medication treatment plan and may worsen the condition.

> Cultural factors may play an important role in causing psychiatric disorders,
>
> via their roles as stressor, resource/support system,
>
> definition and standard of normality/abnormality,
>
> and the concepts of self and personhood.
>
> Antony J. Marsella and Ann Marie Yamada – *Multicultural Mental Health*, 2000, p. 13

Mental illness in a parent or a child is often kept a secret from the children and the community, as there is a significant shame attached to it. Clients and their families often try strategies such as traditional health methods and general isolation of the individual before they consider going to a physician with psychosomatic complaints. Referral to a mental health professional is usually the last resort and is through the family doctor, the employer, the correctional system or a community agency working with ethnocultural groups. There is often a great fear of the word *mental* in the term 'mental health services,' so clients would prefer to meet elsewhere for the first time, rather than be seen accessing a mental health office. Developing trust with this group and acting as a cultural mediator is a crucial part of the helping process.

For most individuals, including parents with mental illness, a big key to the treatment of their illness is acceptance of the diagnosis. This is also true of the family that surrounds the person with mental illness. From the perspective of both clients and families, the most oppressive component of family burden is stigma. It leads to marginalization and ostracism of the person and affects their jobs, insurance and housing arrangements. It severely decreases the chances that they will seek help.

The stigma also has adverse effects on the client's self-esteem, damages family relationships and increases the feelings of isolation and shame. The changes that are forced on the family eventually affect the offspring, who may internalize the stigma that has surrounded their 'crazy' parent; the situation may be worsened by the tendency for known social supports to withdraw from the family. The devastating impact of the illness is experienced intensely by all members of the family through grief and loss, as well as shock, disbelief, anger, despair, anxiety and guilt. They may feel that parent or partner they had known and respected is lost to them.

This situation often contributes to conflict between the ill parent and the adolescent children. Clients, especially males who have grown up in traditional patriarchal societies, are further burdened by their children's 'lack of respect and communication gap.' They are unable to consider the developmental needs of the youth or to see the relationship between their illness and their children's behaviours. As with the mainstream culture, offspring often take on the caregiving responsibilities, get 'parentified' in the process, and then miss out on meeting their own personal needs. The resentment tends to build up and can lead to explosive interactions and painful experiences for everybody. One mother tearfully related an instance when her 16-year-old told her to "grow up and be mature, Mom! Think of your children for once!" This was after the mother had to be hospitalized for the fifth time and the teenager had to take care of the younger siblings.

Not having enough knowledge about mental illnesses, and perceiving that there is a choice for the parent causes a lot of additional difficulties. A number of other issues can affect the healthy development of offspring, such as feeling responsible for the illness and walking on eggshells, the unpredictability of the parent's moods, and the constant secrecy surrounding the illness.

While these experiences are not significantly different from how other cultures experience parental mental illness, the mental health professional must also consider the influence of the cultural component and how that can make an already difficult situation even more challenging.

Supporting Vancouver Families through Collegial Education of Professionals

The Parenting and Mental Health Committee

Ruth Hess-Dolgin

Ruth is a Coordinator at Vancouver Child and Youth Mental Health Services, Vancouver Coastal Health Authority

In 1999, a group of staff from across several service sectors in Vancouver came together to form a committee for the purpose of educating themselves and their colleagues around the theme of parenting and mental health. Five years later, working 'off the side of their desks,' these dedicated service providers have managed to keep the committee alive and continue to provide relevant educational workshops. (See the article on the next page by Jeri-Lyn Ratzlaff, describing some of the committee's other activities).

The provision of community-based care for persons affected by mental health problems requires a variety of services and supports. It also requires that service providers from different disciplines deliver these across a range of settings. Some of these professionals fall within what we think of as the mental health system, but many come from other sectors.

Learning opportunities that bring staff together from across these sectors to explore common problems and learning needs are one way to build the safety net for consumers and their families. Through the series of workshops that the Parenting and Mental Health Committee is organizing, Vancouver service providers meet, network and learn together.

As the Parenting Committee has been without a budget, the whole endeavour has cost very little, with most expenditures being of the in-kind variety. For example, BC Women and Children's Hospital offers space at the Chan Centre for Family Education; the various constituents of Vancouver Coastal Health have provided a number of the workshop presenters.

A sampling of some of the workshop topics that have been presented includes understanding mental illness and recovery; bonding and attachment; mental illness in pregnancy and postpartum; supporting children and families with parental mental illness; transparenting; mothers, babies and harm reduction; and parenting youth with psychosis. Upcoming workshops include parenting children with anxiety disorders, and street-entrenched youth.

In addition to the representatives from Vancouver Community Mental Health Services and the Vancouver Coastal Health Authority (VCHA), the Parenting and Mental Health Committee includes members from the Ministry of Children and Family Development, Addiction Services (VCHA), Community Health Services (VCHA), and Reproductive Mental Health (BC Children and Women's Hospital). Committee membership has changed, but the spirit of cooperation and dedication within the group has remained constant over time.

For more information contact Ruth at (604) 708-5276 or ruth.hess-dolgin@vch.ca

The Super Saturday Club

Social and leisure fun for kids living with parental mental illness

Jeri-Lyn Ratzlaff

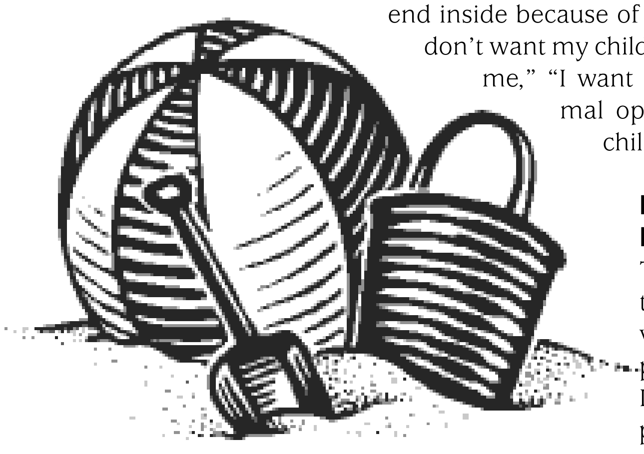
Jeri-Lyn is a member of the Committee for Supporting Families with Parental Mental Illness. She coordinates the Volunteers in Partnership Program at the Canadian Mental Health Association Vancouver-Burnaby Branch, where volunteers provide one-to-one social and leisure support for adults with a mental illness

Background

Children living with a mentally ill parent are faced with challenges their peers will probably never face. The challenge of service providers is to strengthen and support families to enhance protective factors that contribute to both the parents' and children's mental health. Protective factors for children include supportive environments, strengthening communities, developing interpersonal and personal skills, and a strong relationship with a healthy adult.

The Vancouver Coastal Health Authority (VCHA) Committee for Supporting Families with Parental Mental Illness (SFWPMI) was formed several years ago in an attempt to address these concerns and to advocate for strategies that would target the needs of the family. One noted success for the committee is that VCHA mental health teams now ask adult clients as part of the intake interview whether or not they have children. The SFWPMI Committee also developed a toolkit for counsellors working with children whose parents have a mental illness (see resource list at the end of the article). Another successful project is the Super Saturday Club (SSC) for children living with parental mental illness.

The SSC had its beginnings at the Family Day organized by the Northeast Mental Health Team in February 2001, where parents were given an opportunity to express some of their needs and issues. One of the concerns identified was about children's feelings of emotional loss, even though the parent was physically present in the home; a related concern was about not being able to provide their children with social and leisure activities. Some of the comments from parents included: "I need someone to take my child out when I'm lying in bed all day feeling too depressed and tired to go out," "I feel guilty when my kids spend a weekend inside because of my mental illness," "I don't want my child to end up isolated like me," "I want my child to have normal opportunities like other children have."



Program Description

The SSC was a response to these concerns, voiced by both service providers and parents. It began as a pilot project in July 2001 to provide much needed positive social and leisure access for children, allowing a group of children from the Northeast and Midtown mental health teams an opportunity to go on leisure outings one Saturday a month. In the second year, children of adult clients from the Grandview/Woodlands mental health team joined in. Recently, VCHA has just approved increased funding for Canadian Mental Health Association (CMHA) to add an additional Saturday to the program that will provide support to the South Mental Health Team families. This will mean a total of 24 children and their families will benefit from the program. Coast Foundation will also play an administrative and program development support role.

Now heading into its fourth year, the Vancouver Recreation Department of the CMHA Vancouver-Burnaby Branch has successfully developed a popular, innovative program that enriches the lives of children whose parents have a mental illness. Two Saturdays each month, two separate groups of 12 children ranging in ages from 8–12 years meet for outings such as skating, bowling, nature park trips and pizza parties.

The recreation therapists and activity workers at CMHA – Tess Rogalsky, Brent Cross and Arietha Jacks – have developed a strong, cohesive group of children who benefit socially and emotionally from the semi-monthly outings. The staff have also become role models and mentors to the children. According to staff, many behavioural and social problems happened in the beginning, but as the months passed, a cohesive, supportive group dynamic developed. Says Tess, "They look out for each other. Friendships have developed outside the monthly meeting."

The staff is also sensitive to issues that impact the family as a whole. Children of parents with a mental illness often miss out on opportunities for socialization and recreation due to a number of factors such as lack of financial resources, lack of transportation and the impact of the parent's mental illness on their ability to plan for and carry out these events. Single parents, in particular, have the added stress of trying to occupy their children on weekends without the support of a spouse and are often without resources for respite such as babysitting. The program addresses such barriers, as there is no cost for children to participate in this program, which includes lunch as well as a fun day of activities, and children are picked up from their home in the morning and dropped off at the end of the day.

Impacts of the Program

Through the program, the children who participate get a chance to experience safe, enriching, social and recreational experiences that they probably otherwise would not get a chance to have. The program also expands the social networks of the children and promotes social skill-building. While their children are on the Saturday outing, parents benefit from an opportunity to focus on their own self-care.

Within the first year of the program, adult case managers from VCHA mental health teams had already seen the positive overall impact on participating families. For instance, one therapist said that her client struggles with profound negative symptoms of mental illness, specifically apathy and lack of motivation. Despite what would ordinarily be barriers to her child, the SSC allows her daughter to have fun with other children in a safe and positive environment. Another client suffers from depression and shares little play activity with her son. During the child's participation in SSC, the family and child worker has noticed an increase in positive social interaction and also in his self-esteem.

Feedback from parents is equally supportive of the SSC. One parent said that the SSC alleviates the guilt she feels about not having enough money to help her daughter enjoy enriching activities. Another parent, who suffers from panic disorder, is often too anxious to go out and has difficulty focusing her attention on her son's needs. Through the program, however, her son's recreational and social needs can be addressed.

Perhaps the greatest strength of the program is the consistency it has provided for the children – despite the changes they are faced with regarding their parents' mental health, or custody arrangements, or challenges to their own coping skills. The SSC is designed to provide long-term support to children who cope with parental mental illness. Even though the program and activities are designed for a specific age group, children are not automatically asked to leave the program once they reach a certain age. Instead, they are allowed to naturally mature out of the program, based on their own decision about when they are ready to graduate. Many of the children are part of the original group that started in 2001.

Tess Rogalsky explains that a big part of the program is that it gives the kids a place to 'sound off' if they need to and receive some support as well. The SSC provides an environment where the kids know that both the adults and kids are going to understand if they've had a bad week at school or home.

Jim Marsh, the CMHA Community Rehabilitation Team Leader, concurs. He says: "True friendships have developed. For many children, this program is the most stable part of their lives. It's too bad that more resources aren't available for this type of service because when treating mental illness, you need to treat the whole family."

Summary and Conclusion

Having a mental illness may make parenting difficult, but good clinical care, active management of symptoms, and access to effective rehabilitation services can enhance outcomes for both parent and child. Partnerships between adult mental health services and child services are essential for supporting families with parental mental illness. The SSC is a perfect example of bridging professional and community supports to enhance a child's chances for success as he or she matures.

Funding for the pilot project came from Vancouver Community Mental Health Services, Vancouver/Richmond Health Board, the CMHA Vancouver-Burnaby Branch and private donors. Now a full-fledged program at CMHA, the SSC is funded by the VCHA until March 2005. CMHA is currently seeking funding opportunities to cover the $24,000 annual cost to maintain this valuable program on an ongoing basis.

The SFWPMI Committee feels that one of the key reasons for securing future funding is to maintain this cohesive group of children so that important social and community supports are enhanced in the families' lives. Everyone involved in the SSC program – from service providers, to recreation staff, to the parents themselves – acknowledge the value of these supports outside of a clinical setting. The friendships formed among the children will become part of the positive social networks that will get them through adolescence, and make it easier for them to cope with their parent's illness as they go through life.

resource materials

Helping Children Whose Parents Have a Mental Illness
A Toolkit for Counsellors

The toolkit is a collection of current resources and reference materials designed to assist case managers and family and child workers from the mental health teams in the Vancouver Coastal Health Authority (VCHA). This toolkit was developed by the VCHA Committee for Supporting Families with Parental Mental Illness, in partnership with the Justice Institute of British Columbia. It is available from their website at www.jibc.bc.ca/clcl

The Super Saturday Club

A Review of an Innovative Recreational Program
for Children Living in Families with Parental Mental Illness

(August 2002). Canadian Mental Health Association, Vancouver-Burnaby Branch. This is the program evaluation after the first year of the pilot project. See www.cmhavb.bc.ca

Principles and Actions for Services and People
Working with Children of Parents With a Mental Illness

(April 2003). Australian Infant, Child, Adolescent and Family Mental Health Association – Children of Parents with Mental Illness Initiative. This draft document is based on consultations across Australia and an extensive literature research. See www.aicafmha.net.au

Kids in Control

Hylda Gryba and Nicole Chovil

Hylda is the Past Coordinator of the Kids in Control Program for the Fraser Valley. She currently works as a mental health counselor for children and youth

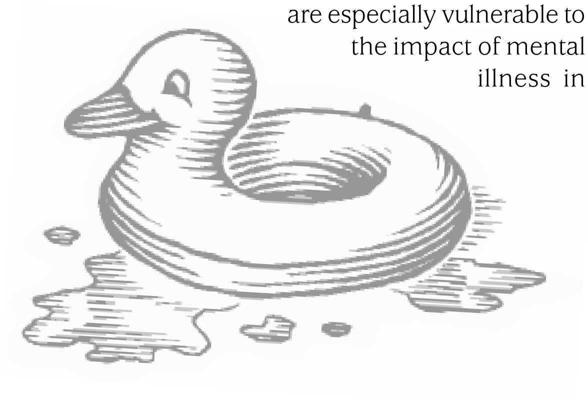
Nicole is the Director of Education for the British Columbia Schizophrenia Society

Reprinted with permission and adapted from an article by Hylda Gryba that originally appeared in Family Connections, Spring 2000: Focus on Children Whose Parents Have Mental Illness, *published by the BC Council for Families. For ordering information see www.bccf.bc.ca, email bccf@bccf.bc.ca, or phone (604) 660-0675 or 1-800-663-5638*

Growing up in a family in which one or both parents has a mental illness can present challenges for children. What must it be like to be dependent upon a caregiver who is actively psychotic, paranoid, or so deeply depressed they can hardly function? What skills do children have to cope with such circumstances?

Some children take over adult responsibilities such as taking care of younger brothers and sisters. Sometimes they also provide for the emotional or physical needs of their parent. They may feel ashamed and unable to understand the often dramatic events that occur and, as a result, avoid making connections with peers, and wind up feeling isolated and alone. For many children, it is as if they straddle two worlds: the normal one outside their home, and the unpredictable and secret one within.

Diane March, PhD, in her research on mental illness and its impact on children, found that children are especially vulnerable to the impact of mental illness in parents, due to limited coping skills and strategies. Young children, in particular, are more dependent on adults and have fewer psychological defenses.



The children of parents with mental illness are a largely forgotten group, yet are at great risk for developing behavioural problems and learning difficulties. By early adulthood, their risk for developing adjustment disorders, depression and drug and alcohol abuse is double that of the lifetime risk of the general population.

It has taken a long time to recognize that services and supports for families should include services targeted to meet the specific needs of dependent children. Fortunately, this is changing and one program presently offered in BC offers a way to support children who have a parent with a mental disorder.

At present, seven communities in BC offer a program specially designed for children who have a parent with a mental illness. The British Columbia Schizophrenia Society (BCSS)-sponsored program, Kids in Control, provides education and support to children between the ages of 8 and 13. The program runs for eight consecutive sessions, and holds meetings every few months to provide the children with ongoing support and a safe place to discuss and deal with difficulties they may be experiencing.

During the weekly one-hour sessions, children are given information about mental illness, as well as the opportunity to develop and practice healthy strategies for coping with the difficulties they may be facing. Children are given several important messages such as they are not alone; other children also have parents with a mental illness. Through these messages, normalization and connectedness take the place of isolation, shame and secrecy.

Using interactive games and activities, the program delivers messages of healthy communication, self-care and self-esteem. By allowing children choice around activities, the program gives the children the message there are, in fact, some things they *can* control – even though there are many things in their lives which are beyond their control. The children are also given opportunities to build their resilience and develop skills to deal with societal attitudes about mental illness. As one facilitator commented, "At times I am almost overwhelmed when I think about the difficult circumstances some children face; but, at other times, I am struck by the fortitude, resilience and hopefulness some children possess."

A unique feature of this program is the involvement of an adult co-facilitator who has experienced the special circumstance of growing up in a home with a parent with mental illness. The co-facilitator brings a level of compassion and understanding that only those who experience similar circumstances can comprehend.

Facilitators note that children consistently find several aspects of the program particularly helpful. The first thing routinely mentioned is the fact that learning about mental illness has helped to allay their fears because "when you learn about it, you don't worry as much," as one youngster explained. Another very important topic of discussion relates to stigma and helping children resist messages of self-blame and responsibility.

It is clear that awareness is growing, judging from the increasing number of requests for information regarding the Kids in Control program. As awareness grows, and as more resources become available, we hope that all children in communities throughout the province will receive the much needed support and attention they deserve.

For more information about the Kids in Control program, please contact Nicole Chovil at (604) 270-7841, 1-888-888-0029 or email nchovil@telus.net

Advice to Parents from a Child Protection Worker

An Interview

This article is an interview Visions held with a child protection worker who contacted us, wishing to provide some information and advice to parents with mental illness

What is child protection all about, and how would a child protection social worker become involved in a situation?

Child protection is exactly what it says – protecting children from neglect, physical abuse, sexual abuse and emotional abuse. Social workers become involved when someone from the community calls to report a concern about a child. The Child, Family and Community Services Act requires social workers to investigate child protection reports. These calls may come from professionals such as police, hospital staff and teachers. Neighbours and family members may also call to report concerns.

Many of these reports are not serious enough for investigation or intervention. Social workers get involved when a parent is exhibiting clear symptoms of untreated mental illness or drug and alcohol addiction, and when children are noticeably neglected – such as always being hungry, having poor hygiene, being transient, or chronically absent from school. Children's behaviour that is sometimes an indication of a problem at home includes being either very aggressive or very withdrawn. Sometimes the reporters of abuse are the children themselves. Some children talk about wanting to kill themselves or begin to self-harm.

> Social workers know – and research shows – that in most cases families provide the best support for a child during periods of high stress or a crisis, or even in the long term.

What would the next step in the process be after a worker has been contacted, and what options are there for a parent with mental illness to make the initial contact(s) safer or to help them show their strengths or capabilities?

Sometimes the initial contact is in the form of an unannounced phone call or home visit. Though most people's initial reaction to contact from a social worker is fear and anger, try to remember they are only doing their job and that responding to the social worker's concerns in a cooperative way is helpful in establishing trust (easier said than done).

If the first contact is a phone call requesting an in-person appointment, you can have someone with you during that interview – for instance, an advocate, friend, trusted family member, or a professional who is involved with your family such as a counsellor or teacher.

If at any time during your involvement with the Ministry of Children and Family Development you feel unfairly treated, you can ask to speak to the social worker's supervisor or make a complaint with Quality Assurance at (604) 981-0165.

What are other options for support during the process?

Many times, the result of an investigation will be the conclusion that the child protection concerns can be addressed with support from the community. Programs such as parent education, daycare for the child, family mediation, mental health or addictions counselling, or support groups can be helpful for the parent and child. When a parent begins attending these recommended services, often the file will be closed as it is determined that the family is getting help in the community. Showing that parents and children have a healthy supportive network goes a long way in reassuring the social worker that the child or children are safe and cared for.

Under what circumstances would a child be legally removed? What options would a parent have in these situations?

If the social worker determines that your child is in need of protection and more intrusive legal action is taken – including removing the child(ren) from the parents' care – alternate dispute resolution such as mediation and family conferencing is available. These are ways for a neutral person to facilitate the discussions between the social worker and parents and among family members. In mediation, the neutral person (the mediator) is always in the room with the participants and all the issues are discussed together. In family conferencing, part of the meeting allows for the parents and their support network – extended family members, friends, and other supportive people such as neighbours and church members – to meet privately without the social worker or facilitator to discuss a safety plan for the child(ren) and present it to the social worker and supervisor. Alternate dispute resolution only works if there is some acknowledgement by the parents that there are issues to be resolved in the family. The social worker must also be open to a negotiated care plan allowing the family to make all or some of the decisions.

Mediation and family conferencing allow for the family to have more ownership of the problems and the solutions. Sometimes a child does need to be out of a parent's care while the parent attends treatment, finds safe and stable housing and works on the issues that resulted in social worker involvement. In these situations, if extended family or friends can provide the placement for a child, some financial support can be provided. Social workers know – and research shows – that in most cases families provide the best support for a child during periods of high stress or a crisis, or even for the long term.

If an alternate dispute program is not successful or appropriate – all participants must be meeting in good faith with an openness to resolving the issues – then court action is likely the next step. Contact legal aid to get a lawyer to attend all court matters. Even if legal action has been taken, court can be postponed to convene an alternate dispute meeting, if that option has not already been tried. If a child has been removed from the parent's custody, sometimes children are returned under a supervision order whereby certain conditions must be met. Examples of the conditions are to attend counselling, to not have contact with a certain person (a violent boyfriend for example), or to ensure the child is always supervised.

What about the concern by parents with mental illness if they ask for mental health care, then this might make them more likely to have their capability to parent questioned?

If parents are seeking mental health care, social workers see that as a sign of strength and health in the family. That shows acknowledgement and acceptance of the illness, and it is well known by social workers that most mental illness can be successfully treated. Some parents work out a Ulysses Agreement with their support network and social worker, so that if a parent begins to have symptoms which could compromise their ability to parent, a safety plan is in place for the child(ren). When mental health care is in place, child protection files are usually closed because the child protection concerns are being addressed in the community.

Any other advice you could offer?

Remember that removing children from parents and family is a very last resort and is done only under extreme situations. Social workers, like most people, do have their biases and weaknesses and can sometimes make ill-informed decisions. However, in most situations, social workers work cooperatively with the family to strengthen the family's capacity to parent their children. Let the social workers know your strengths and stories about all the good and loving things you do for your child(ren). But at the same time, if you are having struggles, and are making poor decisions that negatively impact your child(ren) and need help, tell the social worker that part too. There are many resources that can help you and your children.

share your story in our next issue

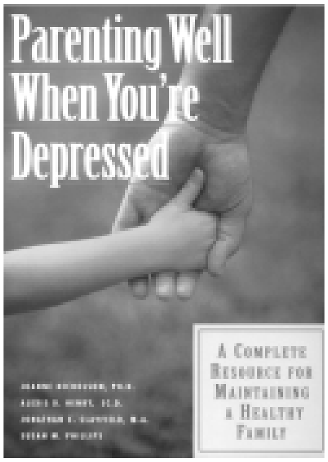
Our summer issue of Visions is out in July. If you would like to share your experience as a person living with a mental disorder or a substance use problem, or as a family member, friend or service provider, contact our editor, Eric Macnaughton, at (604) 688-3234, toll-free at 1-800-555-8222 or via email at emacnaug@cmha-bc.org about your idea and to receive a copy of our submission guidelines.

BC Partners for Mental Health and Addictions Information

Visions

Parenting Well When You're Depressed

A complete resource for maintaining a healthy family



By Joanne Nicholson, PhD; Alexis D. Henry, ScD; Jonathan C. Clayfield, MA; and Susan M. Phillips

New Harbinger Publications, Inc.
226 pages; $26.95

Parenting Well When You're Depressed is a practical book. The content is sensitive and respectful, and the issues explored are significant in people's lives. The selection of topics reflects the existing research, but is also based on the experiences of parents, family members, service providers and policy makers. Although the authors address the issues of parents who have depression, the book can easily apply to parents with any mental illness, or to all parents in general. Most parents do not have all of the answers. All through the book, parents are reminded that parenting is difficult whether you have depression or not.

The authors obviously understand the challenges of families living with depression. As they say so astutely in the introduction, the range of skills among parents who are depressed is not so different in its diversity from those of parents who don't have depression. However, parents who have depression are sometimes harder on themselves and may have very high expectations of their performance. Throughout the book, the authors reinforce the message that parents with depression can be good parents and that everyone has strengths.

Parenting Well When You're Depressed is well organized, and written in a way that is easy to read. It's divided into eleven chapters, each having its own significant theme. Parents can read the chapter that seems the most interesting, useful, practical, helpful and relevant to them. The book is part self-help and part workbook, providing worksheets, such as a budgeting worksheet and a shopping list. I tried the budgeting worksheet for myself and found it quite helpful. The book also helps parents draw up action plans for dealing with various situations, such as dealing with potential relapses, handling crisis situations, and planning for child care in the event of the need to go into the hospital.

This book not only talks about treatment, therapy and medication, but also about lifestyle choices. It does not forget about other important things such as family-of-origin issues, connections with good friends, diet, exercise, play and leisure, getting a good nights' sleep and spirituality.

Talking about mental illness to children is an especially difficult issue for parents, which the book addresses by offering a number of creative suggestions for initiating a discussion. The authors suggest ideas such as using audio cassettes, videos, writing letters and drawing pictures, so that parents can choose what would be most comfortable for them and their children. Another important topic the book addresses is asking questions. The authors remind us that asking questions is important, and provide some examples of questions to ask doctors, psychiatrists and/or attorneys.

The book is very comprehensive and covers all the bases. If there was one thing I would have appreciated more emphasis on, it is relationships with partners and the exploration of couple issues. When parents have a difficult or stressful time with each other, it usually affects all other areas of their lives, and may contribute to discomfort and tension in the home for all family members.

Overall, I really like this book and strongly recommend it. Knowledge is a powerful tool and *Parenting Well When You're Depressed* provides a lot of information.

Feeling confident in one's ability to parent is a challenging task for all parents whether you are depressed or not. Being depressed certainly adds to the difficulty, but the authors have provided a wealth of information that may make it a little bit easier to face those parental challenges.

Being prepared is also a powerful tool. If you are prepared and organized, difficult situations can be made less stressful when they do arise. This resource book helps parents become active participants in their own parenting journey.

**Review by
Lyne Brindamour, MSW, RSW**

Lyne is a family counsellor with Family Services of the North Shore

The book may be available in your local bookstore or library. If not, it is available to order from www.chapters-indigo.ca, www.amazon.ca or www.parentbooks.ca

Resources for Offspring

- **Someone in my Family has a Mental Illness.** Brindamour, L. (2000). Family Services of the North Shore, British Columbia. An educational workbook designed for children ages 7 to 14, for use by community professionals, parents and caregivers. See the BC Council for Families website at www.bccf.bc.ca (see the Family Life section of the catalogue), email family@familyservices.bc.ca, or call 1-800-663-5638.

- **When Moods go Up and Down, When Things are Sad and Gloomy,** and **When Things get Really Weird.** Three booklets for children with parental mental illness. Available from the BC Schizophrenia Society. Call 1-888-888-0029; order form online at www.bcss.org

- **SANE.** (Australia) For materials for young people affected by parental (or sibling) mental illness, go to the Bookshop link at www.sane.org

- **Understanding Mental Illness: For Teens who Care about Someone with Mental Illness.** Johnson, JT. (1989). Lerner Publications Co, Minneapolis. Available from www.amazon.ca

- **How to Cope with Mental Illness in your Family.** Marsh, D & Dickens, R. (1997). Tarcher/Putnam. A groundbreaking guide that draws on the experiences of siblings and offspring of parents with mental illness.

- **My Parent's Keeper.** Brown, EM. (1989). New Harbinger. Another book in the series is titled *My Sister's Keeper,* which is about a sibling with mental illness. Available from www.amazon.com

don't forget all the resources listed at the end of Visions articles as well!

Resources for Parents

- **Out of the Darkened Room.** Beardslee, WR. (2002). This book draws on Dr. Beardslee's research in prevention programs with families affected by parental depression – bringing the subject of depression out of the dark and into an open family discussion. Little, Brown and Co., Boston. ISBN 0-316-08549-9

- **Invisible Children's Project.** A project of the National Mental Health Association in the USA. See www.nmha.org/children/invisible.cfm for a project overview and list of fact sheets and resources for parents and professionals.

- **Parenting Well.** Project website includes resources for families and service providers on the topic of parenting and mental illness, including a Parent Self-Assessment Tool. See www.parentingwell.org

Resources for Professionals

- **Helping Children whose Parents have a Mental Illness: A Toolkit for Counsellors.** Developed by the Centre for Leadership and Community Learning of the Justice Institute of BC, in collaboration with the Supporting Families with Parental Mental Illness Working Group. See www.jibc.bc.ca/clcl (click on 'Publications and Videos'), phone (604) 528-5632 or email clcl_pr@jibc.bc.ca.

- **Substance Abuse and Mental Health Services Administration.** (USA) The following publications may be ordered or downloaded at www.mentalhealth.samhsa.gov/publications/allpubs
  - **Critical Issues for Parents with Mental Illness and their Families.** Nicholson et al. (2001).
  - **Steps Toward Evidence-Based Practices for Parents with Mental Illness and their Families.** Hinden, B et al (2002).
  - **The Prevalence of Parenthood in Adults with Mental Illness**, Nicholson, J et al (2002).

- **Visions journal #9 on Sexuality, Intimacy and Relationships.** Available online at www.cmha-bc.org/visions. A limited number of back issues are available for purchase at $7 apiece. Call or email the Canadian Mental Health Association's provincial office at 1-800-555-8222 or office@cmha-bc.org

BC Partners for
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