

# **Steps Toward Evidence-Based Practices for Parents with Mental Illness and their Families**

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## OVERVIEW

### The Issue

Despite the prevalence of parenthood among adults with mental illness, mental health systems have traditionally served *individual* patients through categorical funding streams that do not allow for family-focused services. Over the last decade, however, there has been increased attention to parents with mental illness and their children. In some cases, this increased awareness has led to the availability of funding and the development of innovative programs for parents with mental illness in the United States and elsewhere. Programs for parents have generally been developed on a small, local scale with limited funding, and have remained largely isolated from one another. As a result, we knew little about programs for parents or their impact on outcomes for adults and children. Before conclusions can be drawn about practices for parents with mental illness and their families, the development of an empirically supported evidence base is necessary.

### The Current Project

Our goal in the current project was to take the next steps toward evidence-based practices for parents with mental illness and their families by identifying and systematically describing existing interventions. We report data from two studies. In the first study we identify programs and conduct in-depth telephone interviews with administrators and providers to describe, compare and contrast programs along selected dimensions. In the second study we define explicit logic models with hypothetical links between target populations, practices, processes, and outcomes for selected programs, using data obtained in comprehensive site visits.

### Findings

Taken together, data from the two studies are used to identify core program components, key ingredients, and relevant outcomes. *Core components* include comprehensive family case management, access to a comprehensive array of services, coordination of multiple services and the facilitation of communication among multiple providers, flexible funds to meet unique family and individual needs, crisis intervention services, education about child development that enhanced parent-child relationships, and parenting skills training.

With respect to *key ingredients*, the data presented here indicate that family-centered, strengths-based values and practices may be the key to program success and improved outcomes for parents and children. Family-centered approaches posit the family as the unit of service, and optimal family functioning as the desired outcome. A family-centered approach is best served through the integration of adult and child services and systems, interagency collaboration, and the availability of non-categorical, flexible funding. The other key ingredient identified across programs was a trusting, emotionally supportive relationship between provider and consumer. Strengths-based, non-judgmental approaches, and unconditional care appeared to be the foundations for this relationship.

Finally, several *relevant outcomes* for rigorous program evaluation were also defined by the current studies. These included optimal functioning of both parent and child across role domains, improved parent-child relationship, preservation of family unit, achievement of basic family needs, enhanced social networks, and child-related outcomes such as school readiness, and school attendance. These outcomes are discussed with respect to strategies for assessment and methodological challenges.

### Conclusions

Rigorous evaluation of programs for parents with mental illness will be possible only when the necessary resources and technical assistance are provided to support the standardization and manualization of current interventions. Research methods and tools must also be identified or developed that reflect participant and program goals and theories of change, capture program process and fidelity, and objectively measure meaningful outcomes related to adult, child, parent, and family functioning.

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## Introduction

Millions of adults in the United States are affected by mental illness (U.S. Department of Health and Human Services, 1999). The majority of these men and women are or will become parents (Nicholson, Biebel, Hinden, Henry, & Stier, 2001; Nicholson, Nason, Calabresi, & Yando, 1999). Despite the prevalence of parenthood among adults with mental illness, mental health systems have traditionally served individual adult and child patients through categorical funding streams that do not allow for family-focused services for adults with mental illnesses and their children, or for services for the parents of children with serious emotional disturbance who may have mental health issues (Nicholson, Geller, Fisher, & Dion, 1993). Pervasive stigma and realistic fear of losing custody of their children have contributed to the “invisibility” of parents with mental illness as well as their children.

Over the last decade, sympathetic providers, who could not deny the reality of their clients’ lives and who recognized the power of family roles and relationships, joined with consumers, mental health advocates and scholars to bring attention to this issue. There is increasing awareness that parents comprise a large subgroup of adults receiving mental health services, and that parents require specialized services to meet their needs (Cook & Steigman, 2000; Mowbray et al., 2000, 2001; Nicholson & Henry, in press; Nicholson, 1996; Nicholson et al., 1998a, 1998b). In some cases, increased awareness among policy makers and providers has led to the availability of funding and the development of innovative programs for parents with mental illness in the United States and elsewhere (Cowling, 1999).

This step is exciting and hopeful. However, there are many more steps to be taken. Few states have explicit policies regarding parents with mental illness (Nicholson et al., 2001) and none, to our knowledge, provide guidelines for interventions with parents and families. Programs for parents have generally been developed on a small, local scale with limited funding, and have remained largely isolated from one another. As a result, we knew little until this point about programs for parents or their impact on outcomes for adults and children. We did not know how many programs exist, or where they are located. We did not know whether programs reflect similar or divergent developmental histories, theoretical orientations, structural organization, funding streams, practices, or outcomes. We did not know whether programs are effective, and whether particular programs or practices can be identified as more effective than others, or more effective under certain conditions with particular families.

Before conclusions can be drawn about practices for parents with mental illness and their families, the development of an empirically supported evidence base is necessary. Rigorous evaluation requires systematic, standardized description of target population, program practices, and the theoretical relationship between clients served, practices and desired outcomes (Mueser et al., in press). Treatments must be shown to improve outcomes that are meaningful to participants, and that are measured objectively in research conducted by independent investigators (Mueser et al.).

Our goal was to take the next steps toward evidence-based practices for parents with mental illness and their families by identifying and systematically describing existing interventions. We report data from two studies designed to facilitate, ultimately, the rigorous evaluation of interventions. In the first study we identify programs and conduct in-depth telephone interviews with administrators and providers to describe, compare and contrast programs along selected dimensions. In the second study we define explicit logic models with hypothetical links between target populations, practices, processes, and outcomes for selected programs, using data obtained in comprehensive site visits. These are the necessary next steps in creating an evidence base.

## Methods

### Study I: The National Program Survey

The National Program Survey consisted of two parts. To identify existing programs, a mailing was sent in late 1998 to members of a large mailing list of programs and providers known to work with parents with mental illness (N = 300). This mailing list was developed by Nicholson and colleagues as part of the Parenting Options Project (POP). POP, funded by the National Institute on Disability and

Rehabilitation Research from 1997 to 2000, focused on developing resources for parents with mental illness and their families, and providing technical assistance and consultation on the issues and needs of parents and their families. The mailing included a cover letter explaining that the investigators were interested in learning about any and all programs for parents with mental illness. Mailing list recipients were asked to complete and return an addressed and stamped postcard with contact information for any relevant programs or services for parents and their families.

Thirty-seven relevant card responses were received. Others wrote back describing related services, e.g., legal consultation services. These responses were supplemented with program data from a prior study of programs for parents with mental illness (Nicholson et al., 1993), and a concurrent survey of state mental health authorities about policies and program for parents (Nicholson, Biebel, Hinden, Henry, & Stier, 2000), to create a list of 53 known programs. Programs were categorized into high-, medium-, and low- specificity with respect to focus on parents with mental illness. “High-specificity” reflected programs developed for and targeted to meeting the needs of parents with mental illness. “Medium-specificity” reflected programs that provide parenting services but not specifically to parents with mental illness. Often parents with mental illness receive these services with other “at-risk” parents. The “low specificity” category included programs in which adults with mental illness participate, but services are not available to address their needs as parents.

An interview for program directors was developed to explore the following program characteristics: program development; program funding; theoretical orientation; target population; program goals; program models, services and interventions; and outcomes. Program directors were contacted by telephone, and an interview was scheduled with those who agreed to participate, or with their designees. All interviews were conducted on the telephone during the winter and spring of 1999. Initially, we intended to interview a representative from all programs. However, after several interviews with medium- and low-specificity programs, it became evident that comprehensive interviews were inappropriate for these respondents. A briefer interview reflecting program development, program funding, and services was developed for medium- and low-specificity programs. Interview data were coded for content and analyzed qualitatively. A logic model template was developed for use in Study II.

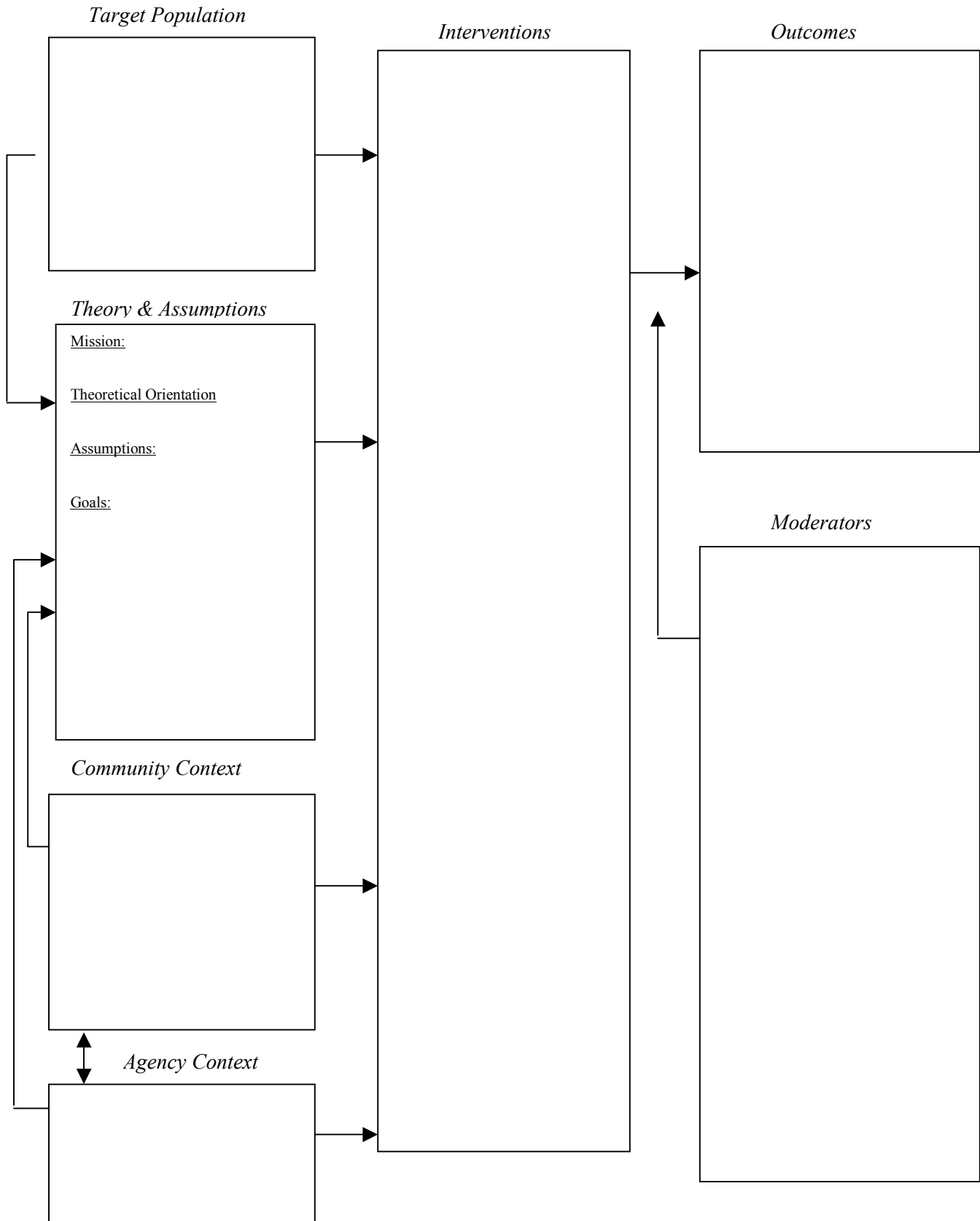
## **Study II: Site Visit Study**

Qualitative analyses from Study I indicated that programs could be defined in terms of the following factors: Target population; theory and assumptions (including the programs’ mission, theoretical orientation, assumptions, and goals); community context (such as the state and local political and economic environment, as well as the availability and accessibility of community collaborators); agency context (including such dimensions as agency philosophy, structure, resources, and staffing); program model (interventions and services); moderators; and outcomes.

In addition, interview data from Study I revealed that these program features could be related to each other as represented by the logic model in Figure 1. Target population in combination with theory and assumptions, and community and context influenced development of a program model and planned interventions and services. Program model and actual interventions, in combination with enhancing or obstructing moderators, determined outcomes. Moderators included both environmental conditions, e.g. local economy, and individual characteristics, e.g., severity of mental illness. The logic model defined by the National Program Survey was used to facilitate program description, and to delineate hypothesized links between target population, processes, practices, and outcomes for programs selected for site visits in Study II.

Five programs from the high-specificity group were selected for site visits in the spring and summer of 2000. Programs were selected to reflect diversity on three dimensions: geographic location, funding source, and program type or “model.” Two or three investigators visited program sites for two to three days. During visits, interviews and discussions were conducted with program administrators, staff, participants, and community collaborators. Agency documents and budgets, e.g., annual reports and contracts, were reviewed. Data collection was organized around the logic model developed in Study I.

**Figure 1: Logic Model**



During the last day of the visit, investigators presented a draft of the logic model to program administrators and staff, and asked for feedback. Logic models were revised after the site visit and additional feedback from program staff and participants was requested and integrated via mail and telephone. Discussions with program staff and participants included explanation of the relationship of the logic model to building program evaluation efforts.

The following programs were selected for site visits:

**Children and Parents Together (CAPT).** CAPT is located in Commack, New York, a suburb of New York City. CAPT is funded primarily by non-categorical state mental health dollars and Medicaid "re-investment" dollars. Parents receive support through case management and psychoeducational support groups. Children ages 0 to 3 years participate in a therapeutic nursery program.

**Emerson Davis Family Development Center.** The Emerson Davis Center is located in Brooklyn, NY. Residential case management services for parents with mental illness and their children aged 0 to 12 years are provided. Primary funding for Emerson Davis comes from the state Office of Mental Health and HUD grants made available for services for homeless people with mental illness in the city of New York (New York/New York program).

**Family Support Services/PACE Program (FSS/PACE).** FSS/PACE is located in Iowa City, IA. FSS/PACE uses a clinical case management model to provide services to parents with mental illness and their children. Children may be any age as long as they are living with their parents. State mental health block grants and reimbursement for clinical services support FSS/PACE.

**Invisible Children's Program (ICP).** ICP is located in Orange County, NY, a large rural area approximately 100 miles north of New York City. ICP provides family case management services for parents with mental illness and their children. ICP relies on the New York State Office of Mental Health for primary funding.

**San Francisco General Hospital Programs.** Three programs in the Department of Psychiatry at the San Francisco General Hospital were chosen to reflect a continuum of co-existing services. **The Consultation/Liaison Program to OB/GYN (C/L program)** in the Department of Psychiatry provides outpatient and inpatient psychiatric services to pregnant and postpartum women with mental illness. The program is funded by state contracts with the Department of Psychiatry, and clinical reimbursement from the state health insurance program, MediCAL. **The Infant Parent Program (IPP)** provides parent-child psychotherapy for families in which children are at risk for developmental problems. IPP receives funding through the Departments of Psychiatry at San Francisco General Hospital and the University of California at San Francisco, as well as from MediCAL. **The Women's Issues Psychiatric Program** is an inpatient psychiatric program with a focus on gender and reproductive issues for women with mental illness. It is a multi-disciplinary program funded by state mental health contracts with the Department of Psychiatry at San Francisco General Hospital, and MediCAL.

## Results

### Study I: National Program Survey

**Identifying Programs.** Five programs were eliminated from the original roster of 53 programs after initial phone conversations with program and agency directors indicated that these programs had been discontinued or did not work with parents. Of the remaining programs (N=48), 20 were categorized as high-specificity, 13 were categorized as medium-specificity, and 15 were categorized as low-specificity. Despite multiple attempts, we were unable to schedule an interview with directors from one high-specificity, one medium-specificity and six low-specificity programs. Thus, 40 interviews were performed in total. During interviews, directors for two of the high-specificity programs told us that funding for their programs would be discontinued in the next funding cycle (January 2000). Thus, at the time of this printing there were only 18 programs in the United States known to us, focusing specifically on services for parents with mental illness and their children.

**Geographic Location.** Parents with mental illness can undoubtedly be found in programs serving adults with mental illness across the United States. However, high-specificity programs were located in 11 different states, and included in all four quadrants. New York (n = 5), Chicago (n = 2), and California (n = 4) had multiple programs, while Rhode Island, Washington, D.C., Michigan, Missouri, Iowa, and New Mexico each had one program. Colorado and Alaska also had one program each that was scheduled to close at the end of the current funding cycle. It is possible that we were unable to identify all existing high-specificity programs, and that additional programs were initiated subsequent to our survey. However, it is far more likely that medium- and low-specificity programs provide the majority of services and supports for parents with mental illness, and that families and providers are “piecing together” a patchwork of services to meet families’ needs.

**Program Development.** Program and agency directors reported two primary avenues of program initiation. One group of programs grew out of the recognition among adult mental health providers or policy-makers that there was a need for specialized services, and a recognition of the gap in existing services for pregnant women or parents with mental illness. A second group of programs developed among early intervention providers or theorists (e.g., Selma Freiberg), who realized that many “high-risk” families for whom early intervention programs had been developed included a parent with mental illness. Initiation and development of sustainable programs, regardless of original impetus, appeared to rely upon the passionate commitment of at least one advocate devoted to the “cause” of parents with mental illness, who was able to engage sufficient political and economic support to begin services or programming.

In contrast, program developments and changes over time reflected several processes. These processes included continued community education and political advocacy; the activities of dedicated, committed, and skilled providers; increased knowledge and expertise of providers; and a recognition of the changing needs of consumers, and changing funding opportunities. These processes in turn were continually influenced by the changing political, economic, and health care contexts.

The length of time programs were in existence across all programs ranged from 8 months to 85 years. The median duration was 11 years. Among the high-specificity group, program duration ranged from 4 to 22 years, with two programs scheduled to be discontinued at the end of the current funding cycle due to lack of funding.

**Program Funding.** The most common primary funding source across programs was the adult division of the state mental health agency. This was particularly true among medium- and low-specificity programs where parents received services in programs designed for adults with mental illness regardless of parenting status. Several medium- and low-specificity programs working with parents reported that they had been denied additional funding from adult mental health to initiate high-specificity programming. Medicaid money was also identified as a primary revenue source for several programs across specificity groups. Primary funding from adult mental health and/or Medicaid was supplemented by additional state funding (Departments of Health, Public Health, and Welfare), federal programs (e.g., HUD, McKinney, Early Start), specialized city funding (e.g., New York, NY), and private organizations and foundations (e.g., United Way). One high-specificity program reported a continued history of funding through the federal Early Start initiative. Two programs reported funding by state child welfare and child protection agencies. However, one of these changed funding when conflict-of-interest issues arose between program staff, in their role as advocates for parents, and child welfare staff.

**Theoretical Orientation.** Programs reflected a diverse range of theoretical orientations, and no single model dominated among the high-specificity group. High-specificity programs were reported to be necessarily “pragmatic/eclectic,” relying on a variety of approaches to meet the multiple and complex needs of participants. At the same time, providers were also able to identify theoretical orientations upon which programs were more fundamentally based and then augmented. These models included psychosocial rehabilitation, psycho-dynamic/attachment theory, substance abuse/community treatment models, a solutions-focused/problem-solving orientation, family systems theory, family-centered intervention strategies, trauma treatment approaches, and psycho-education models. Among the medium- and low-specificity groups, a psychosocial rehabilitation approach was somewhat more prevalent, as these

services were often located in clubhouses or community mental health centers designed to serve the greater population of adults with mental illness.

**Target Population.** Target population varied to some degree by “specificity” status. In the high-specificity group, parents with serious and persistent mental illness eligible for public sector mental health services were the most commonly targeted population. This same population was reflected in the medium- and low-specificity groups, however, these groups also included “high-risk” parents whose children may have been involved with early intervention services, and parents of “high-risk” children such as those with developmental delays, or emotional and behavioral problems.

Eligibility requirements differed by program. The most frequent requirement was parent age ( $\geq$  18 years), parent status (custody or planned reunification), and diagnosis of serious and persistent mental illness, with eligibility for public sector state mental health services (secondary to program funding streams). Mental health systems that were county-based also required residency in the county where the program was located. Some programs only enrolled parents with young children, e.g., 0 to 5 years old, and some programs required a history of homelessness and co-occurring substance abuse and trauma history, generally related to funding or mission. Some programs also required a period of sobriety prior to admission or the ability to “contract for safety.” Diagnoses of parents included Schizophrenia, Major Depression, Bipolar Disorder, and Borderline Personality Disorder, often with co-occurring substance abuse and trauma history. Post-traumatic Stress Disorder and Panic Disorder were other, less common, identified disorders among the target population.

Race and ethnic characteristics of parent program participants varied greatly by geographic location. Caucasian participants accounted for four percent to 98% of program populations, with programs in Rhode Island, New York State, Colorado, Iowa, Montana, and Alaska having at least 50% Caucasian participants. African American participants ranged from fewer than 1% to 95% of program participants across programs, with programs in New York State and New York City having 50% African American participants, and Detroit, Washington, DC, and Chicago having greater than 90% African American participants. Hispanic participants comprised between less than one percent to 65% of program participants across programs. Programs in New York City and New Mexico reflected the greatest proportion of Hispanic participants. Programs identified relatively small numbers of Asian participants, with programs in San Francisco, California reporting approximately 11% Asian participants.

Many programs were unable to tell us how many children they had served. As noted above, however, some programs required children to be preschoolers. Overall, programs reported child age ranging from birth to 18 years, with the majority of programs serving preschool or early school age children. Only one program focused on adolescent children, and one program that provided housing would not accept families with children older than 12 years at intake. There was clearly a decrease in services for children as child age increased. This appeared to be related to a variety of causes. Programs directed at early intervention were defined by and organized around services for families with preschool age children (e.g., therapeutic nursery). Programs without such mandates may reflect the reality that many parents with mental illness lose custody of their children during the preschool years. One program that provided supported housing in a staffed residence acknowledged that they did not have the capacity to provide appropriate supervision for potentially troubled adolescents, and were concerned for the sustainability of the larger program should they enroll families with older children

**Program Goals.** Goals identified by providers and participants were consistent across programs. Provider goals varied in their emphasis on independent living for the adult participant versus enhancement of the parent-child relationship and parenting skills. Differences observed across programs appeared to be related to program development, theoretical orientation, and funding variables. Programs that developed out of early intervention or child welfare initiatives had a parenting and child development or prevention focus, while programs that grew out of adult psychosocial rehabilitation models were more likely to focus on adult independent living skills, illness management, and overall functioning, of which parenting was one aspect. Within these broad foci, program providers and participants identified many more specific goals:

- Access to safe and affordable housing
- Referral to occupational training and employment opportunities
- Access to entitlements
- Access to health care
- Access to prenatal and postpartum healthcare
- Healthy pregnancy and delivery
- Retaining or resuming child custody
- Discontinuation of child welfare involvement
- Decreased hospitalizations
- Increased self-esteem and self-efficacy
- Improved communication skills
- Decreased social isolation
- Increased knowledge about mental illness and its impact on family life
- Improved child behavior management skills
- Improved child functioning

**Program Model: Interventions and Services.** A wide array of services was provided across programs. Figure 2 portrays the “types” of programs and services described by program representatives, placed on a continuum of increasing comprehensiveness of services. As illustrated in Figure 2, programs might have an adult component, a child component or both. None of the programs had only a child component, and several did not offer any direct services for children. Again, this focus appeared to reflect the primarily adult funding sources and consequent training and expertise of the providers. The primary distinction among program models was the provision of case management services. Programs that were more diverse and comprehensive generally provided case management and coordination of multiple services, e.g., a “wraparound model.” Comprehensive case management was also associated with provision of services for all family members. Programs not providing case management often served adults who received case management and additional, often uncoordinated services elsewhere. All programs reflected family-centered values and principles.

Case management programs were further divided into “care coordination” models and “clinical” models. Care coordination models provided emotional and practical support, and referral to and coordination of multiple services, but explicitly did not provide clinical services for mental health issues. Similarly, clinical models provided referral to and coordination of multiple services, but also provided individual and/or family therapy as part of case management home-based visits, and billed for these visits.

**Outcomes.** No program had standardized outcome evaluation measures or data for parents or children available at the time of our interview. Two program administrators reported they were collecting data, but did not yet have the resources to review or analyze the data collected. Outcomes for program participants were tracked and evaluated with respect to individual goals and service or treatment plans. Progress on identified goals was monitored and recorded in participant records. Programs may have had outcomes and collected information related to the mandates of funding sources, e.g., achieving family reunification or reducing number of hospitalizations, but these were not obtained or measured consistently across programs and offered little basis for comparison. In addition to individualized progress evaluation, most programs collected consumer satisfaction data and reported very high rates of satisfaction with services (>90%).

## **Study II: Site Visit Study - Program Similarities and Differences**

Data from the site visits are summarized below with respect to similarities and differences across programs on the key aspects defined by the logic model template in Figure 1. Program data are also provided in the form of in-depth case studies and program specific logic models for each program that can be found in the Appendix.



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## Target Population

Programs served a common population of adults (> 18 years old) with serious mental illness who have children. Programs varied in their requirements for child custody. Some programs worked only with parents who had custody of their children, while other programs enrolled adults who wished to gain custody and were able to show a plan for reunification, and/or a “sincere” desire to gain custody and parent their children. Programs also varied with respect to the ages of the children in the families they served. Many programs limited their services to parents with young children, e.g. ages 0 to 3 or 0 to 5 years. Age requirements usually reflected “child-centered” funding sources, e.g., Early Intervention, that also influenced theoretical orientation, program design, and services provided. For example, the Infant-Parent Program (IPP) based at San Francisco General Hospital provides services and supports to parents with mental illness. IPP was developed and designed to enhance child outcomes and foster the parent-child relationship in families “at risk” for the development of relational difficulties and child problems. IPP services are limited to families with children ages zero to three. Other programs focused on prevention of child problems through “school-readiness,” and served families with children ages 0 to 5. There appear to be more programs for families with younger children than with school-aged or adolescent children. This may be a consequence of available funding, or may reflect the likelihood that parents with mental illness are likely to lose custody of their children at a young age. Thus, families with children older than five years reflect a gap in services and a group potentially at risk for problems.

## Theory and Assumptions

**Mission.** Programs generally shared a core mission of serving “families” or “parents and children.” Service to parents and families often included the mission to “support and empower” parents and families across multiple domains of functioning. Differences in program mission statements were often related to differences in targeted populations or program focus. For example, programs developed for adults with mental illness had mission statements related to enhancing *parent and family* functioning and quality of life, while programs developed to improve child developmental outcomes had mission statements related to *child* functioning first and foremost. Several programs did not have their own mission statements, but developed goals and programming consistent with the mission of the agencies or institutions in which they were housed. Two hospital-based, inpatient services shared the central mission of reproductive choice and healthcare, and the stabilization of psychiatric symptoms for pregnant and postpartum women. The mission and goals of these programs did not extend beyond this defined area. However, as detailed above (see The Consultation/Liaison Program, San Francisco General Hospital in particular), securing a healthy pregnancy and delivery requires interventions that extend beyond the medical office. For one program this entailed developing strong relationships with community-based programs and providers who could offer services to participants after delivery. A second parallel program provided ongoing care to women receiving inpatient services.

**Theoretical Orientation.** Programs and services reflected a variety of theoretical orientations, and many programs identified multiple or “eclectic” orientations. Similar to program mission, differences in theoretical orientation were often related to differences in target population. For example, programs designed specifically for families in which a parent had mental illness were most often founded upon psychosocial rehabilitation values and principles, such as recovery, normalization, independence, and community integration. This was true for both inpatient and community-based programs and services. In contrast, programs designed to prevent child developmental delays and enhance child outcomes reflected orientations that focused on strong and positive emotional attachment between parent and child, parent empathy, and age appropriate child skills and school readiness. Despite these differences in theoretical orientation, programs reflected strong consistency in the core underlying value placed on providing “family-centered,” “strengths-based,” “flexible and responsive,” “non-judgmental” and “unconditional, long term” services. In addition, most programs relied on an interagency/inter-provider/interdisciplinary “team approach.”

**Program Assumptions.** Similar to program consistency in values, programs appeared to share several central assumptions: 1) Adults with mental illness have strengths and can be parents; 2) 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; 3) enhanced parenting is related to enhanced child development; and 4) a trusting relationship between provider and participant is central to a successful intervention.

**Program Goals.** Program goals reflected the essential similarities across programs. Although emphasis might differ as a function of the targeted population, there was remarkable consistency in goals across programs. First and foremost, programs sought to improve parent and child functioning and quality of life. More specifically, programs sought to stabilize the parent's mental health, decrease hospitalizations, decrease the family's sense of stigma, decrease family isolation, build family networks, and promote parenting skills, parenting efficacy, and parent-child relationships. Programs targeted to adult populations also sought to support independent adult functioning in all areas of life, such as housing and employment. Training student professionals, who might go on to provide services to parents and families, was also often a shared goal of programs.

### **Community Context**

Several community factors were identified consistently by providers as influential in program development and success. These factors reflected federal, state and local influences on funding and community dynamics. For example, Federal legislation such as the American Safe Families Act and TANF directly impacted the ability of parents to participate in services and for programs to be funded and sustained. Awareness of and commitment to the issue of parents with mental illness among both state and local legislators was identified as important to program sustainability. Local political and economic climates, and local resources such as availability of affordable housing, transportation, and childcare were all identified as important contextual influences on program development, as were local issues such as crime and substance abuse. The organization and structure of state or county mental health systems, reimbursement policies, and the availability and accessibility of a broad array of services all provided defining contextual influences. Program directors spoke in particular about the need for integration between adult mental health and child-serving service sectors, e.g., within the mental health system and across systems such as mental health and child welfare. In general, most identified the lack of integration as a significant barrier to success in working with families in which a parent has a mental illness. Finally, program directors and staff reported that the development of collaborative interagency relationships was critical at both the administrative and direct-service level. Policies and procedures needed to be in place across agencies so that family-centered treatment or service plans that required the cooperation of multiple providers from different agencies could be implemented. Interagency relationships were also critical to working around policies that created barriers to program implementation, service delivery, and client participation.

### **Agency Context**

Characteristics of the agency or institution in which programs or services were housed were important to both program development and sustainability. Programs and services for parents with mental illness were often initiated because the need for and gap in services for this population became apparent at community-based human service agencies that were working with adults with serious mental illness.<sup>1</sup> Agency orientation and prior programming often defined the type of services or program developed for parents. For example, adult-focused agencies that used a psychosocial rehabilitation model for working with adults with mental illness often created specialized services for parents based on this model. Similarly, child-serving agencies that came into contact with adults with mental illness in their role as parents developed programs addressing parenting skills and child development. In addition, agency orientation or philosophy also seemed a critical factor in the degree of agency support for a program for parents. An agency philosophy and agency leadership that supported family-centered values and services were critical to program viability and sustainability. Closely related to agency orientation and support, staff characteristics such as training and orientation also influenced program development.

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<sup>1</sup> The increase of adults with serious mental illness receiving services in the community was related to deinstitutionalization in the 1970's. Deinstitutionalization increased opportunities for adults with mental illness to form intimate relationships and to have children

Existing agency funding streams and affiliations often defined initial program development and ongoing changes. Many programs described changes in funding sources over time as they struggled to keep programs going. Overall, programs for parents were funded primarily from adult mental health agency monies, e.g. Departments of Mental Health. Secondary funding was provided from a variety of other public and private sources. A few programs and services reflected innovative blended or non-categorical, interagency funding from mental health and child welfare or child public health programs, e.g., Early Intervention. Several programs accessed HUD funding or specialized local funding programs, e.g., New York, NY funding.

### **Program Model: Interventions and Services**

Programs offered a variety of interventions and services as well as access to other services. Programs varied in the degree of comprehensiveness of services offered. Comprehensiveness of services was generally related to use of a case management model. Within those providing case management services, programs could be categorized as residential (providing housing or supported housing) or non-residential, and as clinical or non-clinical. Case managers who were also licensed clinicians, and who functioned in the dual role of case manager and therapist defined clinical case management programs. Clinical case managers provided individual and/or family therapy as part of their work with a family, and generally billed for these services separately. “Non-clinical” case managers provided support and mentoring, but were not licensed clinicians and did not bill for therapy as part of their case management time. Programs that did not provide case management were generally more specific in their focus, e.g. psycho-educational parenting groups and dyadic therapy, and, although “family-centered” in principle, were unable to actually provide services to all family members.

Services provided under the rubric of case management included a combination of emotional support and mentoring, concrete assistance (access to entitlements, emergency utility/rent payments), referral to and coordination of services, interface with other providers, advocacy (for parent and children), education related to child development and parenting, and crisis intervention. Three programs provided a specialized model of case management that included a therapeutic nursery component for parents with mental illness and their children. Non-case management services included parent coaching, psycho-educational parenting groups, parent support groups, and supervised visitation services. Figure 2 illustrates the continuum of services for adults and children evidenced by providers interviewed for the current study. The continuum reflects increasing comprehensiveness and family-centered practices.

In addition to direct services, some programs described political “interventions” to which they devoted time and energy. These included efforts to educate and form relationships with legislators, and to advocate for appropriate policy changes and funding streams for services for families in which a parent has a mental illness. Several programs also described active social marketing campaigns to decrease stigma and debunk myths about parents with mental illness, to engender local support for programming in the community.

### **Moderators**

Many of the same outcome moderators were identified in programs. Moderators included many of the environmental and agency contextual factors defined above, as well as family and family members’ characteristics. Community resources such as the availability of affordable housing, transportation and childcare, and community problems such as crime and substance abuse were identified as moderators of individual and family level outcomes. Mental health systems issues and resources also contributed to outcomes for families. Issues such as the unavailability of flexible funding or lack of interagency collaboration, and gaps in available services strongly contributed to poorer outcomes for parents and children. At the agency level, affiliation with a comprehensive human service agency where leadership supported program goals, an array of services could be quickly accessed, and inter-provider cooperation and teamwork were greater, seemed to facilitate better outcomes. On the individual level, providers reported that availability of natural supports, high cognitive functioning, and good symptom management all related to better outcomes for parents, children and families. By contrast, severity of mental illness, presence of a substance abuse disorder or Axis II psychopathology (personality disorders), illegal

immigration status, and severity of child emotional and behavioral problems were related to more negative outcomes.

### **Outcomes**

Outcomes were conceptualized in both general and concrete terms, and were consistent with program goals defined earlier. Providers uniformly spoke about enhancing the quality of life for parents and children, promoting the parent-child relationship, and about preserving the family or establishing successful reunification and decreased need for out of home placements. Programs differed in whether or not they identified and tracked both parent and child outcomes, or focused predominantly on one or the other. Outcomes for parents included increased knowledge about child development, improved parenting skills, enhanced self-sufficiency/independence/problem-solving skills across life domains, fewer crises and hospitalizations, increased parent confidence/self-efficacy, increased social networks, increased access to and coordination of services, medication management, stabilization of symptoms. Child outcomes included achieving developmental milestones, enhanced school readiness, improved child behavior and emotional adjustment, and improved school attendance. For those programs engaged in political advocacy and social marketing, increased public awareness, decreased stigma, and increased funding opportunities reflected positive outcomes.

### **Discussion**

The rationale for achieving the goal of evidence-based practices for parents with mental illness and their families has been documented in previous work (Nicholson, Biebel, Hinden, Henry, & Stier, 2001). The next steps, of describing and documenting existing programs, were undertaken in the studies described in this paper. Core program components and key ingredients have been identified across programs through extensive interviewing and site visits. Program goals suggest relevant outcomes.

**Core Program Components.** Comprehensive *family case management* or care coordination is a common component across programs. Case managers are supported in providing and coordinating services for families as a collective unit, as well as for individual family members. Access to a *comprehensive array of services*, from housing to vocational training to early childhood education, to meet family and individual needs is essential, either within an agency context or in the larger community. *Coordination* of multiple services and the facilitation of *communication* among multiple providers are important to families. The ability to provide concrete assistance such as rent is essential, highlighting the value of *flexible funds* to meet unique family and individual needs. *Crisis intervention services*, available 24 hours a day, seven days a week, were identified as important. Programs also shared a focus on providing education regarding *child development*, enhancing *parent-child relationships*, and developing *parenting skills*.

**Key Ingredients.** The data presented here indicate that family-centered, strengths-based values and practices may be the central key ingredients to program success and improved outcomes for parents and children. Regardless of target population or theoretical orientation, programs uniformly embraced family-centered, strengths-based approaches to working with parents with mental illness; and providers and participants unequivocally said these values and practices were critical to success. In the process of developing program logic models, it became apparent that providers believe these key ingredients directly and indirectly influence outcomes, through enhancing parental self-esteem and confidence, and fostering positive relationships between providers and consumers.

Family-centered approaches posit the family as the unit of service, and optimal family functioning as the desired outcome. A family-centered approach is best served through the integration of adult and child services and systems, interagency collaboration, and the availability of non-categorical, flexible funding in the service of the *entire family*. Equally important to service coordination, the development of a trusting, emotionally supportive relationship between provider and consumer appears to be critical. Strengths-based, non-judgmental approaches, and unconditional care appear to be the foundations for this relationship.

**Relevant Outcomes.** Rigorous program evaluation demands that outcomes are meaningful and important to participants, fit conceptually with programs' theories of change and intervention targets, and are able to be measured in objective, standardized ways. Programs for parents with mental illness and their children share a focus on optimal functioning of parent and child, indicating that assessment of adult and child functioning in significant role domains, as well as reduction in distress or symptoms, and increased number of planned rather than crisis hospitalizations or respite placements could be common outcomes. Program goals of enhancing the parent-child relationship and preserving the family unit suggest important outcomes of increased frequency of positive parent-child interactions, decreased out of home placement, or successful family reunification. The achievement of basic family needs is essential, and reflected in outcomes like securing stable housing or employment, and achieving access to health care or childcare. Enhanced social networks and family supports would be relevant outcomes in most programs. Capturing improvements in parenting skills represent perhaps the most difficult methodological challenge. Child-related outcomes, other than those in functioning or distress cited above, could include developmental milestones achieved, school readiness, and improved school attendance.

### **Next Steps**

The next steps toward evidence-based practices for parents with mental illness and their families involve mustering the resources and providing necessary technical assistance to support providers in standardizing and manualizing their interventions. Research methods and tools must be identified or developed that adequately reflect participant and program goals and theories of change, capture program process and fidelity, and objectively measure important, meaningful outcomes related to adult, child, and parent functioning and the parent-child relationship. Once these steps have been taken, rigorous evaluation across programs and target populations can begin. Standardized, objective evaluation will not happen, however, without an influx of resources—stable program funding and increased research and evaluation support; new and improved research methods and tools; and researchers knowledgeable of both intervention and evaluation challenges when families living with mental illness are the focus.

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**Appendix**

**Program Case Studies**

## **Children and Parents Together (CAPT)**

### **Commack, NY**

#### **Program Description**

The CAPT Center provides a community support system for parents with mental illness, along with an early intervention program for their young children. Located in Commack, New York, the CAPT Center is a program of the Family Service League of Suffolk County, Inc. The primary goals of the CAPT Center are to help adults with mental illness to fulfill their roles as parents, and to promote healthy growth and development in their children.

Mothers and their children participate in CAPT Center two to three times a week, depending on the child's age. Children ages 0 to 3 attend an infant/toddler program two days a week; simultaneously their mothers attend a mother's support group. Children ages 3 to 5 attend a preschool program three days a week while their mothers attend the support group. CAPT also offers a once-weekly group for parents whose children are in foster care, and a "graduate" group for parents whose children are in kindergarten and beyond, and a father's group. The infant/toddler and preschool programs are educational programs designed to foster the child's development. The mother's support groups address a range of needs.

#### **Program History**

Advocacy efforts in NY State in the mid-1980's resulted in the NY State Legislature setting aside money for services to address women's mental health needs. An RFP was issued by the NY State Office of Mental Health, and \$600,000 was earmarked to fund four therapeutic nursery programs in the state. The Family Service League of Suffolk County responded to the RFP, and the CAPT Center program began in 1987.

Although initially funded as a therapeutic nursery, the staff feel this was a "misnomer" from early on. The program quickly evolved to more fully meet the needs of the parents (primarily mothers) with mental illness whose children attended the nursery program.

At the time of the site visit, CAPT was located in a neighborhood school building with other community programs. The staff emphasized the positive impact of this "normalized" setting. In the year after the site visit, CAPT was relocated to a Family Center in Bay Shore, NY (another community nearby) that provides other family mental health services. According to the program director, this change has negatively impacted the "normalization" so appreciated in CAPT's prior location.

#### **Funding History**

The CAPT Center was initially funded in 1987, as one of 4 therapeutic nursery programs in the state (in response to the RFP described above). The program received funding for three years. When this funding ended, the funding from OMH was reduced considerably, but the parent agency, Family Service League of Suffolk County, picked up the cost of the program, with the use of Medicaid "re-investment" dollars. The funding of the program has remained level for the past 10 years, and thus has eroded secondary to inflation. The funding erosion has resulted in a reduction of services over the years.

#### **Target Population**

The CAPT Center serves women with mental illness who have at least one child age 4 or under, or who are pregnant. The program serves approximately 30 children across the three classroom programs (two infant/toddler and one pre-school), with 10 children in each class. This number is flexible however, depending on the needs of the families being served. The program will always accommodate an additional child of a mother already being served. Children in the program range from age 0 to 5. Most of

the mothers served by CAPT have custody of at least one (but not necessarily all) of their children. The program provides supervised visit services for a few families.

### **Theory and Assumptions**

**Mission.** “CAPT strives to empower parents with mental illness and their children to obtain optimal health in all aspects of their lives. CAPT works to educate parents to function better in their personal, family and community lives. CAPT works to educate children to achieve optimal growth and development.”

**Program Goals.** The CAPT Center identifies specific goals for both mothers and children. For mothers, the CAPT Center strives to 1) foster rehabilitation and normalization; 2) prevent hospitalization; 3) reduce isolation and promote socialization; and 4) enable the fulfillment of the parental role. For children, the CAPT Center strives to 1) promote health growth and development; 2) prevent or remediate development delays, physical or emotional problems; and 3) prevent unnecessary foster care.

**Theoretical Orientation.** Although CAPT was initially funded as a therapeutic nursery program, the orientation of the program evolved fairly quickly in response to the needs of the clients served. The program staff recognized early on that the needs of parents for support and skills training had to be addressed. In the late 80's and early '90s, The NY State OMH developed statewide guidelines for outpatient services that reflected a psychiatric rehabilitation approach (Anthony, et al). Specifically, the guidelines stated that the mission of services should be "to assist persons disabled by mental illness to be successful and satisfied in obtaining and maintaining the specific community environments and roles in which and through which they have chosen to live their lives." The guidelines further stated that "this mission is accomplished by assisting disabled individuals to develop the functional skills and environmental supports needed to choose and obtain a new life role and setting, or by making skill and support changes needed to maintain an existing role and setting". The CAPT Center staff felt that this mission statement reflected the work that they do with clients.

Consistent with a psychiatric rehabilitation approach, the program reflects a family-centered and strengths-based philosophy. The program encourages mutual support among the participants, “normalized” involvement in adult roles, and the pursuit of overall health and wellness for family members. Other important program values articulated by CAPT providers include being flexible, consistent, non-judgmental, hopeful, and pragmatic in helping families solve day-to-day problems in living.

### **Community Context**

**Local History.** Commack, NY is a small city located in the center of Long Island, in Suffolk County. Over one million people live in the county. Suffolk County is also large in area, spanning 100 miles end-to-end. Many communities in this part of Long Island are characterized by “suburban sprawl.”

**Community Strengths and Weaknesses.** Suffolk County has a wide range of mental health services. The community lacks affordable housing and has limited public transportation. In addition, affordable childcare and training and education services for low-income individuals are limited.

**Mental Health Resources.** While mental health services are available throughout the county, the lack of public transportation means the services are often inaccessible for families with limited resources. Also, the size of the county means that services are geographically dispersed – again, making access difficult.

### **Community Collaborators**

CAPT collaborates with many other health, mental health and social service program and providers in the area, including the Department of Social Services, Public Health Nurses, a homeless

program, Child Protective Services, and the local alliance for the mentally ill. CAPT also interacts with the Social Security Administration, public assistance, early intervention and the local school system. In addition, as part of FSL, CAPT interfaces with the larger agency. However, many of the services provided by FSL are not easily accessed by CAPT families because they are not close by.

CAPT belongs to the local Service Area Council (SAC). The SAC is comprised of agencies in the area that provide mental health services for adults and children. The SAC meets monthly to keep each other apprised of issues confronted by each agency, changes in agency services, funding or staffing. Although these agencies do not have any formal collaborative agreements, the informal connections enhance the working across the agencies.

The CAPT Center has an Advisory Board made up of representatives from the Office of Mental Health, the Department of Public Health, the Child Protective Services, a local housing program, legal services, children's services, and the FSL. The Advisory Board helps the program overcome barriers, advocate with legislature, access resources, and interface with other providers in the area. At the time of the site visit, the program had lost its lease on the space in the school building and was getting ready for a move to a new location. The Advisory Board had been actively involving in helping the program find a new site in another part of the county.

### **Methods of Collaboration**

Collaboration across provider agencies primarily takes the form of receiving and making referrals. There is no sharing of dollars across agencies, or payment from outside agencies for CAPT services. Other providers and agencies in the area feel that CAPT fills an essential gap in services in the area. No other agency provides the services and the safety net to families that CAPT provides.

### **Agency Context**

CAPT is a program of the Family Service League (FSL), a non-profit, non-sectarian, multi-service agency. The FSL is one of the largest and most comprehensive agencies providing services to adults, children and families across Long Island. Services include counseling and other mental health services, elder services, Clubhouse and supported employment programs, dental services, youth programs, substance abuse services, advocacy and referral, debt counseling, and volunteer services.

The annual budget for the CAPT Center is \$160,000. Less than 20% of the program budget comes from the NY State Office of Mental Health, via Suffolk County. Additional funding for the program is provided by the FSL. FSL receives funding from multiple sources, including State/County, Federal, Local dollars; foundations; Medicare and Medicaid; HMOs and other third party payers; and out-of-pocket payment by clients. The program also receives donations from local businesses (e.g. Federal Express) and from charities such as Salvation Army and the local food bank.

The CAPT Center is staffed by two master's level social workers, one teacher with a BS degree in early childhood education, and one certified pediatric nurse practitioner, who directs the program. There is also a program secretary, who is the only full-time employee. The social workers and teacher are paid on an hourly basis. The nurse/director is a 20-hour per week salaried employee. The Center often has social work and education interns. Although the staff all have distinct job descriptions, they describe their roles as being very flexible. They emphasize that they often need to improvise and always "start where the client is at". As a team, they work together to "do what needs to be done".

### **Program Model: Services and Intervention**

The core component of the services offered by CAPT is the parent support group that co-occurs with the infant/toddler or preschool education groups. The two infant/toddler groups take place on Tuesdays and Thursdays -- one group runs from 10:00 am-noon, and the second runs from 1:00-3:00 pm. The preschool group runs on Mondays, Wednesdays and Thursdays from 10:00 am-noon. The foster care group runs on Wednesday afternoons, and the graduate group runs on Friday afternoons.

Within the context of the parent support groups, many issues are addressed. Broadly, these issues may include education on illness management, on understanding the impact of illness on children, and on

normal child development; parenting skills; social skills; basic community living skills such as money management or using transportation; support around difficult relationships; accessing entitlements and supports; and advocacy. Outside the group, staff typically visit mothers at least once at home to get a sense of the home environment. They also sometimes accompany mothers in the community to help them access entitlements, housing, food stamps, etc, but their ability to do this is limited. The staff function as case managers, and frequently refer mothers to other providers for services the CAPT program cannot provide. The staff describe themselves as doing whatever needs to be done. As one provider stated, "You never know what you'll be asked to do".

Within the infant/toddler and preschool groups, activities focus on enhancing the children's social and emotional development, language and cognitive skills, gross and fine-motor skills and behavioral management. The preschool program also focuses on pre-academic skills and preparing children for kindergarten. All parents spend some portion of their time at the center with their children in the infant/toddler or preschool classroom. In this setting, the staff are able to model positive interactions and caretaking, and are able to coach parents in appropriate ways to play with their children, to set limits and to manage behavior.

Transportation (via taxis) is provided by CAPT to families that have no other means of getting to the program.

Mothers describe the program as giving them the opportunity to meet with other mothers, get advice and support, and get a respite from taking care of their children. Some mothers expressed feeling frustrated that they have to "graduate" from the program when their children enter kindergarten. Although there is a graduate group that meets weekly, some mothers feel this isn't enough.

## Evaluation

**Family Demographics.** At the time of the site visit, the center had 63 mothers and children on their caseload. Nine mothers have children in foster care; a few have had children who have been adopted by others. About 22 to 24 mothers are served by the infant/toddler or preschool programs. The foster care group serves about 9 mothers, and the "graduate" group serves about 6 mothers. At the time of the site visit, the program was serving only one father. The average age of the mothers served by the center is 26; mothers range in age from early 20's to 40's. The program serves very few teen mothers.

Between 60 and 70% of the mothers are Caucasian; approximately 25% are African-American, and the rest are Latino or Asian. The majority of mothers have less than a high school education. Most of the mothers are receiving disability (SSI/SSDI) or welfare benefits. Many mothers previously served by the program who had been welfare recipients have gone back to work, following welfare reform. Only a few of the mothers currently served by the program are working. The staff describe this current group of mothers as "a very disabled group".

**Diagnoses.** Between 50 and 60% of the mothers served by CAPT have a diagnosis of major depression. Other diagnoses include schizophrenia, bipolar disorder, obsessive-compulsive disorder, post-traumatic stress disorder and personality disorders. The majority of mothers have experienced at least one psychiatric hospitalization and most are on medication.

The staff estimates that at least 50% of the children have "mental health needs". Common problems exhibited by the children include isolation, poor socialization skills, speech delays, increased (or decreased) activity level, and difficulty engaging in the normal range of age-appropriate play activities.

**Co-occurring Disorders and Issues.** About 30% of the mothers have a history of substance abuse. Virtually all of them have a family history of substance abuse. As well, virtually all of the women have a history of trauma or domestic violence. A few of the mothers live in their own homes or apartments with spouses or partners. Others live with their parents, in residential programs, in rooming houses or in shelters. At the time of the site visit, none of the mothers were living alone with their children. Many of the families served by CAPT have unstable housing, and adequate, affordable housing

is a significant need. Between 20 and 30% of the mothers have experienced homelessness. In addition, many mothers need help with homemaking skills.

**Family Outcomes.** The CAPT Center does not undertake any formal outcomes evaluation. However, the staff is able to identify outcomes that they feel characterizes a "successful" family. Positive outcomes for mothers include:

- An increased understanding of child development and "normal" child behavior
- Improved parenting skills
- Decreased anxiety and increased confidence as a parent
- An enhanced social network and decreased isolation
- Taking responsibility for managing illness

Positive outcomes for children include:

- Improved social and communication skills
- Improved motor and cognitive skills
- School readiness

### **Client Path**

Mothers are referred to CAPT from a variety of sources, including clinicians and case managers, public health nurses, child protective services, housing programs, programs that serve children with disabilities, and the local school system. Some mothers are self-referred. To be eligible for the CAPT program, mothers must live in Suffolk County, be in treatment with a mental health professional or have a case manager, have at least six months of sobriety and have a child under the age of 5 or be pregnant. Most mothers served by CAPT have a major mental illness.

Before a family is seen face-to-face, basic information such as name, address, and telephone number are taken over the phone. During this initial phone contact, staff also try to get a sense of mothers' mental health concerns and/or diagnosis. The first face-to-face appointment is usually made within a week of referral. Both mother and child(ren) are seen at the first appointment. Generally, the mother is seen by the nurse or social worker. During the first appointment, the primary goal is to make the mother feel comfortable.

A general history is taken, including family history, housing status, health status, personal history of mother and partner, and mental health history including past hospitalizations, drug and alcohol use, and medications. However, the staff report that they do not expect to get a complete history at the first appointment; often a complete history only emerges over time, and. The mothers are given a tour of the facility, including group meeting rooms and the classroom. The CAPT staff emphasize the importance of meeting each mother "where she is at".

At the first appointment, the early childhood educator sees the child. A formal evaluation is not usually done; instead the teacher spends time with the child in the classroom to informally observe how the child interacts both with people and with materials in the classroom. On rare occasions, a developmental screening assessment (e.g. the Denver) may be administered.

If the family meets criteria, the mother is invited to participate in the appropriate group. At this point, the mother is asked to sign a "contract" stating that she agrees to attend regularly and will notify the program if she is going to be absent. The attendance policy states that after three consecutive unexcused absences, the mother's place will not be held. However, this policy is not always enforced; the CAPT staff do a lot of outreach to keep mothers engaged.

At some point during the initial involvement in CAPT, staff try to visit every home at least once. They describe this as having a chance to assess the home environment in terms of safety, general home maintenance, whether the family has furniture and other materials good (e.g. beds, toys, books, food, clothing) that children need. This also gives the staff an opportunity to observe the mother and child in their "natural" environment and to have a chance to do individualized parent skills teaching.

Mothers can continue in CAPT until their child enters kindergarten. Several mothers with multiple children have remained involved in CAPT for many years. After children move into kindergarten, mothers can continue to participate in the graduate group.

### **A Success Story**

The CAPT staff told the story of N and her family. N is a Latino woman in her early 30's. N was referred to CAPT by a public health nurse several years ago after the birth of her first daughter, T. At the time of T's birth, N was a client in a community residence. After the birth, N moved into an apartment with the baby's father, J. N has a diagnosis of borderline personality disorder. N and J met when they were both clients in a sheltered workshop. Both parents have cognitive limitations; the staff reports that N cannot read. After two years, a 2<sup>nd</sup> daughter, C, was born. The staff describe this as a significant increase in stress for this vulnerable family. Although they describe N as an excellent housekeeper, they note that she lacks basic knowledge about child development and typical child behavior. The father, J, has even fewer parenting skills than N. J continues to work in a sheltered workshop.

When the 1<sup>st</sup> daughter, T, was about 4, there were two incidents of N hitting T. Both incidents were reported to Child Protective Services. Both daughters were removed from the home, and were placed in foster care with a family member. During this period, N remained involved with CAPT, attending the foster care group.

After two years in foster care, the children were returned to the parents. CAPT staff describe CPS as very supported. This time, the family seems to be doing better. N seems very invested in keeping custody of her children. The staff report that N is more willing to learn from staff and to follow the recommendations they give on child management issues. CAPT staff describe their work with N as "re-parenting". The work with N and J is very much around managing the day-to-day demands of parenting. Currently, T is a 7-year-old in 1<sup>st</sup> grade, and C is a 5-year-old, who will enter kindergarten next year.

Despite their success in reuniting N and J with their daughters, the staff feels this family still faces challenges because of the lack of resources and supports in the community. While they feel that they have a secure and trusting relationship with N, they see needs for this family that they can't meet. N would benefit from additional in-home supports. She could use assistance around stressful time during the day, such as early in the morning as the children are getting ready for school, dinnertime and bedtime. N could also use additional skills training in community living skills such as money management and cooking. She and J would also benefit from periodic respite care.

### **Challenges**

Many of the mothers and children served by CAPT are isolated in their communities -- their primary social ties are with CAPT providers and other clients. Poverty, inadequate housing, the lack of public transportation and the limited training and education opportunities for these mothers serves to perpetuate the isolation.

Teen mothers and mothers with active substance abuse problems have been difficult for the program to engage.

CAPT staff report that serving families after they graduate is particularly challenging. CAPT has tried to have a graduate group for children, but this was difficult to schedule and fund. CAPT staff feel that children age 8 and older need the opportunity to talk about their experiences with mental illness, but virtually no services are available for these children. In addition, many mothers felt uncomfortable with a discussion of mental illness taking place in a children's group.

The fact that CAPT has been level funded since its inception means that services have needed to be cut back. For example, initially the preschool program ran 4 days a week, but now only runs 3 days.

The lack of funding means that staff cannot provide all the services they recognize that families need. They have very limited ability to provide home based services, they cannot fund respite services for parents, and the program does not run in the summer. They acknowledge that every summer they lose track of a few families.

### **Next Steps**

At the end of the summer 2000, the CAPT Center will relocate to new facilities in Bay Shore, NY. The staff express concern about the move for two reasons. The program currently is located in a school building in a residential neighborhood. The new facilities will be at a site where other clinical services are offered. The staff are worried that mothers may not feel as comfortable in the new location as they have in the school where there is not stigma attached to attending. In addition, they are concerned that some families will be "lost" because they will not want to travel the distance to the new program.

### **Quotes from Mothers**

"My children and I attended the program for three years. During that time I learned about my mental health...and was able to build a support group with the other mothers, one of which I am still friendly with. Our children have also been supportive of each other over the years. The program allowed me to get out of an abusive relationship, become employed and enter college. My children are doing well. We continue to work on future goals as a family".

"When our kids go to kindergarten, you put us out by the garbage pail."

"I have no place I can go and be myself, except here."

"Mary and Evelyn have brought me up to be a good mother."

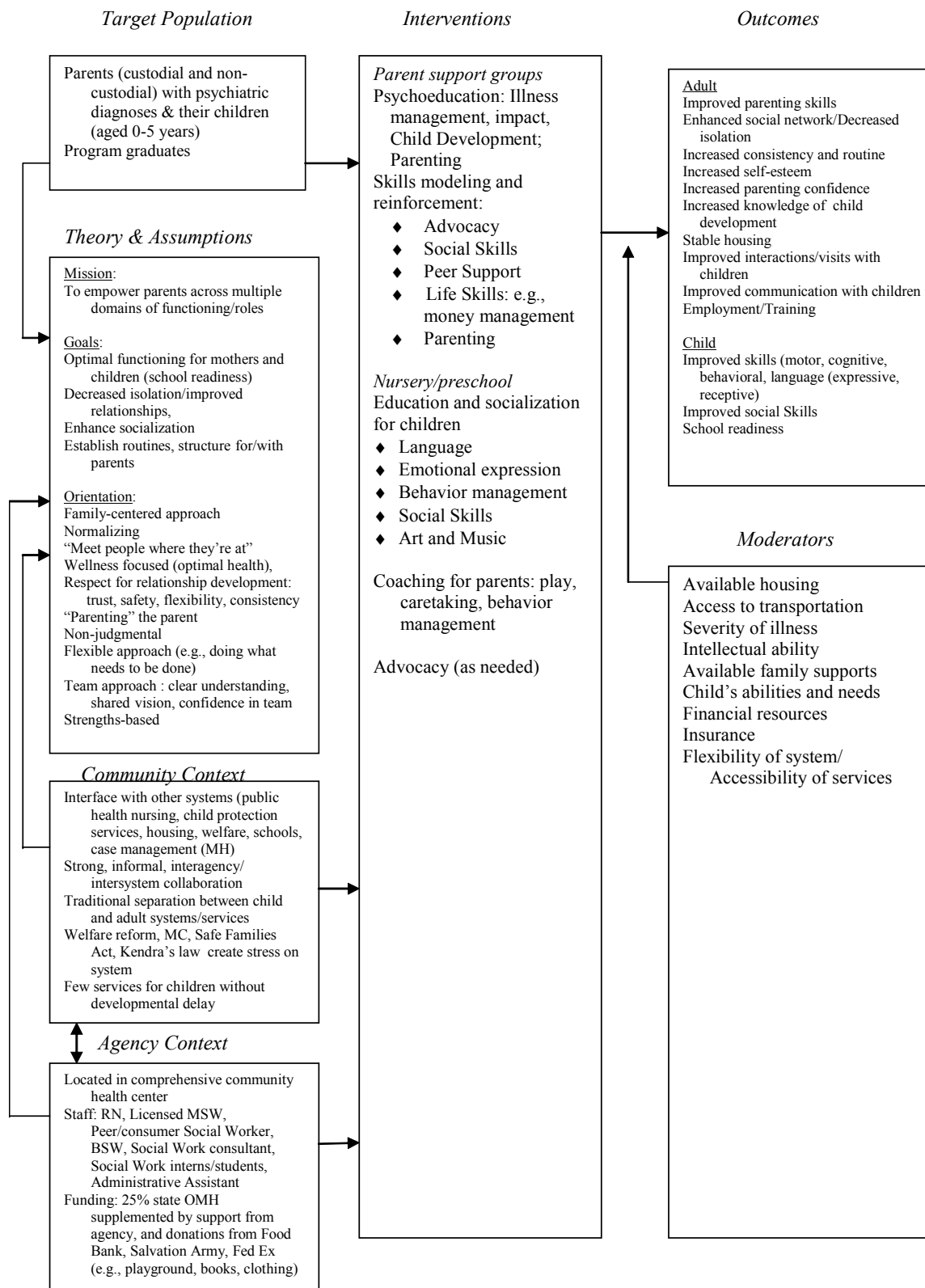
"The program helps you get on your feet. It keeps you aware of what you're gonna do wrong. What you learn from Mary and Evelyn gives you knowledge you need to take care of yourself cause then you can take care of your children."

"I still need the support. Sometimes agencies back out before you're really ready. You gotta do it slow and easy."

"You find out you're not the only one. Other mothers have gone through the same thing. Hearing about people getting their kids back give you hope."

"Mothers get "hooked" because they want better things for their children (CAPT director)."

## Logic Model: Children and Parents Together



## **Emerson-Davis Family Development Center**

### **Brooklyn, NY**

#### **Program Description**

The Emerson-Davis Family Development Center (Emerson-Davis) is a residential treatment program for adults with mental illness and a history of homelessness. Emerson-Davis is located in a remodeled college dormitory in Brooklyn, NY. The dormitory has been converted into 22 one-bedroom apartments for single adults seeking reunification with their children, and 16 two-bedroom apartments for families. The program for families at Emerson-Davis centers around comprehensive case-management and in-home family development services to promote independence and good parenting among residents. A range of services for children in residence with their parents is also available on-site. Emerson-Davis operates eight “satellite” apartments in the community that are available to families after “graduation” from the residential program.

#### **Program History**

Emerson-Davis is a program of The Institute for Community Living (ICL), a large human service agency for individuals with mental illness and mental retardation and co-occurring problems such as substance abuse and HIV in New York City. Using a combination of available state and federal funding, ICL opened the Emerson-Davis Center in 1994. According to the current leadership at ICL, the program for parents was a natural outgrowth of existing ICL residential programs for homeless adults with mental illness and chemical abuse problems (MICA programs). As the adults in their MICA residential programs became healthier and more stable, they expressed a desire to reunify with their children, who were living with relatives or with foster families through city child protective services. Initially, there were two separate programs at Emerson-Davis – one for the single adults in residence, and one for families. Experience with this model made it evident that integrating the programs for single and parenting adults fostered a stronger sense of community and recovery.

The program at Emerson-Davis, like all programs for parents with mental illness, was developed in a vacuum of knowledge about “best practices” for parents. Administrators and staff “borrowed” and adapted models designed for different populations (e.g., substance abuse) with which ICL had experienced success. Over time, it became apparent that additional services for children were desirable. Funding from federal Housing and Urban Development (HUD) and private foundations allowed for the establishment of “The Family Enhancement and Learning Program” at Emerson-Davis, a program devoted to educational and preventive interventions for children and families. It was also determined that satellite apartments and a modified program were needed to provide an intermediate step between the more intensive residential program at Emerson-Davis and full independent living in the community. In 1999, ICL leased its first satellite apartment in the Crown Heights sections of Brooklyn.

#### **Funding History**

The Emerson-Davis Center was established with funding from the New York State Office of Mental Health and HUD program. HUD grants (McKinney grants) were made available to states to distribute in a competitive grant program according to local priorities. In New York, these monies were assigned to housing for persons with a history of homelessness, and mental illness as part of the historic State/City, New York/New York Agreement. ICL, a New York based human service agency with a history of providing clinical and residential services for a variety of vulnerable populations since 1986, was well situated to respond to this priority. This funding has continued since the program’s inception.

In addition to these primary funding sources, Emerson-Davis receives service support from local child welfare agencies, schools, hospitals, child care and legal assistance programs. Local community groups have sponsored funding drives for the Center.

### Target Population

Emerson-Davis provides services for adults (18+ years) with serious and persistent mental illness and a history of homelessness (requirements of New York/New York funding) who wish to live with their children and work toward independence. Parents must be eligible for SSI benefits, and be willing to authorize Emerson-Davis and ICL to be payee of these benefits. Emerson-Davis also requires participants to be drug-free for at least one-year, stable with respect to psychiatric symptoms, and to have custody of their children or have a reunification plan. Parents must also show a “genuine yearning” to be with their children, and to learn to manage parenting stresses, that “grows out of their capacity” for empathy and delayed gratification for their child’s benefit (p. 44; Lieberman et al., 1999). Children must be twelve years or younger at the time of admission.

### Theory and Assumptions

**Mission.** The mission of the Emerson-Davis Family Development Center is to promote family reunification for its target population and to develop innovations that promote success of this endeavor. Emerson-Davis also shares in the formal mission of ICL, its parent organization.

**Program Goals.** The goal of the program at Emerson-Davis is “to blend a sufficient number of interventions to establish a safe, home-learning environment which supports parents and children in successfully building a family and personal life” (p. 43, Lieberman et al., 1999). Within this program goal, families determine their own goals and plans to achieve these goals. Independent living is central among goals for all families at Emerson-Davis.

**Theoretical Orientation.** Emerson-Davis is family-centered and strengths-based. The program is founded upon five “guiding principals” that reflect this orientation and approach. These principles are listed in Table 1 (see below; Lieberman, Campanelli, Ades, Cruz, Nagel, & Palmer, 1999). The family is prioritized as both a social and clinical unit. Parents are supported to develop individual and family goals, and service plans that address the broad psychosocial needs of both parents and children are the center of the intervention at Emerson-Davis. The program at Emerson-Davis is strongly influenced by the “Community as Method” model developed for persons with substance abuse and developmental disabilities. Parents and children are challenged by multiple providers at the residence (e.g., house staff, case managers, family development specialists) to participate fully in a social community of staff and other residents. The Community model is further supported by use of the Social Problem-Solving Skills program developed by Elias and Clabby (1989). This program was originally developed to promote prosocial behavior among children and youth. Clabby has provided direct consultation to Emerson-Davis, and facilitated program modifications to address the needs of the families served by Emerson-Davis.

Table 1  
Emerson-Davis “Guiding Principles”

|   |   |
|---|---|
| 1 | Parents who want to care for their children are less impaired by psychiatric disability than those who do not.  |
| 2 | Foster care, too frequently, has disappointing results.   |
| 3 | Lack of an adequate residence is a major determinant of poor outcomes for individuals.  |
| 4 | Parents need and can benefit from support in their parenting role. Housing packaged with targeted social services is an ideal vehicle for the purpose of delivering this support. |
| 5 | Housing must be accompanied by broad social service supports that are available in an integrated fashion.   |

## **Community Context**

**Local History.** Emerson-Davis is located in the Clinton Hill district of Brooklyn, NY. Clinton is an ethnically and economically diverse area that has been undergoing gentrification during the last five years. The center is accessible to both bus and subway routes that access the entire city of New York. The Emerson-Davis residence is adjacent to Pratt Institute.

**Community Strengths and Weaknesses.** Participants in the Emerson-Davis program identify the resources of New York City as an asset of their community. They report that the program at Emerson-Davis helps them access many of the recreational and educational opportunities available to them, and to integrate these resources into their family lives. For example, case managers help parents plan weekend family activities that may include a trip to the zoo or a museum, all accessible (and sometimes free) from the extensive public transportation system. In addition to its proximity to public transportation, the neighborhood itself also has strengths. Most notably, Emerson-Davis is located within walking distance from an elementary and middle school, and from day care centers used by program participants. This encourages parent participation in school, and supports attendance at parent-teacher meetings. New York City also has its disadvantages, however. The cost of living is very high, work is competitive, and affordable and safe housing is difficult to find. Program staff note that lack of affordable housing provides a significant barrier to independence for residents at Emerson-Davis. There are few realistic opportunities for housing comparable to the apartments at the Center – large enough for a family, safe, and accessible to school and daycare. Additionally, the quality of public school systems varies greatly across neighborhoods in New York.

**Relationship of Community to Emerson-Davis.** Initially, the community immediately surrounding Emerson-Davis was not welcoming. Neighbors were concerned about having a residential treatment program for adults with mental illness in their neighborhood. With support from ICL, Emerson-Davis engaged in an extensive social marketing campaign directed at both political leaders and the community. Relationships were created with the local state senator, and city council members. Community programs were initiated to introduce Emerson-Davis to politicians and neighbors, to encourage community involvement and participation, and to educate the local community and political leaders about mental illness and stigma. These efforts have been highly successful at eliciting generous support from the community. After seven years, Emerson-Davis is well integrated into the neighborhood. Community members are active members of the program’s advisory board (see below), and sponsor a yearly Toy Drive for residents. Holiday parties and yearly block parties provide opportunities for community members to meet the families at Emerson-Davis, ask questions, and see that the families living at Emerson-Davis are “just like everyone else.” Staff at Emerson-Davis say that the relationship with the immediately surrounding community is so strong that there is a sense of “community ownership of the children” and an “open door policy” for children at neighbors’ homes.

## **Community Collaborators**

Emerson-Davis lists multiple community collaborators across state agencies, local providers, and community organizations. These collaborators include child welfare and local private non-profit foster care agencies, mental health providers, schools, vocational rehabilitation services, day care providers, churches, and local businesses. Members of these constituencies participate on Emerson Davis’s community advisory board.

## **Methods of Collaboration**

Collaborators are engaged in different ways on multiple levels. For example, on a political level, Emerson-Davis has forged strong relationships with the local state senator and city councilor, both of whom have been instrumental in the success and continued funding of the program. On the agency level, Emerson-Davis has created strong and cooperative relationships with child welfare, foster care agencies, local daycare providers, and vocational rehabilitation services. These relationships prove mutually

beneficial in that Emerson-Davis can access a comprehensive service array for program participants, and the work of providers is facilitated through consistent communication with and support from Emerson-Davis. This collaboration ultimately enhances outcomes for parents and families. For example, state child welfare has a strong interest in family reunification. Housing and supervision of child safety can be major obstacles in establishing reunification. Emerson-Davis can address these issues and facilitate safe reunification by providing supervised apartments for parents with children in state custody.

To support these relationships, ICL sponsors an annual conference for community collaborators and providers focused around issues of local interest. For example, a conference is being planned on Parenting and Mental Illness: What's in the best interest of the child?

### **Agency Context**

**Mission and Goals.** Emerson Davis is a program of the Institute of Community Living (ICL). The Mission of ICL “is to assist people with mental illness and developmental disabilities to improve their quality of life and to participate in community living by providing high-quality services and support.” According to its own administrators, ICL is engaged in an ongoing process to accumulate the resources necessary to meet the multiple service needs of the at-risk populations it serves. The growing array of ICL programs provides access to quality services that the ICL’s service population, stigmatized by history, often finds difficult to obtain by other means.

Affiliation with ICL provides benefits to Emerson Davis’s residents and staff. ICL’s wide array of services are readily available to Emerson Davis families, and can often be better coordinated as a result of existing intra-agency channels of communication. For example, ICL has an “Entitlements” department that specializes in accessing entitlements (e.g., SSI) for which participants are eligible, and is available to all clients of any ICL program. Thus, participants at Emerson-Davis have access to this service by virtue of their affiliation with ICL, and case-managers at Emerson-Davis do not have to be burdened with this aspect of participants’ needs.

Affiliation with ICL also offers a wide range of staff development opportunities. ICL offers comprehensive 2-day orientation to all new employees, and regular training seminars for all staff. Staff at Emerson-Davis often come to the program from other ICL programs. High level administrators emphasize the value of this “within agency” experience with respect to skill development, and staff morale and loyalty. Many staff have a genuine investment in the agency and its mission that enhances morale and decreases turnover and disruptions. These features in turn are believed to enhance services to participants.

**Agency Characteristics.** ICL employs approximately 850 individuals that staff more than 40 programs throughout New York City and eastern Pennsylvania. Emerson Davis staff are all employees of this larger organization. Emerson-Davis supports a masters-level Program Director with extensive experience in working with adults with mental illness and/or substance abuse. In addition to a single administrative assistant, the Program Director oversees two integrated programs for families: Case-Management, and Family Development. Each of these programs is run by an experienced staff member with bachelor’s degrees in related disciplines. The supervisor for the Case-Management program supervises four bachelor or associate-level case-managers, six front-desk counselors, and four on-call front desk staff. Case managers provide direct case management and crisis intervention, while front desk staff provide a structured milieu and crisis intervention. The Family Development Specialist supervises four childcare staff who provide supervision and structured recreational and educational activities for children after school. As noted in Figure 1, The Learning Center is an integral component of the program at Emerson-Davis, but is supervised by a doctoral level psychologist. The Learning Center is staffed by a masters-level family specialist, and an academic tutors at either the masters or bachelors level. A subsidiary ICL family and children’s services clinic the Guidance Center of Brooklyn provides onsite child psychotherapeutic interventions and parent counseling in the Learning Center.

Staff at Emerson-Davis attend weekly staff meetings that provide regular in-service education and training. In particular, staff are asked to examine their own values about parenting and mental illness, and

to develop increased sensitivity and acceptance of diversity in parenting. Staff also attend weekly community meetings that include all staff and program participants. Community issues are raised and addressed at these meetings, and community events are planned.

### **Program Model: Services and Interventions**

The program for families at Emerson-Davis revolves around two fully integrated and complementary programs: The case management program and the family development program. These programs are embedded in the “Community as Method” program that defines Emerson-Davis. Additional programming on-site includes psychoeducational parenting group, Family Enhancement and Learning Program, the afterschool program for children, Scattered Site Program, and Alumni Association. Case-managers at Emerson-Davis also provide referral and coordination of mental health (e.g., psychotherapy, medication management), vocational rehabilitation, and drug treatment services for parents, as well as for any other services and supports need by families living at Emerson-Davis.

**Social Problem Solving.** For the purposes of finding an easy to use common language for discussing and fostering prosocial behavior among Emerson-Davis program participants, ICL has adapted and modified modules that were designed by Clabby and Elias for inner city school populations. The development of these modules is an ongoing process.

**Community as Method.** Emerson-Davis is a community residence that is staffed 24 hours a day, 7 days a week. House staff provide round-the-clock supervision, support, and crisis management. All staff at Emerson-Davis function as a whole to foster a sense of community at the residence. Both staff and program participants say that the greater proportion of learning at Emerson-Davis occurs spontaneously through continuous daily interactions between residents and staff that emphasize respect for pro-social behavior and community obligations. Community meetings for both staff and adult participants are held weekly to address both administrative and social house issues.

**Case Management.** Case managers are selected to provide as good a “fit” as possible for each family. While no formal protocols have been established for this purpose, it has been observed that some families require a warm, but firmer and more intrusive case management approach than others. Case Managers meet with parents a minimum of five visits a month. Initial meetings focus on a comprehensive assessment (see Client Path below), identification of goals and development of an appropriate, goal-directed service plan. At subsequent meetings, participants and case-managers review progress and service plan implementation, and address problems/concerns that have arisen. Case-managers are a source of education for parents about the multiple issues of independent living. They provide comprehensive referral and coordination of all services determined to be appropriate to a family’s goals.

**Family Development.** Each family works with a Family Development Specialist who visits the family in their apartment at least once per week. The Family Specialist provides support and education related to all aspects of parenting and family life. In particular, the specialist discusses child development and parenting concerns with parents, and provides role modeling for good parenting skills, behavior management, advocacy, and general problem-solving. The specialist is also available to accompany parents to school meetings or court dates related to child custody.

**Parenting Group.** The parenting group is an integral and required part of the program for parents living at Emerson-Davis. The group meets weekly and is led by the Family Development Specialist. Childcare is provided during the meeting time so that all parents can attend. Groups focus on diverse issues related to family life, and can be general or specific. For example, groups may focus on strategies for behavior management or on planning for educational and recreational activities during a school break. Issues are determined in collaboration between the specialist and parents.

**The Family Enhancement and Learning Center Program (Learning Center).** The Learning Center is located in the basement of the Emerson-Davis Center. This program provides both educational and clinical services for families who have identified these service needs in their service plan. Professional tutors are hired to meet with children to address learning and other school related difficulties. Mental health counselors from a local community mental health center travel to Emerson-Davis to meet with children and families for individual and family therapy.

**After School Respite Program.** Emerson-Davis hires per diem childcare staff to provide supervision and structured activities including both homework supervision and recreation for children at the residence. Respite childcare is provided daily during the school week from 3 to 5pm. Children are not required to attend the After School program, but participation is strongly encouraged. Parents interviewed at Emerson-Davis reported that the After School Respite program was extremely helpful. It allowed parents time for themselves to take care of necessary errands such as marketing, to “decompress” from the stresses of the day, to focus on preparing dinner, and to gather energy for parenting into the evening.

**Summer Program.** In the summer when children are not in school, Emerson-Davis coordinates two trips per week for the children who are not in summer school or attending camp. Less regular activities are coordinated that both parents and children can attend together.

**Scattered Site Program.** Emerson-Davis leases eight apartments in various parts of Brooklyn. These apartments are available for rent to participants who “graduate” from the residential program. Participants at the scattered sites continue to receive a modified program of support and services from Emerson-Davis. They meet with case-managers once a month in their apartments, are welcome to attend the parenting group and receive support and guidance from the Family Specialist. Graduates may also continue to take advantage of the After School and Respite programs available for families at Emerson Davis. Unfortunately, many graduates move to parts of the city that make access to the residence and these services difficult.

**Alumni Association.** Emerson-Davis continues to provide services to past parents and children who remain in the area. They sponsor a monthly meeting for Alumni to socialize and provide support for each other. Some parents also hold supported employment positions at the residence. Alumni are also offered childcare so that they keep up with important community commitments.

**Treatment Team Meetings.** The program director and supervisors of the Case-Management, Family Development, and Learning Center programs meet weekly to review participant treatment/service plans and progress, and to address challenging issues related to families. Case-managers are invited to attend when discussions center on participants with whom they work. Input is gathered from all house and childcare staff prior to meetings to inform team discussions.

### **Client Path**

Referrals to Emerson-Davis come from a range of providers. The greatest proportion come from homeless shelters, psychiatric inpatient units, and other ICL programs. All referrals must go through the New York/New York application process, and be eligible for services (i.e. diagnosis with SMI and history of homelessness). Applications are screened by a staff team composed of the program director, director of the Learning Center (doctoral level psychologist), and the family development specialist for promise of success in the program. Applications are examined for strengths, psychiatric stability, and genuine yearning and capacity to parent. Consideration is given to the “fit” of the applicant with current case-management staff.

Applicants are invited for one to two intake meetings in which they learn about the program and about expectations for participants. The directors of the Case Management, Family Development, and Family Enhancement programs, and a case manager are present for the intake meetings. These staff

emphasize the “staff intensity” of the program to help potential participants decide whether the approach will be too intrusive for them. If both staff and applicant agree, an admission agreement is signed. Within 24 hours of admission, the client’s ability to exercise “self-preservation” in the case of a fire or other house emergency is assessed.

The first six months after admission is considered an “assessment period” where strengths and needs are broadly assessed. An interim service plan is developed immediately that includes regular meetings with a case manager and family development specialist, and attendance at the parenting group. Over the first 30 days in residence, the participant and case-manager complete a “Level of Functioning” assessment, that examines strengths, interests, social networks, medical history, and psychosocial functioning. The completed assessment is reviewed by the participant and the Director of Case Management. In addition, over the first 30 days in the program, meetings with both the case-manager and family development specialist focus on identification of goals across a broad spectrum of functioning, and development of a service plan tailored to meet those goals. For example, participants identify residential, educational and occupational goals. They identify personal and interpersonal development goals such as “Assertiveness” and “Community Integration,” and they develop parenting goals. Parents often arrive before having regained custody of their children. In these cases, the reunification plan developed with child welfare or other supporting agency is integrated into the participants overall service plan. Service plans are monitored weekly, and reviewed quarterly for progress and modification.

Treatment and service planning for children is separate and takes place through the Family Enhancement program. Child progress is often discussed at the weekly Treatment Team meetings discussed above.

There are no strict criteria for graduation from Emerson-Davis. Participants together with staff providers determine when rehabilitation goals have been met, symptoms are stable, and parenting skills and family functioning are satisfactory. Lack of available housing is often a barrier to graduation for participants who otherwise feel ready for increased independence in the community. The majority of participants live at Emerson-Davis for 1 ½ to 2 ½ years (contingent upon housing in the community) before entering independent living in the community. Graduates who remain in Emerson-Davis community apartments (scattered sites) continue to meet with their case-manager on a less regular basis of once per month, although more intensive support is available when needed. Some participants continue to participate in activities and groups at Emerson-Davis, while others do not. Distance from the residence can be prohibitive for continued involvement in house activities.

## **Evaluation**

Emerson Davis collects data on family characteristics, family outcomes, and family satisfaction with the program.

**Family Demographics.** Between its opening in 1994 and January 2000, Emerson-Davis has provided services for 45 parents with 63 children. Ninety-three percent of parents have been mothers, 62% were African American, 20% Latino, 15% Caucasian, and 3% Asian. Parents range in age from 18 to 56 years. Over 64% have never been married, and 36% have completed high school.

**Diagnoses.** Parents at Emerson-Davis carry primary diagnoses of Schizophrenia and related disorders (42%), mood disorders including Major Depression and Bipolar Disorder (40%), and other Axis I diagnoses. Approximately half of program participants have a history of co-occurring substance abuse diagnoses.

**Children’s Characteristics.** Children at Emerson-Davis have ranged in age between 0 and 14 years old, with 50% being under the age of 6 years. Children older than 12 years at the time of their parent’s enrollment are not eligible for residence at Emerson-Davis. Most children at Emerson-Davis have been involved with child welfare and foster care settings. Forty-one percent of the children have

psychiatric diagnoses, including Mental Retardation, Learning Disabilities, ADHD, depression, anxiety, and psychotic disorders.

**Family Outcomes.** Twenty-four of these families have left Emerson-Davis for independent living with families intact. Adherence to service plans developed with case managers and family development specialists are high, ranging from 87% to 100%. Surveys of staff indicate that they perceive that 86% of parents and 90% of children show positive outcomes with respect to psychiatric symptoms, overall functioning and development. Substance abuse relapse rates are low, with 3.6% of parents having some type of relapse. Twelve and one-half percent of the parents require psychiatric hospitalization annually, but can return to the residence and resume family life after discharge. Children can often be cared for in the residence, but sometimes must enter foster care temporarily. Emerson-Davis facilitates their return once the parent's crisis has resolved. There are plans to begin more rigorous data collection on clinical outcomes for both children and parents.

**Family Satisfaction.** Participant satisfaction reports show that 93% of the participants are satisfied or very satisfied with the program at Emerson-Davis with respect to achieving their goals.

### A Success Story

Janice arrived at Emerson-Davis in December 1999. Her stated goals were to maintain sobriety, regain custody of her two children who were in foster care, and become independent. At the time of her admission to Emerson-Davis, Janice had completed a long-term, residential substance abuse program and was involved in an internship to train her to be a drug and alcohol counselor. Janice was living in a homeless shelter.

Janice arrived at Emerson while her children were still in state custody. She began having visits with her children at Emerson-Davis one month after her admission. Janice recalled that her case-manager and the family development specialist helped her arrange the visits with DSS, and provided a lot of support during visits. Janice felt she needed support because she was not used to parenting, and had never parented while sober. The family development specialist also helped Janice understand the special needs of one of her children who has medical issues, and to access the services he needed.

Janice regained custody of her children six months after arriving at Emerson-Davis. When we met Janice, her children who are 10 and 12 years old and in the 4<sup>th</sup> and 7<sup>th</sup> grade respectively, had been living with her for just over one month. She reported that they were initially quiet and withdrawn, but seemed to adjust quickly and were now laughing and taking part in house activities with other children. Janice said that the childcare workers and afternoon (Respite) activities have been very important in helping her children adjust at Emerson-Davis and in general.

In addition to regaining custody of her children, Janice has completed her internship since beginning the program at Emerson-Davis, and has begun the practicum component of her training. She is employed as a Residential Assistant at a homeless shelter and drug treatment facility. She facilitates groups and assists with client needs. Janice recalled that things started to change for the better shortly after she arrived at Emerson-Davis. When asked what these changes were, she stated that she began to trust people and to ask for help, and be willing to receive support. She thinks this has been the most important and influential change in her life. In addition, Janice said that she felt that staff at Emerson-Davis listened to her and respected her "voice." They were not rigid, and responded to her expressed needs and goals. For example, Janice's internship was located in the Bronx. The travel time required to get to her internship from Emerson-Davis and back, made it difficult for her to attend more than one meeting with her case manager a week. The program accommodated her need. In addition, the program supported her maintaining her relationship with her prior therapist instead of insisting that she receive services through a more conveniently located clinic.

Janice is currently working on increasing her independence and acquiring permanent housing. At the time of our visit, she was looking forward to celebrating her 4<sup>th</sup> anniversary of sobriety. She feels that

there need to be more programs like Emerson-Davis available for parents, and that providers need to be more aware about resources like Emerson-Davis that are available.

### **Challenges**

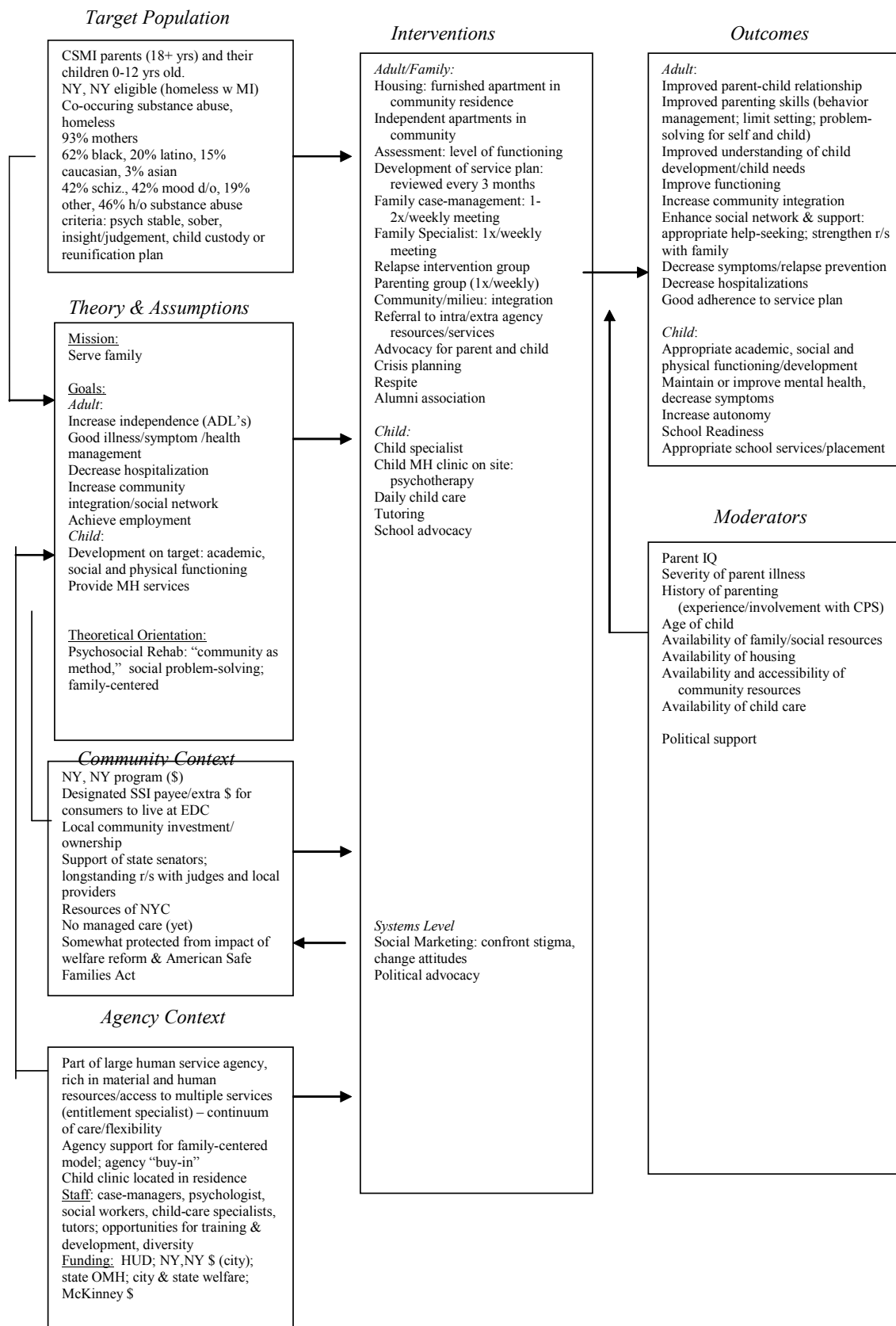
At the program level, Emerson-Davis is challenged by the waiting list for enrollment. Applicants often need to wait for six months for an apartment to open up. In addition, the high standard of living makes it difficult to retain staff at the rate of pay that the program can support. At the systems level, safe and affordable housing is in short supply in New York. This influences the waiting list as clients can not graduate.

### **Next Steps**

Program procedures are being formalized through the development of protocols for admissions and community placement. Additionally, a range of parent and child assessment and outcome measures are being gathered at least semi-annually for service planning and program evaluation purposes. The intent is to turn the residence into a shorter-term family reunification center that has a greater range of supported community placement options than currently exists.

ICL believes that family unification programs working with this population have a long-term obligation to serve families longitudinally throughout their vulnerable years. With this in mind ICL has organized a Family and Children's Service with the broad goal of providing family preservation services to at-risk populations in Brooklyn. Already there are four community mental health clinics in place, three new residential programs in development for single parent families (two for HIV+ parents), two school-based mental health clinics, and a juvenile justice program. There is also a plan for comparing the family reunification outcomes of this system with traditional foster care.

### Logic Model: Emerson Davis Developmental Center



## **Family Support Services/PACE Program**

**Iowa City, IA**

### **Program Description**

The Family Support Services/PACE (FSS/PACE) program is a program of the Mid-Eastern Iowa Community Mental Health Center (MCMHC), located in Iowa City, Iowa. PACE stands for Parents, Advocacy, Coordination and Education. The program provides clinical case-management for families in which a parent has a serious and persistent mental illness, and has minor children living in the home. The primary goal of FSS/PACE is to prevent or reduce child welfare involvement and unplanned hospitalizations, and to increase the quality of life for families while building a bridge between mental health services and other service delivery systems.

FSS/PACE case managers form supportive, therapeutic relationships with families. Building on families' strengths, case managers focus on the development of problem solving skills, mental health counseling, and education for both parents and children about mental illness.

### **Program History**

The FSS/PACE program began in 1995 as an initiative of the Johnson County Department of Human Services (DHS). DHS administrators realized that a substantial percentage of children in foster care placement had parents with serious and persistent mental illness, and that these children were likely at risk for long-term placement. In addition, DHS staff and administrators recognized that they were not well trained to work with adult mental health issues, particularly as they related to parenting. DHS decided that they would benefit from a collaboration with mental health providers in providing services for this population of children and families.

In November 1995, DHS contracted with MCMHC, a local community mental health agency, to create FSS/PACE. Initially, all referrals came through DHS. As contracted, FSS/PACE provided therapy and case management services to both parents and children. Custody was not required. Approximately one-third of the first families served by FSS/PACE had at least one child living in foster care at the time services began.

The relationship between DHS and FSS/PACE proved to be challenging. Differences in basic philosophies, and approaches strained the collaboration. FSS/PACE case managers often felt that DHS was not able to integrate the needs of parents with mental illness into family plans, and that DHS goals were often unrealistic for families where a parent has a serious mental illness. DHS and FSS/PACE worked together for four and a half years until January of 2000, at which point DHS funding for FSS/PACE ended. MCMHC became the primary funding source for FSS/PACE.

As a result of these changes, FSS/PACE underwent programmatic changes as well. First, the new budget could accommodate fewer families. Second, custody became a criterion for program enrollment. And, third, referrals came from agencies other than DHS, although long-standing relationships with many DHS workers were maintained, and continue to enhance outcomes for families that are shared by the two agencies. Thus, although the initial collaboration with DHS was not sustained, FSS/PACE was able to gain autonomy as an independent program, advocate more earnestly for families as a result of this independence, and become more focused on parenting rather than reunification issues.

### **Funding History**

Funding for FSS/PACE must be divided into two distinct periods: The period before January 2000, and the period after January 2000. Prior to January 2000, decategorized federal money, channeled through DHS, provided the majority of FSS/PACE's funding. Other funding sources at this time, included a one-time grant from the Alliance for the Mentally Ill, and on-going support from local charities that provided "flexible funds" that could be used for small, "one time" expenses such as overdue electric bills, summer camp, or a home appliance.

After January of 2000, MCMHC became the primary funding source for FSS/PACE. MCMHC's allocated their portion of a federal block grant for adult community mental health services, to FSS/PACE. Overall, funding for FSS/PACE decreased when the contract with DHS was discontinued. MCMHC funding is able to cover staff salaries only. Clinical case management services are funded through third party billing to Medicaid when appropriate (not all case management time can be billed, but because case managers are licensed clinicians and provide therapy as part of case management, much of direct service time can be billed). In addition, FSS/PACE continues to receive money from local charities, including an arrangement to receive consignment shop proceeds from one of these agencies.

### **Target Population**

Prior to 2000, FSS/PACE worked with parents with serious mental illness who were involved with child welfare and had either lost custody of their children or were at risk for custody loss. Since 2000, FSS/PACE has targeted families in which a parent has mental illness but has established custody of her or his children.

### **Theory and Assumptions**

**Mission.** The FSS/PACE program does not have its own mission statement. The mission of the larger mental health agency is to provide accessible, high quality mental health care in collaboration with other agencies

**Program Goals.** The goals of the FSS/PACE program are: "To prevent or reduce child welfare involvement and unplanned hospitalizations by: Increasing the quality of life of the family; providing a bridge between mental health services and other service delivery systems; and, offering mental health interventions in the home.

**Theoretical Orientation.** First and foremost, FSS/PACE embodies a family-systems/family-strengths model. While the individual needs of parents and children are identified, the family is the unit of attention and intervention; all actions and events are considered within the context of the family. The abilities, not the limitations, of families are the focus of care. Work with families centers around identifying and utilizing their strengths to achieve their goals. Within this family systems/family strengths context, clinical case managers also use psychodynamic and cognitive-behavioral techniques.

FSS/PACE staff establish supportive, unconditional, and therapeutic relationships with families. FSS/PACE act as both therapists and case managers, and both staff and families report that the relationships formed are strong more like family than patient/therapist. The combination of clinical skills and supportive, non-traditional approaches used by case managers creates a unique environment for both clinicians and families; and both parties report that this is beneficial. The long-term commitment between FSS/PACE staff and families makes for a unique caregiver relationship.

### **Community Context**

**Local History.** Iowa City is a small, metropolitan area with a population of 63,000. Home to the University of Iowa, students comprise a large portion of the population; Iowa City is very much a college town. Small suburbs surround the town, while outlying areas are more rural.

**Community Strengths and Weaknesses.** Iowa City is rich in cultural resources relative to the rest of the state. It is also a somewhat diverse, politically liberal and tolerant community. Providers and consumers both reported that these qualities decrease the amount of stigma experienced by people with mental illness. However, as is the case in many university towns, there is a shortage of available and affordable housing, especially during the school year. Public transportation is limited. While the city itself is small and accessible on foot, surrounding areas are more isolated and difficult to access without a car. Families also report difficulty finding affordable and reliable child care.

**Mental Health Resources.** Iowa City is a “mental health town” in that it is abundant in resources. Many persons seeking public mental health care come to Iowa City in search of services not available elsewhere in Iowa. Iowa City has a small, intimate community of health care providers, a situation that reportedly facilitates and enhances collaboration. One area of weakness noted in the local mental health community is a lack of adequate respite services for both adults and children.

### **Community Collaborators**

In 2000, FSS/PACE collaborated with over 60 different agencies to provide case management services to families. FSS/PACE worked in partnership with multiple systems including schools, juvenile justice, housing, mental health, corrections and legal. FSS/PACE also collaborated with various advocacy organizations (Alliance for the Mentally Ill), charities (Goodwill, Salvation Army), after-school programs, Big Brothers/Big Sisters, personal physicians and nurses, insurance agencies, utility companies, summer camps and emergency services.

FSS/PACE coordinates multiple providers around individual families. Collaborators may include MCMHC staff, other community providers such as DHS case managers, school social workers, home care nurses and supported community living staff. Collaborators feel Iowa City has “a case management mentality” – there is an acknowledgement among providers about the need to collaborate with one another. Providers feel their ability to collaborate successfully is aided by living in a small community where providers are familiar and friendly with one another.

### **Methods of Collaboration**

From its origins, FSS/PACE sought out collaborative relationships with other providers. Initially, FSS/PACE staff visited local agencies to describe services and encourage referrals. Collaboration occurs through regular and “as needed” telephone contact, and through scheduled, case management meetings. In schools, collaborations often occur during parent conferences. FSS/PACE is seen by other providers in the community as the primary service “thinking about parenting and families.” One nurse stated, “Before FSS/PACE, we could provide for clients, but there was no focus on parenting. Things were disorganized. I felt scared as a provider to watch kids being taken away. Now, working with FSS/PACE, I don’t feel the same horror. I don’t feel alone. FSS/PACE is the first program to really pull all the players together, around the issues of families.”

Providers feel they are better able to focus on their work with families due to the presence of FSS/PACE. “I can be more effective working with families. I can get the information I need and not duplicate services” observed a family liaison counselor from a local elementary school. Other providers also note that FSS/PACE offers a very valuable perspective on the family “in the home” that many providers can not otherwise access. As stated by one of these providers during the site visit, the ability of FSS case managers “to give information about what is going on in the home is invaluable.”

While collaborators share referrals and information, funding is not shared. Collaborators feel that DHS, the public mental health system, Medicaid and the school system should all contribute to paying for services for families where a parent has a mental illness. While individual agencies are supportive of working with FSS/PACE, collaborative efforts often can not be billed for, leaving some providers less inclined to collaborate.

Not all collaborations have been positive. Problems have arisen when providers came to the table with their own agendas, or when important stakeholders could not be engaged in collaborative efforts. In particular, among the community collaborators interviewed during the site visit, many felt that child protective services, primary care physicians, juvenile justice and probation were absent from the collaborative process. Community providers identified three critical elements for successful interagency collaboration. First, is an openness to being educated about mental illness. Many providers may be misinformed about what it means to have a mental illness, and how it may and may not impact parenting. They will need education about how to help parents with a mental illness parent successfully. Second, is the need for trust, mutual respect, positive reinforcement, support and a common vision for serving

families and providing appropriate services. Third, collaborators felt it was important to acknowledge that one did not have all the answers, and there was a lot to learn from one another.

### **Agency Context**

**Mission and Goals.** FSS/PACE shares in the mission of the larger mental health agency in which it is located (MCMHC). The mission of MCMHC is “to promote and provide quality and accessible mental health care through an array of accredited mental health services and to work collaboratively with other community entities in the development of services to meet community mental health needs.”

**Agency Characteristics.** MCMHC is a medium-sized, community mental health center with 43 employees, 26 of whom offer clinical and/or direct care services. The agency is funded by federal, state and county dollars and client generated fees. Clinical operations are divided between medical services (with five staff), supported community living (seven staff), psychotherapy (15 staff), and FSS/PACE (two staff). FSS/PACE staff consist of two part-time clinical case managers, one of whom is the program’s Clinical Director. Both case managers are licensed clinical social workers. The Clinical Director oversees clinical services to families and is supervised by the agency’s Executive Director. MCMHC provides a range of mental health services including counseling and psychotherapy, psychiatric consultation (e.g., medication monitoring and evaluation), in-home family support, intensive psychiatric rehabilitation, supported community living, outreach, psychosocial rehabilitation services, peer counseling for the elderly, emergency mental health care, and consultation and education to the community.

The working environment at MCMHC is friendly, collegial and professional. MCMHC staff emphasize the importance of working in collaboration with one another to providing effective services. Respect for the individual contributions of different providers is critical to the agency’s teamwork ethic; “teams leave the professional hierarchy at the door.” Agency staff also note that clients feel more confident in their services knowing that providers trust and respect one another, and are working as a team. Consistent with this philosophy and practice, FSS/PACE staff work closely with other agency staff. Staff with expertise in areas related to the care of FSS/PACE families, provide both formal and informal consultation. Staff directly involved with FSS/PACE family members (e.g. child therapists) often work collaboratively in service and goal planning and plan implementation.

A family-centered orientation is part of the agency philosophy and is included in the agency’s larger mission. This approach is actively promoted and supported by agency leadership and policy. Many MCMHC staff are graduates of the University of Iowa, School of Social Work, where family-systems/family-strengths approaches are the primary theoretical models taught. Most staff at MCMHC believe that working with the family as the unit of intervention is an effective way to provide services. “It’s just easier to think about a family.” Staff collaborate around families and share information with one another. Staff emphasize the importance of this commitment to family-based work across agency programming, and at all levels of administration and direct service. In addition, MCMHC also has a history of leadership by social workers, which has facilitated a psychosocial and systems approach and response to clients’ needs.

### **Program Model: Services and Interventions**

FSS/PACE offers a variety of service. Clinical case managers provide case management, service coordination, psychotherapy, and advocacy for both parents and children. “Clinical” work focuses on development of problem-solving skills, education regarding mental illness, child development, and parenting, and financial planning. FSS/PACE also offers a monthly social/support group for mothers, 24-hour on-call support, emergency assistance, transportation, tenant/landlord mediation, financial assistance, crisis planning, transitional planning (e.g., hospitalizations, foster care placement), housing assistance and referrals to agency and community resources.

How services are provided is as important as which services are offered. In-home services are integral to FSS/PACE. They are preferred for many reasons. In-home meetings allow staff to work with families in a safe and comfortable space, where strengths are likely to be more evident. Families may be

more likely to discuss difficult issues in a familiar environment rather than in an unknown, clinical setting. Also, it is much easier to see multiple family members in their own home, as opposed to scheduling an office appointment. FSS/PACE staff share their “in-home” information with other members of a family’s treatment team. As a result, a more well-rounded picture of the family is formed that provides valuable information regarding families’ strengths and abilities.

## Evaluation

**Family Demographics.** As of May 1, 2000 FSS/PACE had served 48 adults and 68 children aged 0 to 18. Families are racially and ethnically homogeneous. Forty of the 48 adults served have been Caucasian, five have been African American, and two have been Latino/Hispanic. Most often, the mother has been the parent identified with mental illness. However, FSS/PACE has served fathers and single fathers in the past. Since its initiation, approximately half of the children have been between five and 11 years old, and approximately one-third have been between 12 and 18 years.

At the time of the site visit, 12 families (18 adults and 25 children) were receiving services from FSS/CAPT. With the exception of one biracial child, all of the adults and children in these families were Caucasian. Parents and children served by the program tend to be slightly older since funding and referrals changed in January 2000. Currently, three-quarters of the parents are between the ages of 30 and 45, and two-thirds of the children are adolescents (12 to 18 years old), and one-quarter are between the ages of five and 11.

Most families live in their own homes or apartments; some families receive HUD or Section 8 housing subsidies. All parents have custody of their children.

**Diagnoses.** The most frequent diagnosis among the parents served by FSS/PACE is Major Depressive Disorder, experienced by a third of participants. Other diagnoses include Bipolar Disorder, Schizophrenia, Generalized Anxiety Disorders, Post-Traumatic Stress Disorder, Dysthymia, and Obsessive-Compulsive Disorder. Some of the children involved also qualify for psychiatric diagnoses. Most common among these are Attention Deficit Hyperactivity Disorder, and Oppositional Defiant Disorder.

**Co-occurring Disorders and Issues.** FSS/PACE families experience a variety of co-occurring issues, including poverty, substance abuse, lack of and high cost of housing, trauma and domestic violence. For many families, the issues of poverty and substance abuse are more problematic than the issues related to mental illness.

**Family Outcomes.** There has not been any formal evaluation of the FSS/PACE program. Interviews with FSS/PACE staff, community collaborators, and families all provide very good anecdotal reports on the program’s success. FSS/PACE staff measure success by several explicit family outcomes. These include decreased hospitalizations, decreased child welfare involvement, increased problem solving skills, increased self esteem, increased decision-making skills, increased parenting skills, increased knowledge of child development, increased medication management, increased appointment adherence, increased quality of life, increased self-advocacy, increased confidence in parenting and a positive personality change. Staff say that many, if not all, of these outcomes have been experienced by all families involved with FSS/PACE.

Family participants in the FSS/PACE program identified the following in response to the question, “*What are the components of a successful family support program?*”

- Having staff that can respond to my needs
- In-home visits
- Knowing there is someone I can talk to and share my ideas with
- Knowing I can talk to someone 24 hours a day, 7 days a week
- Having access to resources and support

- Learning how to diffuse difficult situations
- Improved decision-making skills
- Acceptance of my mental illness
- Learning coping and communication skills
- Having someone to talk to about my kids
- Help with transportation
- Help with paperwork

### **Client Path**

Families come to FSS/PACE in a variety of ways. MCMHC providers (e.g., psychiatrists, nurses, social workers, physicians assistants, psychologists) will identify clients they feel are appropriate for the FSS/PACE program. Referrals also come from external sources, including DHS, the school system and supported community living programs. To be eligible for the FSS/PACE program, clients (the identified parent with a mental illness) must either have an Axis I diagnosis OR have experienced intensive inpatient or residential psychiatric treatment or have impaired employment, parenting or basic living skills. Clients also must have at least one child under the age of 18 living in the home, must not be receiving family preservation services through DHS or be adjudicated by Child In Need of Assistance (CHINA), or be under investigation for child abuse or denial of critical care. Finally, clients must be interested in receiving FSS/PACE services and must feel they would benefit from the program.

Potential participants are interviewed by FSS/PACE staff to assess interest and appropriateness for the program. Clients are questioned regarding family history, history of mental illness and treatment (for all immediate family members), substance use, family strengths and resources, finances and treatment plan ideas. Since FSS/PACE is a voluntary program, clients must consent to receive services. Clients and their families are assigned a FSS/PACE clinical case manager. Together, the family and case manager create a treatment plan detailing family concerns, strengths, potential barriers, goals, and possible action plans. The amount and type of contact between FSS/PACE staff and families is determined by the needs of each individual family. FSS/PACE staff and services are flexible, and can be modified at any time depending on the needs of a family.

There is no time limit to a family's involvement with FSS/PACE. Families can stay with FSS/PACE for as long as they need services and have minor children living in the home. Approximately half of the families currently being served have been with FSS/PACE for over five years. No waiting list exists, and the number of families that can be served depends on the intensity of services required across families and the availability of clinical case managers. When families enrolled require only minimal services, it is possible to serve more families. Many families, especially those involved since the program's beginning, require less intense contact, allowing for increased admission of new families. Most families have a minimum of one contact per week, with telephone follow-up.

### **A Success Story**

Terri is a 31-year-old African-American woman who is diagnosed with Schizoaffective disorder. Terri has a history of 75 psychiatric hospitalizations. She was referred to FSS/PACE by DHS, who was concerned about her parenting abilities. Terri was in and out of the hospital, and was emotionally unstable. She was angry, paranoid and did not adhere to her prescribed medications.

At the time of her referral to FSS/PACE, Terri's children, aged six and eight, were living in the home but had a history of foster care placement. Terri had few resources and supports, but expressed a desire to take back control of her life. FSS/PACE worked to advocate for services for Terri. "We worked very hard with Terri. We worked on very concrete ideas." Initially, Terri was in constant contact with her case manager. Through these calls, Terri and her case manager established a trusting and supportive relationship – a crucial component to helping Terri create and maintain a safe and healthy environment for herself and for her children.

It was unclear, however, that even with support from FSS/PACE Terri would be able to be the primary caregiver for her children. Five months after starting with FSS/PACE, DHS conducted an emergency removal of her children. At this time, FSS/PACE worked with DHS to determine what was in the best interest of this family. FSS/PACE wanted Terri to maintain involvement with her children even if she could not be their custodial parent. FSS/PACE successfully advocated for custody to be transferred to Terri's mother. At the same time, FSS/PACE and Terri established other support systems. Terri connected with an outpatient clinic and FSS/PACE encouraged her to attend the local clubhouse psychosocial rehabilitation program. Through her intensive involvement with FSS/PACE, Terry began treatment for a previously diagnosed brain injury. Terri also began to receive employment services, and returned to the work world. After 24 months in foster care, DHS transferred custody of the children to Terri's mother. Shortly thereafter, Terri's parental rights to her daughter were terminated.

Despite the loss of child custody and parental rights, this is a success story for many reasons. Terri, who had been frequently hospitalized and treatment resistant prior to FSS/PACE involvement, had stayed out of the hospital and was working effectively with a treatment team. Terri established a supportive relationship with her FSS/PACE case manager and developed a network of support services. Terri was able to have her children as a part of her life in the only way that she could. This illustrates that FSS/PACE works for the best interest of the *family*. When it became clear that it was not in the best interest of the family for Terri to be her children's primary caregiver, FSS/PACE facilitated another way to keep the family together, while providing necessary supports and safety for both mother and children.

### **Challenges**

Stigma is a huge challenge for both FSS/PACE and for the individual families with whom they work. FSS/PACE staff need to educate the community, including schools, child welfare case workers, lawyers, judges, primary care physicians and landlords, about the myths and realities of mental illness. Through education, FSS/PACE hopes to lessen the struggles that families face daily. Co-occurring problems, such as poverty and substance abuse, also provide great challenges for FSS/PACE and families. Finally, FSS/PACE is challenged in getting all relevant collaborators to the table to support and coordinate care for families where a parent has a mental illness. Service gaps in the community include lack of housing, limited respite care and insufficient public transportation.

### **What is Missing from FSS/PACE?**

Families felt nothing was missing from FSS/PACE. One mother stated, "The perfect program looks like FSS/PACE." FSS/PACE staff report that resources are lacking to serve all of the families in Iowa City that might benefit from their program. Narrowing the focus of whom to serve (i.e., only families with custody of their children and without involvement of child protective services) has enabled FSS/PACE to "streamline" their efforts and deliver services more effectively. However, there are still many families that they can not reach with only two part-time social workers. Serving more families would require an increase in funding, resources, and collaboration with providers in the community.

### **Next Steps**

There are not currently any program changes for FSS/PACE. They are adjusting their program to the new funding and referral structure (i.e., no DHS funding), and tailoring the program to work only with parent that have custody of their children. FSS/PACE hopes to continue to meet the program goals and objectives and MCMHC's mission.

In addition, specific goals for the future include: Continuing the monthly mom's social/support group, developing a budget club to assist with families' financial concerns, creating a monthly FSS/PACE newsletter for families, and establishing a FSS/PACE resource library.

### **Quotes from Families**

“It was important to know there was security in the services, that you could contact FSS/PACE when you needed to. This felt most helpful to the kids.”

“The kids felt they could call Kit (FSS/PACE case manager) in crisis situations. The kids benefited from knowing there was someone they could call.”

“Before FSS/PACE, everything was at a great distance. Now, things are at arms-length. It’s easier to access things with FSS/PACE.”

“FSS/PACE helped me learn how to communicate with my spouse.”

“I’ve been able to make friends easily now. This was something I was never able to do before. This is because of my daughter. She gives me hope, someone to care for. My daughter makes me want to stay well and be healthy.”

“Without Kit? I don’t even want to think about it! She helps me to talk about my kids, with my medication, making phone calls, paying the bills, filling out paperwork and problems with the kids.”

“I’ve figured out what makes me nervous and tense. I’m better at knowing what I need to do to feel ok.”

“Nothing [is missing from FSS/PACE]. If I’m having problems it really helps, takes a lot of the stress off. I don’t have a lot of bad days but when I do, Kit is there.”

“When I need a little help, she gives a little help. When I need a lot of help, she gives a lot of help.”

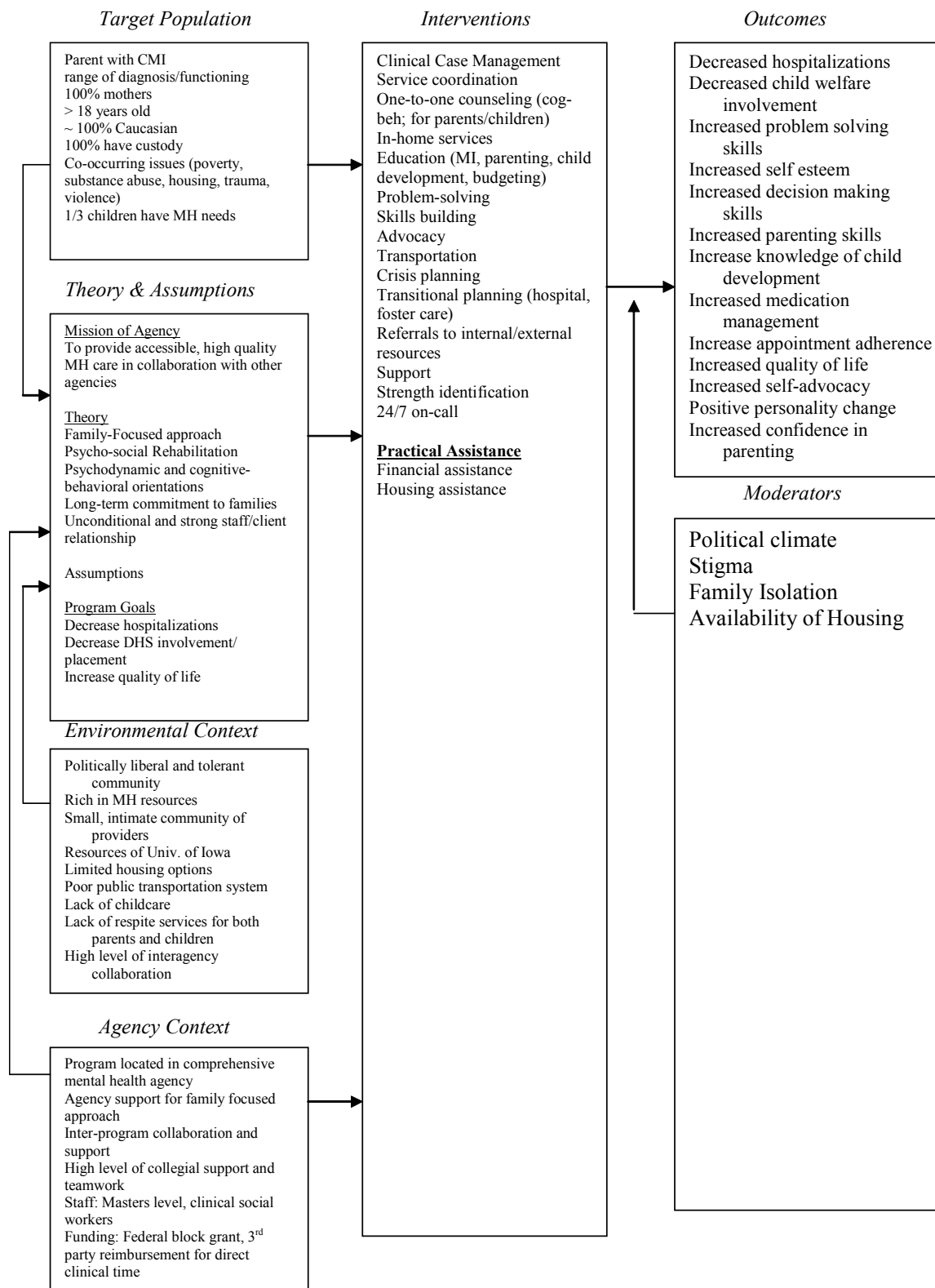
“My kids don’t look at me like a crazy person anymore.”

“The program is a god-send to me and my family.”

“I don’t know of any other program that comes into your home for people with mental illness and their families.”

“I never thought 10 years ago I’d be where I am today.”

### Logic Model: Family Support Services/Parents Advocacy Coordination Education



## **Invisible Children's Program**

### **Goshen, NY**

#### **Program Description**

The Invisible Children's Program (ICP) is a nationally recognized program for parents with a mental illness and their children. ICP is a program of Mental Health Association in Orange County, Inc. (MHA), a private, not for profit organization, in Goshen, New York. ICP embraces two guiding principles: 1) Parents want to be the best parents they can be; and 2) the act of parenting is a significant, oftentimes healing role for adults with mental illness. This innovative program's central focus is to empower parents and assist them in the creation of a safe and nurturing environment for their children while supporting efforts to keep the family unit together. ICP offers 24-hour family case management services including referrals and linkages to community resources, crisis services and advocacy, and support services including respite child care, parenting education, access to financial assistance, and supported education and employment as well as supported housing services. ICP families benefit from services offered by the MHA including a 24-hour helpline, Compeer, consumer run support groups, vocational training and supported education.

#### **Program History**

ICP began as part of a larger effort to increase awareness about parents with mental illness and their families. In 1990 Lucinda Sloan-Mallen, MHA's Executive Director at the time, observed that mental health consumers in MHA programs were bearing and parenting children. Given her personal history as the child of a single mother with Bipolar Disorder, she understood firsthand the struggles of these families. Sloan-Mallen knew parents with mental illness and their families were not a targeted population for policy-makers, service providers or advocates, and that this identity was often disregarded for individuals with mental illness. She also knew that ignoring the parenting role resulted in inappropriate and inadequate services for families in need of support. The name, "Invisible Children" describes the children of parents with mental illness overlooked by the traditional mental health system.

In 1990, the prevalence of parenthood among adults with mental illness in Orange County was unknown. In 1991, Sloan-Mallen, the local Department of Mental Health, and the Middletown Psychiatric Center surveyed a sample of clients receiving public mental health services. Results indicated that 45% of persons receiving public mental health services had children under 18. Forty-five percent of female, Intensive Case Management clients, 40% of the homeless mentally ill, and 25% of supported housing clients had children. Most parents were single women without custody of their children. Parents averaged 2.1 children.

1993 was significant for parents with mental illness and their families at both the state and local level in New York. The New York State Office of Mental Health (NYSOMH) and the Department of Social Services (DSS) formed a State Task Force on Mentally Ill Parents with Young Children. Public hearings provided testimony from consumers and providers. These testimonies led to recommendations on systems changes and improvements in service provision for families in which a parent has a mental illness. The Associate Commissioner of the NYSOMH, Dr. Andrea Blanch, worked closely with Sloan-Mallen to create statewide interest in addressing the needs of parents with mental illness and their children. Locally, the Orange County MHA created ICP, serving 10 families.

The work of the Task Force led to the development of the New York State Parents with Psychiatric Disabilities Support Project in 1994, which has directly impacted how parents with mental illness are served in the New York public mental health system. Specifically, state policies have been created to address parenting issues such as determining parental status during hospital admissions, incorporating parenting issues into discharge planning, and supporting children's visitation of hospitalized parents. Several statewide conferences on the concerns and issues of parents with mental illness and their families were held in New York between 1994 and 1998.

To date, ICP has served over 500 persons in families where a parent has a serious and chronic mental illness.

### **Funding History**

Original ICP funding came from the New York Office of Mental Health (NYOMH). In 1994, ICP received a \$250,000, two-year demonstration grant from the New York State Department of Health to study the impact of early intervention for children ages zero to three, at-risk from parental mental illness and co-occurring disorders. At the end of two years, the majority of ICP funds shifted back to NYOMH. In 1995, ICP received a five-year HUD Shelter Plus Care grant to house and provide case management for six additional families. Other monies include the United Way (with a match from MHA), MHA fundraising, and state reinvestment money, money saved from closing state hospitals to fund community services. ICP does not receive third-party reimbursement for any of its services.

The true costs of ICP can not be reflected on paper. Programs serving families rather than individual “identified clients” require “flexible funding” for costs not covered by traditional adult mental health funding streams. For example, ICP strives to enhance and normalize the life of children, which may include buying sneakers and clothes, goods that don’t always fit into line item categories. Much of ICP’s flexible monies are provided by Orange County MHA.

Mental health funding in New York has changed within the last ten years. Funding has shifted away from statewide initiatives implemented at the county level. Currently, mental health funding is driven more by local politics and idiosyncrasies, with little continuity between counties.

### **Target Population**

ICP works with adult (18+ years) parents with serious mental illness who are eligible for state/county public mental health services and case management.

### **Theory and Assumptions**

**Mission.** ICP shares in the overall service mission of MHA (see below).

**Program Goals.** The goals of ICP are to “empower parents and assist them in the creation of a safe and nurturing environment for their children while supporting efforts in keeping the family unit together.”

**Theoretical Orientation.** ICP embodies a family-centered/family-strengths case management model. ICP staff work with families as a team to assess strengths and determine needs. The abilities of families are the focus of care. ICP has a “whatever it takes” philosophy - they’ll do whatever it takes to help a family. ICP, with support of MHA, has the ability to flex time, services and funds outside the traditional parameters inherent in most community mental health agencies.

ICP’s approach includes embracing the following assumptions: Parents want to be the best parents they can be; Parents have strengths; Parents may require services from multiple systems; Children are usually better off with their parents; There are instances in which a parent may not be the best caregiver for his/her child, Families need and deserve support; Mental illness is not the cause of good or bad parenting; Enhanced parenting leads to enhanced child development; Supporting parenting contributes to recovery from mental illness; and Dependable, consistent relationships are therapeutic.

Trust and respect between ICP staff and families are paramount. One case manager states, “I approach families with the same care that I would a friendship. You need to be real with people. Some providers are uncomfortable with this level of involvement.” Staff creates meaningful relationships with families, getting to know them as people, not just as clients. One mother recounts, “I saw an MHA staff person at the local fair and I couldn’t believe she came over and talked to me like a person – I never expected that.”

## **Community Context**

**Local History.** Orange County is an ethnically diverse community in rural, upstate New York, approximately two hours from New York City. Orange County has traditionally been an agricultural community. The last five years have seen an influx of residents moving north from Manhattan, resulting in an increasing population and changing socioeconomic climate.

**Community Strengths and Weaknesses.** While Orange County is a politically conservative community, MHA and ICP have created strong relationships with local providers. “It’s a fluke that MHA has been able to fit into a very conservative community. This has happened by developing trust, showing success, following through and being recognized at a national level.” A small community allows for longstanding relationships between providers, which are vital to securing services for ICP’s vulnerable families.

Public transportation is extremely limited, and safe and affordable housing is scarce. Available housing is often in dangerous neighborhoods that are inappropriate for families..

**Mental Health Resources.** Stigma about mental illness is a large problem in Orange County. Providers from other systems (e.g., child welfare, education) as well as family and community members often need education to debunk the many myths about mental illness. The local mental health system lacks specialized services for families including daycare during treatment and therapy and children’s visitations during hospitalizations.

## **Community Collaborators**

ICP collaborates with multiple agencies and systems at the local and state level, including policy administrators (e.g., Mental Health Association in New York State, DSS, NYSOMH, Department of Health), providers (local psychiatric centers, therapists, social workers), and legal advisors (lawyers, judges). ICP has strong relationships with philanthropic organizations including Jewish Family Services and the United Way. In addition, ICP has participated in research, evaluation, and replication projects with the University of Illinois in Chicago, the University of Massachusetts Medical School, and the National Mental Health Association

ICP is unique in its ability to coordinate providers and services around individual families and administrators at the larger policy-level. ICP promotes change at the local, state and national level around how services are (or are not) provided to families where a parent has a mental illness. MHA Executive Director Lucinda Sloan-Mallen explains, “We want to change the way people do business,” to facilitate a shift in thinking from “identified clients” to thinking about families, a concept the adult mental health system has yet to embrace.

## **Methods of Collaboration**

From ICP’s beginnings, Sloan-Mallen was purposeful in coordinating key stakeholders to think about families where a parent has a mental. “ICP is valuable in bringing different players with different mandates to the table,” stated an DSS administrator.

At the individual, family level, ICP facilitates providers wrapping services around families. ICP attends, and often organizes, Network Meetings where parents, school, mental health, DSS, and other invested parties coordinate services with a family. ICP is especially powerful in helping parents and families find their voice and advocating for families unable to advocate for themselves. A local mental health provider noted, “ICP gives consumers a voice, and many of us have learned from this.” ICP educates providers to family strengths, reinforcing that persons with mental illness can parent and care for children. ICP gains credibility, especially from DSS, by identifying when children are at-risk and, when necessary, advocating for out-of-home placement.

At the administrative, policy level, ICP helps agencies see the benefit of collaborating around families. For example, families involved with ICP require fewer out of home placements, one of DSS’ largest expenses. ICP involvement with a family frees up scarce DSS resources that can be redirected

towards other families. “ICP helps families, which in turn helps all other agencies achieve their goals for their families.”

Collaborators were clear to point out that successfully “selling” ICP requires answering the question, “What’s in it for me?” Providers, funders, and administrators will invest in programs that in some way benefit them. Collaborators will support program that ease their service provision and attract money. There needs to be benefit for investors to facilitate a buy-in. “Selling the program to legislators requires a focus on outcomes and a personal approach.”

### **Agency Context**

**Mission and Goals.** “Mental Health Association of Orange County, Inc. seeks to promote the mental health and emotional well-being of Orange County residents, working towards the prevention of mental illnesses and developmental disabilities. In partnership with consumers and their families, MHA strives to fulfill its mission through direct services, public education, advocacy and responsiveness in times of community emergency.”

“We share a belief that every person has dignity and is to be treated with respect, compassion and acceptance. MHA values the contributions of our members, volunteers and staff in providing quality, cost-effective services.”

**Agency Characteristics.** MHA is the primary community mental health provider for Orange County, with 50 full-time employees, two clerical support staff, and a board of directors. MHA averages over 300 volunteers a years, who assist with fund-raisers, answering helplines, and providing direct services. MHA provides various mental health services including crisis intervention and prevention, rehabilitative social clubs, rape and incest survivor support groups, job placement and respite services, 24-hour hotline, case management, compeer and early intervention programs. MHA contracts out for clinical services.

ICP has two full-time staff: a project coordinator and a case manager, both of whom have bachelor’s degrees and previous experience providing mental health services at MHA. ICP contracts for services both within MHA (e.g., respite workers) and with consultants (e.g., in-home clinical consultants, art therapists). MHA is funded primarily (93%) through state, county, and federal grants. Additional funding comes from private contributions, membership drives, memorial endowments, and community fund-raisers.

Teamwork is part of the MHA culture. “It has to be because we’re under-funded. A positive consequence of this is teamwork and unity.” Support at all agency levels, from the line staff to the board of directors, is crucial. Agency staff respect and support one other, and believe in the importance of the work. The mission of the agency trickles down to all programs.

### **Program Model: Services and Interventions**

ICP offers a variety of services including 24-hour case management, supported housing, respite childcare, family crisis planning, advocacy with schools, DSS and courts, support groups, vocational training, supported education, information and referral, pregnancy and post-partum education, children’s art therapy, and parenting skills support. In-home clinical services are provided via consultants.

Most ICP services are provided in families’ homes. Since Orange County is such a rural area, ICP staff often transports families to appointments and accompanies families wherever needed, including schools, doctor’s visits, and meetings with DSS. ICP staff try not to be “the case manager with the clipboard,” instead creating meaningful relationships with families and modeling appropriate parenting behaviors.

### **Evaluation**

**Family Demographics.** At any given time, ICP serves approximately 16 families. While the majority of clients are mothers (80%), some fathers (20%) are the identified client, and many families

have two-parent households. Half of families served are Caucasian and half are African American. The majority of children are between 3 and 12; almost 50% of parents are 30 to 39.

**Diagnoses.** Diagnoses of parents include Manic Depressive Disorder, Schizophrenia, Anxiety, Depression, and Personality Disorders. Fifty percent of children served have identified mental health needs.

**Co-occurring Disorders and Issues.** Fifty percent of parents are dually diagnosed with substance abuse or developmental disabilities or have histories of trauma or domestic violence. All families experience some co-occurring issues such as poverty or homelessness. Most parents (80%) have custody of their children, but many families are at-risk for children's out-of-home placement. Almost half of ICP families live in HUD-funded housing, while others live in supported or independent apartments.

**Family Outcomes.** ICP case managers identify successful outcomes for families as increased self-esteem, increased confidence, increased self-determination, increased residential stability and independent living and decreased hospitalizations. Positive outcomes for children include increased school attendance and performance, improved behavioral control and communication skills, and a decrease in out-of-home placements.

At the policy level, success includes increased awareness of and knowledge about parents with mental illness among policy-makers and providers including parenting and treatment planning and simply asking the question: "Are you a parent?" Goals for the future include steering the New York Office of Mental Health towards a family-centered model of mental health care. At the local level, ICP is successful if it increases community awareness and knowledge about parents with mental illness.

In 2000, ICP received one year of SAMHSA/CMHS-funding to evaluate the program's cost-efficiency. ICP has contracted with the University of Massachusetts Medical School to explore families' involvement with DSS pre and post ICP involvement. Researchers are analyzing DSS and ICP costs to determine if ICP is a cost-efficient alternative for families where a parent has a mental illness. Specifically, are children less involved with DSS since working with ICP? Are there fewer out-of-home placements? The case study format will include family interviews as well as DSS and ICP case manager interviews in an effort to "tell the story" of families experiences before and since working with ICP. Focus on cost-efficiency will help frame working with families as a valuable, preventative service.

### **Client Path**

Families are referred to ICP through Orange County mental health professionals, DSS preventive units, foster care and outpatient clinics. Few applications come from prisons and self-referrals. ICP notes an increase in referrals from schools, as teachers and administrators see problems within families that are beyond the scope of school governed services.

To be eligible for ICP services, the parent (the identified client) must meet New York State Office of Mental Health criteria for serious and persistent mental illness. Eligible families are placed on a waiting list and are referred to other services both within and separate from MHA.

When an opening becomes available, ICP case managers screen wait listed families. ICP meets with parents in their homes to identify risk factors including the status of benefits, levels of services, community linkages, and the risk of out-of-home placement for children and determine families' need and interest in receiving services. Risk is the main criteria for family selection for ICP.

Selected families complete a one-hour intake with an ICP case manager. ICP collects information on schools, social security and Medicaid, designated contact people, and completes consent forms. Next, the ICP case manager and parent begin service planning, identifying strengths and goals, and areas needing assistance. Typical family goals include helping families stay together, forging links with public services, securing transportation, and advocating for children's needs. There are no formal assessments of adult or children's functioning. Oftentimes, families have difficulty identifying strengths

and need prompting. Typical family strengths having informal support systems (e.g., church), being motivated to improve their lives, and keeping their families together. ICP's first few visits are scheduled when the whole family is present, allowing time to establish comfortable relationships.

There is no time limit to families' involvement with ICP. On average, families stay with ICP from two to three years: one family has been with ICP for seven years. ICP can serve up to 18 families at one time. The number of family contacts depends on the intensity of services required. Most families are visited at least once weekly, interspersed with telephone contact with case managers. For most families, the intensity of contact with ICP decreases over time. Families can remain with ICP as long as services are still needed and minor children are still living in the home.

### **A Success Story**

Shelly is a 35 year old, African American woman with a 10 year old daughter, Samantha. Shelly is diagnosed with Schizoaffective Disorder and has a history of psychiatric hospitalizations. Shelly and Samantha have been involved with ICP since 1996. At time of referral, Shelly was recently discharged from a psychiatric hospital, living with her daughter in a homeless shelter. Shelly, who had previously worked as a nurse, had no services, had difficulty maintaining her medications and had little social support.

ICP and Shelly worked together to create a family service plan, establishing her family system, support network, strengths and barriers. Like many ICP families, Shelly initially had difficulty identifying her strengths. ICP was quick to connect Shelly and Samantha with Crystal Run, a local non-profit housing program that often partners with ICP around families.

Securing safe housing was a turning point for Shelly and her daughter. Shelly was able to complete a day treatment program, achieve medication compliance, establish a plan for Samantha in case of hospitalization, and create a support network, primarily through her local church. Shelly returned to work full-time as a case manager for another MHA program.

ICP is careful not to set limits or boundaries for families, believing families know what is best for them. Since working with ICP, Shelly has had only one psychiatric hospitalization. "Shelly is happy, confident, and has increased self-esteem. This happened through increased support – before ICP, she had none." (Shelly's ICP case manager)

### **Challenges**

At the program level, ICP is most challenged by the large waiting list for enrollment. Families may wait for 2-3 years before starting with ICP. Ironically, not being accepted into ICP may increase a family's level of risk since risk factors increase the longer families are not receiving appropriate services. MHA is serving more dually diagnosed mentally ill/developmentally disabled clients. Some of these clients are parents (there are currently three MR/DD in ICP), and ICP needs further resources to serve these families. Finally, ICP case managers are challenged by the constantly changing resources in Orange County.

At the systems level, funding is always a concern. Funding streams do not represent how most agencies provide services. The true cost of ICP is not accurately reflected on paper. Adult state mental health money is for "identified clients," not for families. Therefore, ICP must find flexible money from other areas to cover "family costs" not addressed by traditional mental health funding.

### **What's Missing from ICP?**

Families were unable to identify anything missing from ICP. As one family said, "We have what we need." Families were aware of the uniqueness of a program like ICP and were concerned that only a few lucky families were able to access such services.

### **Next Steps**

In partnership with the National Mental Health Association, SAMHSA/Center for Mental Health Services, and the U.S. Department of Health, ICP is providing technical assistance to five NMHA

affiliates addressing the needs of parents with mental illness and their families. During this one-year project, MHAs in New York, Tennessee, New Jersey and Virginia will undertake collaborative strategic planning efforts in their communities in an effort to plan for and replicate the ICP model of service delivery.

ICP hopes their program will be replicated, not duplicated. “Our dream is to have our core values incorporated into how other people conduct business, not to have ICPs all over the place.”

### **ICP’s Vision for the Future**

ICP plans to continue their current path – to show program success, secure investment from local and state systems administrators, and to gain national recognition. ICP sells its program by sharing families’ stories and talking about the issues no one else wanted to talk about.

As managed care and Medicaid increasingly become primary funders of mental health services, ICP is invested in having a clearly articulated product with proven outcomes. If ICP can show a decrease in costs (e.g., decreased hospitalizations), this program becomes an attractive service to managed care organizations interested in the bottom line. ICP needs to be able to compete in the competitive market.

ICP is also looking for crossover areas with other service systems. ICP is interested in integrated funding streams that address families needs rather than funneling children and adults into separate service systems. Money should meet the needs of families rather than trying to make the needs of families fit into available funding streams.

### **Quotes from Families**

“With ICP we learned that today is just one day – we can do it. Before, we would yell a lot and quickly punish our daughter.”

“Anything they (ICP) tell us to try, we do.”

“Normally, I’m screaming and my daughter is screaming. Now, I have Monique (ICP case manager) to talk to. When we stop crying, we can talk about what’s going on. I’m really learning.”

“Our children are our motivators. We’ve been through a lot of problems. We have too much to lose now.”

“With ICP I have a place to live, someone to call, someone who cares about me, someone I trust and someone who respects me.”

### **Quotes from ICP Case Managers**

“We’ll go anywhere for a family if they feel they need an advocate.”

“Shelly has gone from a cog in a wheel to a motivator of change.”

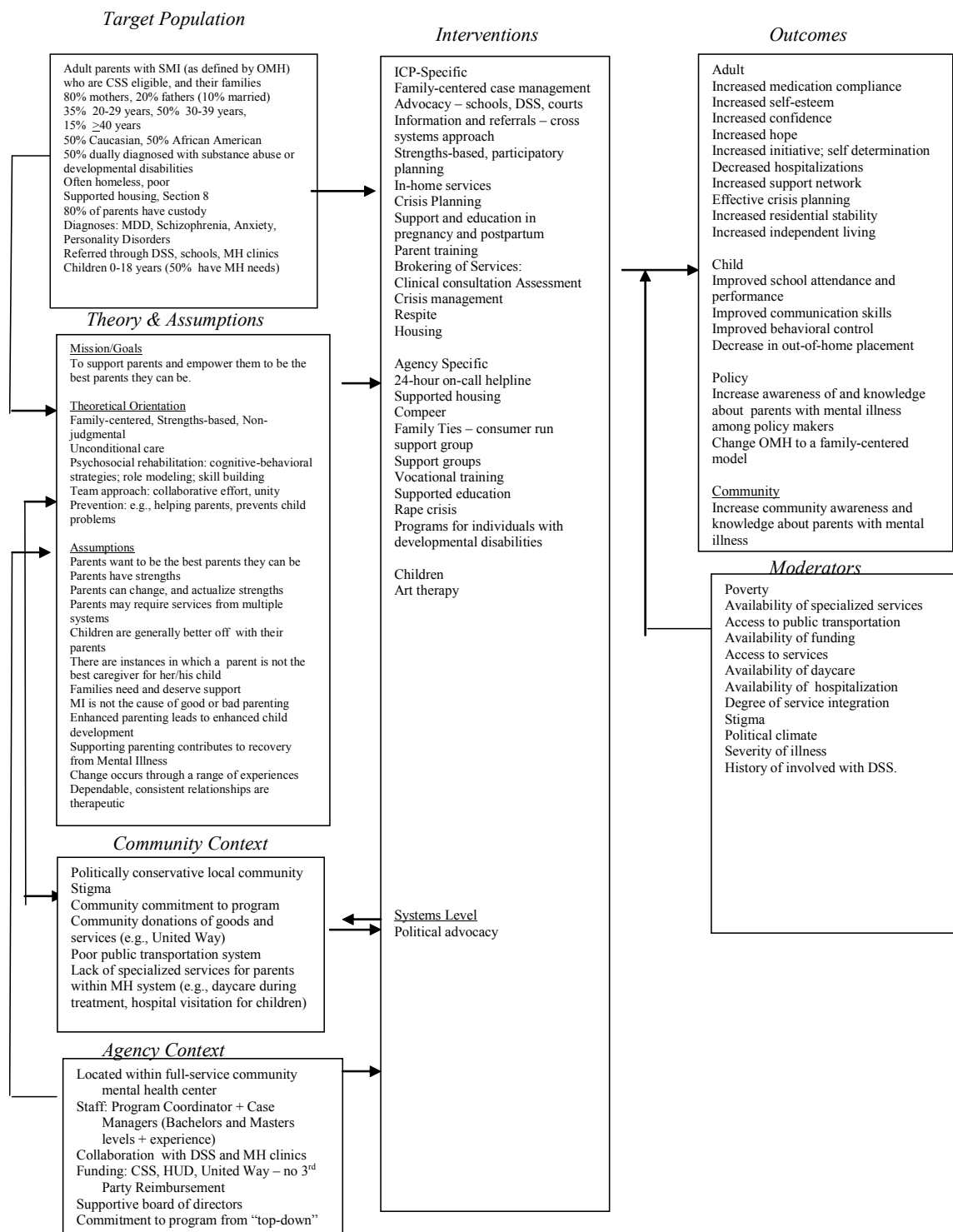
“The bottom line is that parents love and want to be with their children.”

### **Quotes from Community Collaborators**

“ICP is a good opportunity for community planning and growth.”

“Before ICP, we’d treat mental illness as separate from parenting.”

## Logic Model: Invisible Children Program



## **San Francisco General Hospital: Consultation/Liaison Program**

### **San Francisco, CA**

#### **Program Description**

The Consultation/Liaison to OB/GYN (C/L) program at the San Francisco General Hospital is a specialized psychiatric consultation service at the San Francisco General Hospital (San Francisco, California). The program focuses on providing psychiatric consultation to women receiving inpatient and outpatient obstetrical and gynecological (OB/GYN) services at San Francisco General. Psychiatrists and trainees in the program are knowledgeable about the interface of psychiatry and reproductive health, and can see women for emergency consultations in the hospital or scheduled outpatient visits at the hospital's High Risk OB clinic. The outpatient C/L program allows women with psychiatric and/or severe substance abuse problems, including women with Serious Mental Illness (SMI), to receive psychiatric care during their regular prenatal and postpartum healthcare visits. The program is also a training site for medical residents in psychiatry and OB/GYN. The following program description will focus on the outpatient clinic rather than the inpatient consultation service.

#### **Program History**

The C/L program began in 1989, and extended the care of the already existing "Women's Issues Consultation Team." It shares its origins with the Inpatient Women's Issues program (please see description in earlier chapter).

#### **Funding History**

The program is funded by the Department of Psychiatry at San Francisco General Hospital. All hospital services are required to fund a consultation service. As all programs in the Department of Psychiatry, the C/L program is funded through the Department of Psychiatry's contract with the Community Mental Health Service of the city and county's Department of Public Health. This funding continues to date, but is supplemented with reimbursement from the public state health insurance (MediCal).

#### **Target Population**

The C/L Program serves women 18 years and older with psychiatric concerns who receive OB services at San Francisco General Hospital. Women can be seen through their third month postpartum. After the third month, they are referred to clinics in their catchment area.

#### **Theory and Assumptions**

**Mission.** The C/L service supports reproductive choice for women with serious mental illness, and provides high quality mental health care during pregnancy and the postpartum period.

**Program Goals.** The over-riding goals of the program are to assist women in having a healthy pregnancy, safe delivery, and a smooth transition to home for baby and mother, and to postpartum care. Short-term goals include regular prenatal and psychiatric care during pregnancy, and development of a labor and delivery plan in collaboration with OB providers.

**Theoretical Orientation.** The C/L program stems from the same feminist psycho-dynamic theoretical base as the Inpatient Women's Issues program (see earlier chapter). This orientation is supplemented with a variety of approaches as needed to address the complex needs of the women seen. It does not have an explicit mission statement separate from the Department of Psychiatry. Similar to the Inpatient Women's Issues program, however, the C/L program's primary objective is to provide information and education to women with SMI who are pregnant or postpartum, help them identify

priorities/goals and participate meaningfully in decisions about their care, and provide consultation so that goals can be achieved.

### **Community Context**

**California Mental Health System.** The California Mental Health System is organized and funded at the county level. Consumers are eligible for case-management services only after they have used over \$50,000 in mental health services. Thus, while case-management is available for consumers with the most severe problems, there is a lack of case-management services geared toward individuals at the earlier stages of mental illness, and in particular for women with young children. As a result, potentially manageable conditions progress to more chronic and entrenched disorders that can not be well managed even with case-management that becomes available after high-end service use. Case-management is reported to be a good service once in place, but is not available to many who could benefit in both the short and long-term.

**Community Strengths and Weaknesses.** San Francisco is rich in resources. However, organization of mental health services at the county level obscures this wealth with respect to those in need. The city of San Francisco is both a city and a county. As a city, it attracts a large population, including mental health consumers seeking increased resources. As a county, however, San Francisco is small relative to the population it must support. The proportion of poor, inner-city neighborhoods to middle class and affluent ones is high. Thus, although relatively rich in resources, supply does not meet demand.

**Mental Health Resources.** According to providers and consumers, mental health issues are deeply embedded in local economic and social issues. San Francisco has one of the highest standards of living in the United States. There is little affordable housing available. Adults with mental illness are therefore at high risk for homelessness and substandard housing in crime-ridden neighborhoods. Substance abuse is a major local issue. San Francisco reportedly has the highest rate of substance related Emergency Room visits in the United States.

### **Community Collaborators**

The C/L program works most closely with the OB/GYN department at the hospital, and with referrals from OB clinics in the community. It also has relationships with community-based programs for high-risk families, including the Infant-Parent Program described in this document, and Ashbury House, a one-year residential program for women with SMI and their children. The availability of these resources in the community allows for continuity of care and enhanced follow-up, which can relate to increased stability for the women in the program. Women who grow comfortable or attached to mental health providers they have worked with at San Francisco General can often continue to see these providers in the outpatient mental health clinic.

### **Agency Context**

The C/L program is part of the larger Consult/Liaison service in the Department of Psychiatry at San Francisco General, a public teaching hospital in San Francisco, CA. Staff for the program include an attending psychiatrist, who is the program director and is also the program's founder, and two to six psychiatry residents. Generally, the providers are women. The C/L program works in collaboration with physicians, residents, nurses, and social workers from OB/GYN. Integration of service and education is facilitated by weekly rounds attended by all providers (psychiatry and OB/GYN), and the development of a well-formed, well-integrated, collaborative treatment plan for all women served.

### **Program Model: Services and Interventions**

Pregnant women receive their psychiatric care during routine prenatal and postpartum visits to the outpatient OB clinic. Psychiatric consultation includes medication management, and where indicated, pregnancy and postpartum psychotherapy, and linkage to community-based resources.

### **Evaluation**

**Demographics.** The program provides consultation for between 75 and 150 women each year. Of the women seen, 32% are Latina, 28% are African American, 23% are Caucasian, 13% are Asian, and 5% fall into an “other” category for race/ethnicity. The clinic serves more Latina women than the inpatient service, and serves a high percentage of non-documented, recently immigrated women. In addition to requiring bi-lingual staff and translations services, non-documented women are ineligible for many of the community based services and entitlements often accessed for clinic clients. In addition, addressing issues of domestic violence is problematic for women who do not wish to be known to law enforcement authorities.

**Diagnoses.** The most common diagnoses among the women are Depression, PTSD, Adjustment Disorder, Bipolar Disorder, and Schizophrenia.

**Co-occurring Disorders and Issues.** Substance abuse and trauma are the most common co-occurring issues, though many women experience housing issues and homelessness. Thirty-three percent of the women served in the outpatient clinic have a history of or current substance abuse, and 34% have history of trauma and/or childhood sexual/abuse.

**Family Outcomes.** The C/L Program monitors progress toward individual goals established with each woman, for the period of time that women receive services at the high-risk OB clinic. Approximately 10% of the women go on to need a psychiatric hospitalization each year. Because current policy requires women and their children to be transferred to a local clinic for psychiatric care at three months postpartum, neither neonatal nor psychiatric outcomes beyond three months are known. For the same reason, little is known about the ability of women seen in the clinic to maintain child custody beyond three months post-partum.

### **A Success Story**

Women experiencing their first pregnancy and living in difficult social situations often require psychotherapy to problem-solve and develop strengths and self-confidence. In addition, pregnant women are often concerned with body-image issues. Pregnant women with SMI often experience similar concerns and issues as women in the general population. However, for women with psychotic disorders or severe depression, these concerns can become distorted. For example, several women have come to the C/L program describing delusions about people talking about them and their bodies, or fears that their partners will leave them for other women. In addition, women with SMI often lack support from families who are critical of their decision to go through with the pregnancy. In the context of a psychotic illness, women coming to the clinic often believe that family members want to poison them, kill them, or spy on them.

The C/L program at the High Risk OB clinic can provide psychotherapy and medication management to address and normalize these concerns related to pregnancy and relationships with partners, family, and community. For psychotic women a major emphasis is also on the centralization of the administration of psychiatric medication at the OB clinic. Psychiatric consultants at the clinic, using all the information on the impact of medications during pregnancy, are in the best position to provide an accurate risk-benefit analysis, and assist women in choosing the best approach for herself and her baby. Practitioners in the community often lack current information and strongly advise women against using any medication during pregnancy, resulting in rapid decompensation and a negative experience of pregnancy.

Several women with SMI who were closely followed at the OB clinic were able to transition to a local, community-based program for pregnant women with SMI and their children, where over a year's time they were able to develop parenting skills, and achieve greater stability. These women were then able to transition to independent living in the community with their partners or family.

### **Challenges**

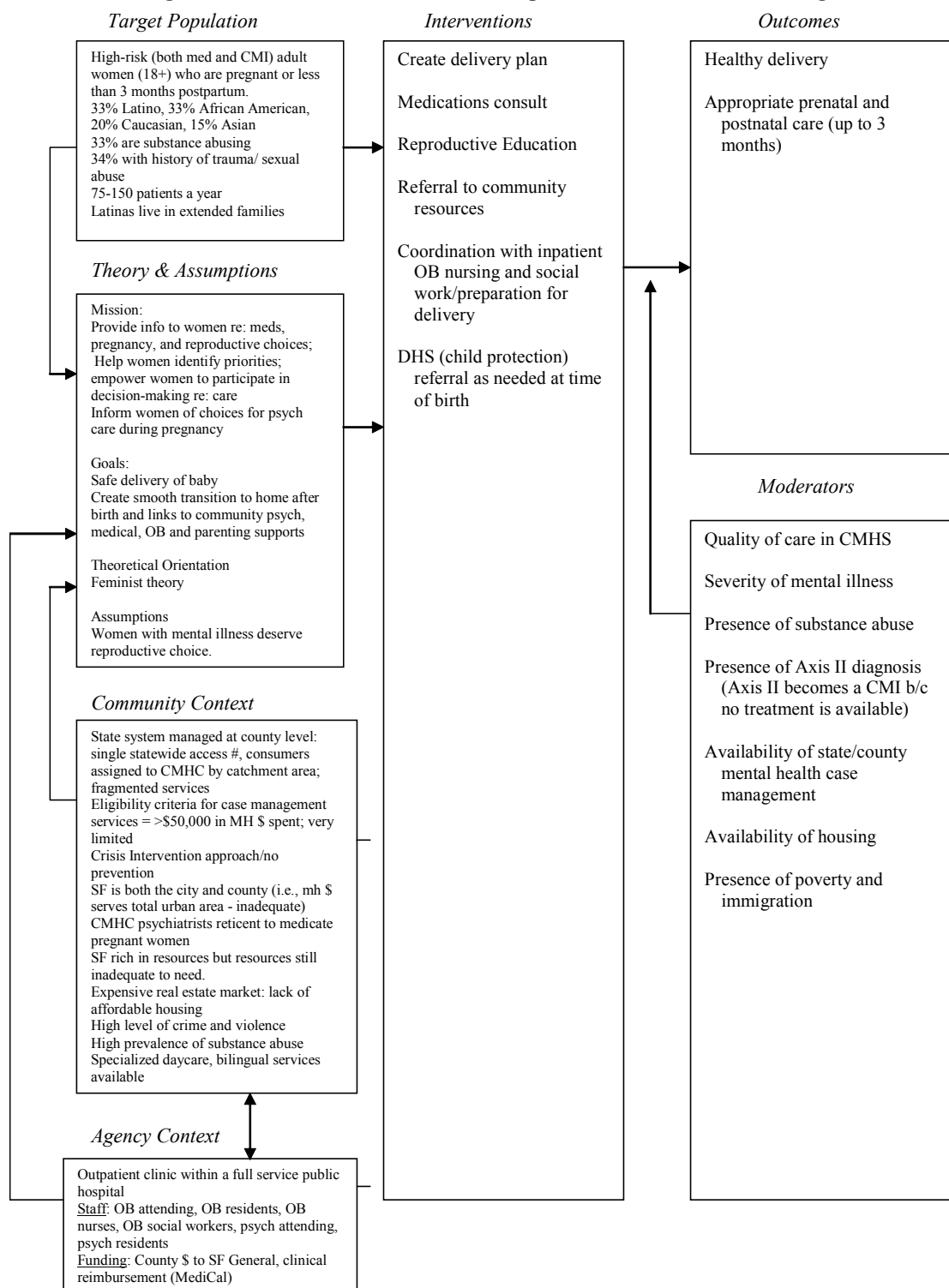
The C/L program shares in the same economic, social, and systemic challenges experienced by the Inpatient Women's Issues Program. Challenges more immediate to the C/L program include policies that require women to transition to non-hospital services in their local community (catchment area) after the third month postpartum. Thus women must change health and mental health providers during a particularly vulnerable period for themselves and their infants. Many women who have come to feel "safe" at the clinic, and become accustomed to receiving medical and mental health care at the same location, are fearful of changing providers, and may be less likely to follow through with postpartum and mental health care. This may be particularly difficult for women who are living in the United States illegally, or for whom English is not a first language. In addition, providers at local clinics are often less comfortable than the providers in the C/L program, using psychiatric medications during pregnancy and postpartum (due to lactation issues), and are not often able to coordinate mental health and OB/GYN care. This often results in medication changes despite stability, and less consistent psychiatric and/or medical care. In-home postpartum services for families in which a mother has mental illness are difficult to access. Thus, many mothers end up receiving poor mental health care that can compromise parenting.

An additional challenge for the C/L program is that faculty in the Department of Psychiatry are primarily service providers, while faculty in the OB department are under greater pressure to do research. Thus, psychiatry often finds itself in the position of having to advocate on behalf of the program, and a "holistic" approach to treatment with the OB/GYN faculty, who sometimes place a greater value on conducting research.

### **Next Steps**

The C/L program is currently slated to be continued indefinitely as part of the larger psychiatry consultation service at San Francisco General. Variation in the interest and commitment of the OB/GYN leadership to the collaboration with psychiatry, and holistic care of pregnant women with psychiatric disabilities can influence the strength of the program and care provided. The leadership of the C/L program, however, is committed to advocating for this collaboration, "whatever it takes."

### Logic Model: San Francisco General Hospital Consultation/Liaison Program



## **San Francisco General Hospital: Infant-Parent Program**

### **San Francisco, CA**

#### **Program Description**

The Infant Parent Program (IPP) is a specialty mental health program serving infants, toddlers and their families. Relationships between parents and children are the focus of treatment. IPP provides infant-parent services to families in distress through weekly in-home visits. IPP's approach includes concrete assistance, emotional support, non-didactic developmental guidance and insight-oriented psychodynamic psychotherapy. Other available services include developmental neuropsychological assessment, mental health consultation to childcare, and a one-year training program for mental health professionals focused on infant/family mental health.

#### **Program History**

IPP was established in 1979 as part of the University of California, San Francisco (UCSF). The vision behind IPP was Selma Fraiberg's Child Development Project, an infant mental health program developed at the University of Michigan, and brought to UCSF by Fraiberg herself. Fraiberg resisted the notion of a single "model" of infant mental health. She noted, "Our ... conception of infant mental health would embrace a large number of models, each reflecting the unique problems of a particular infant population, each adapted to the setting in which the work is performed and the professional expertise represented in its staff." (Fraiberg, 1980). IPP continues to embody Fraiberg's vision. However, the families currently seen by IPP are different from those originally treated by Fraiberg. IPP families are often dealing with multiple stressors, not just mental health issues. IPP families are impacted by substance abuse, poverty, and immigration issues that must be integrated into the therapy offered by IPP. In addition to these changes, IPP has added two new programs: mental health consultation to childcare, and Neuropsychological/Neurodevelopmental assessment.

#### **Funding History**

Initially, a consortium of five foundations provided seed money for IPP. This was supplemented by county funds (Community Mental Health, Department of Social Services), the University of California, and physical space and in-kind resources from San Francisco General Hospital. Since its beginning, IPP has received additional funding from a number of sources including a Career Development Grant for preventative intervention from the National Institute of Mental Health as part of a mentoring effort for young professionals, money from the Children's Trust Fund of the California Department of Human Services, and state and city monies from the Department of Children, Youth and Family. Private foundations and independent donations have also provided funding over the years. As of August 2000, IPP had 18 separate funding sources.

#### **Target Population**

IPP is a program for young children determined to be at risk for socioemotional or developmental problems as a result of parent-child relationship issues. Children aged 0 to three years and their parents are eligible for IPP. The child is the "identified client" for IPP.

#### **Theory and Assumptions**

**Mission.** The IPP works to "protect and support the natural capacity of very young children to grow up valuing themselves, care about others and competent to contribute to society.

**Program Goals.** The goals of IPP are "to provide outpatient mental health services to infants, toddlers, and their families when serious difficulties exist in their relationship, and to offer consultation

and collaboration to other child-serving agencies in the community around cases involving infants and toddlers.”

**Theoretical Orientation.** Based on Selma Fraiberg’s seminal work in infant mental health, IPP builds on prevention and early intervention concepts that recognize the importance of healthy infant-parent relationships and the potentially damaging effects of neglect, deprivation and early trauma for infants and toddlers. IPP seeks to intervene with children and families before problems become entrenched and impact functioning in school and the community. IPP staff practice infant-parent psychotherapy and its four components: concrete assistance, emotional support, non-didactic developmental guidance, and insight-oriented psychodynamic psychotherapy. Through concrete assistance, therapists help families identify struggles and develop problem-solving strategies. Concrete assistance may include finding resources, advocating for families, transportation to appointments, and securing childcare. As families need emotional support, therapists listen to and elicit information from parents and children, offering understanding about the struggles of families. Therapists provide developmental guidance about age-appropriate behaviors, issues and concerns to help understand children’s experiences in responses to parents’ questions and concerns. And insight-oriented infant-parent psychotherapy involves work with parents to clarify their perceptions of and feelings about the child – with the aim of freeing the child from misperceptions arising from the parents’ past experiences.

### **Community Context**

**California Mental Health System.** Like all mental health programs in San Francisco, IPP is influenced by the organization of public mental health services in California. The California Mental Health System is organized and funded at the county level. Consumers are eligible for flexible, intensive case-management services only after they have used over \$100,000 in mental health services. Thus, while case-management is available for consumers with the most severe problems, there is a lack of case-management services geared toward individuals at the earlier stages of mental illness, and in particular for women with young children. As a result, potentially manageable conditions progress to more chronic and entrenched disorders that can not be well managed even with case-management that becomes available after high-end service use. Case-management is reported to be a good service once in place, but is not available to many who could benefit in both the short and long-term.

**Community Strengths and Weaknesses.** San Francisco is one of the most vibrant, affluent, and culturally diverse cities in the United States. It is rich in resources. However, it is also plagued with urban problems common to American cities – poverty, substance abuse, lack of affordable housing. The proportion of poor, inner-city neighborhoods to middle class and affluent ones is high. Thus, although relatively rich in resources, supply does not meet demand.

**Mental Health Resources.** According to providers and consumers, mental health issues are deeply embedded in local economic and social issues. San Francisco has one of the highest standards of living in the United States. There is little affordable housing available. Adults with mental illness are therefore at high risk for homelessness and substandard housing in crime-ridden neighborhoods. Substance abuse is also a major local issue. San Francisco reportedly has the highest rate of substance related Emergency Room visits in the United States. These issues impact consumers of mental health services in greater proportion than the general population.

### **Community Collaborators**

IPP collaborates with as many individuals and systems as the family desires and as seems useful and relevant to enhanced outcomes. For many families, IPP works with DHS child welfare workers, attorneys, public health nurses, social workers, mental health case managers, pediatricians and psychiatrists. IPP has a very good collaborative relationship with DHS. Other collaborators can include school systems and childcare providers.

### **Methods of Collaboration**

IPP collaborates with multiple providers around treatment and service planning for families. These collaborations occur formally in scheduled team meetings, and informally on an individual, as needed or urgent basis. Often, the quality of the IPP clinician's relationship with collaborators significantly impacts both the collaborative process and family outcomes.

### **Agency Context**

IPP falls within the administrative structure of several institutions and organizations, each of which affects its operations. Eligibility for clinical services and documentation requirements are determined primarily by the county community mental health system. Funded in large part by this system, IPP follows its eligibility priorities of children and parents with no private means to pay. IPP client records and other protocols comply with standards set for all community mental health providers. The Program is part of the UCSF Department of Psychiatry at SFGH, and staff are employees of UCSF. Both SFGH and UCSF have administrative regulations which apply to IPP. Within this context of multiple affiliations, IPP has maintained its own clear mission.

**Funding.** The Department of Psychiatry receives funding to provide mental health services to the public sector from San Francisco County Mental Health. Further public funding has been secured by IPP through contracts for particular projects.

**Agency Characteristics.** As noted above, IPP staff are employees of UCSF. IPP has approximately 16 employees, including a Director, licensed clinicians, and up to ten trainees. The IPP staff consists of clinical psychologists, a developmental neuropsychologist, a family therapist, social workers, and a consulting psychiatrist.

### **Program Model: Services and Interventions**

IPP has several components: 1) day and evening in-home infant-parent psychotherapy, 2) consultations to childcare agencies to improve services to children, 3) developmental neuropsychological testing, 4) assistance to one classroom working with SED children, and 5) training of clinicians. This paper focuses on the first of these listed programs – in-home infant-parent psychotherapy. Infant-parent psychotherapy focuses on the relationship between parent and child, emphasizing the development of empathy for and understanding of the infant's experience so that parents may come to respond in ways that further enrich the infant-parent relationship and the child's social and emotional development. IPP clients work with a single clinician who is closely supervised by a clinical psychologist with extensive experience in infant-parent psychotherapy. Because clients referred to IPP have multiple stressors and vulnerabilities, IPP clinicians are often play a case-management role in which they access and coordinate needed services that support the viability of their therapy. They also provide concrete assistance as needed.

### **Evaluation**

IPP systematically evaluates its services from a variety of perspectives: the families' served, referral source (e.g., DHS), and the IPP clinicians. They track family characteristics, family satisfaction, and family outcomes.

**Demographics.** Most IPP families have single mother heads-of-household, with children ages zero to three. Grandmothers head eight percent of all IPP families. During fiscal year 2000, 31% of clients (parents and children) were African American, 21% Hispanic, 17% Caucasian, 9% Asian/Pacific Islander, and 1% American Indian/Alaskan Native. Twenty-one percent of clients identified with more than one ethnic group.

**Referral Source.** Families are referred from pediatric providers, nurses, social workers, emergency room staff, and social service workers.

**Diagnoses.** Parental diagnoses are often not recorded in the Program, as children are the identified client. However, IPP staff report that the majority of parents and approximately half of all children have a diagnosable difficulty. Intake information indicates that approximately 20% of parents meet the criteria for serious and chronic mental illness, including Depression, Bipolar Disorder, Schizophrenia and Personality Disorders.

**Co-occurring Disorders and Issues.** Ninety-five percent of families experience co-occurring disorders, including substance abuse and some medical disorders (e.g., HIV/AIDS). Parents working with IPP often have histories of trauma and/or domestic violence, and are confronted with multiple environmental stressors such as poverty, lack of adequate housing and involvement with the legal system. While most parents have physical custody of their children, about half of the families seen at IPP are involved with DHS/child welfare because their children have been deemed to be at risk of neglect or abuse.

**Family Outcomes.** IPP also measures therapeutic progress by using pre- and post-treatment assessment on the Home Observation for the Measurement of the Environment (H.O.M.E.). This instrument is scored by IPP clinicians and provides assessment of parental functioning. IPP also tracks the number of children who are successfully reunified with their parents each year, and who are safely maintained in the home six months after reunification.

**Family Satisfaction and DHS Satisfaction.** IPP distributes a Satisfaction Questionnaire to all families served, and has polled DHS workers in the past. Responses to the family satisfaction survey indicate that 85-100% of families served each year have a positive experience with IPP. In addition, although over half of IPP families are mandated for services, and are reluctant to participate, year after year, at the end of treatment, 100% say that they would refer a friend. Polls of DHS workers indicate that that DHS finds IPP a responsive and valued resource.

### **Client Path**

Clients are referred to IPP from multiple providers concerned with children and their parent-child relationship – pediatricians, nurses, social workers, and child welfare workers. As part of the referral, an extensive intake assessment is done over the phone. This assessment covers the reasons for the referral (the “worry” or concerns initiating referral), the parents functioning, and medical history of the infant if relevant and available. In addition, IPP assesses whether the parent knows about the referral and what their thoughts and feelings are about IPP involvement. Together, the IPP staff and the referral source develop a “Recommendation for a Service Request” for IPP services, and a plan or disposition that outlines an agreed upon plan for IPP to make contact with the family. This plan may call for IPP to contact others involved with the family prior to contacting the family. Names of other important contacts are gathered, and releases arranged. Often, there is a waitlist. IPP makes recommendations for services and supports that may be helpful while clients wait.

When there is IPP availability the referral source is contacted again to assess client need and interest, and “best” plan for initiating contact with the referred client. An IPP clinician is assigned and supervised initially about contacting the client, and then continually about clinical work with the parent and child. Clinicians work with parents to develop an understanding about what IPP is and can do, how the IPP clinician might be useful to the parent, and what should be the focus of treatment. Central to this is an assessment of the parent’s concerns and hopes for their relationship with their child and their own future. A formal assessment and Plan of Care is developed within 60 days (as required by Community Mental Health). Both clients and clinicians must sign the plan of care. On-going assessment of progress, parent concerns, clinician concerns and clinician usefulness is central to IPP’s relationship to the parent.

### **A Success Story**

This story highlights a cooperative relationship between IPP and DHS, and exemplifies the strengths of IPP's intervention approach. Joe is a fifty-year-old man with features of Narcissistic and Borderline Personality Disorder. He has a one-year-old daughter, Laura. Laura had been in foster care for most of her life when Joe was referred to IPP. Laura's mother has a diagnosis of paranoid schizophrenia, is not involved in parenting Laura, and is not an IPP client.

Joe was referred to IPP by DHS as part of a required reunification plan. It was apparent to the IPP clinician that, although DHS has made the referral to IPP and presumably had an investment in Joe's learning how to parent his daughter, DHS expected the intervention to fail. DHS believed that Joe's characterological difficulties would prove an insurmountable obstacle to his forming an adequate parenting relationship with his daughter. Joe was similarly suspicious of DHS. He did not trust their motives or intentions with respect to reunification. This suspiciousness initially extended to the IPP clinician. The IPP clinician advocated for full disclosure of communication between DHS and IPP as a condition of treatment. DHS was resistant at first, but was ultimately persuaded that this was critical to an effective therapeutic relationship between the clinician and Joe.

Joe's limitations were apparent to the IPP clinician; however, he supported Joe's wish to reunify with his daughter and to be a good father. The clinician focused on trying to "give words" to Laura's experience and to translate for Joe, Laura's attempts to make her wishes and feelings known to her father. Although this process was unfamiliar and awkward for Joe, over time he began to value the clinician's input and seek the clinician's suggestions. Successes solidified this approach. When suggestions were not useful, they provided an opportunity for a shared sense of the difficulties of rearing a toddler. Over time, Joe was able to develop a sense of who his daughter was, an empathy for her experience, and the ability to search for ways to respond to her. Additionally, as Joe felt increasingly understood by the clinician, he was able to express his doubts and worries about parenting a toddler in addition to his wishes to do so. The clinician was then able to help Joe to tolerate and normalize these feelings without minimizing the importance of them. Visits increased from several hours each week to overnight visits.

DHS was initially skeptical of the progress described by the clinician, but over time came to see that Laura thrived in Joe's care. In the same way the IPP clinician worked with Joe to normalize and tolerate his doubts, the IPP clinician worked with DHS to tolerate their doubts about Joe. Joe eventually regained custody of Laura and DHS closed the case. As Joe's security and ability as a parent increased, meetings with the IPP clinician occurred less frequently.

Factors essential to the successful collaboration between IPP and DHS on behalf of Joe and Laura included: 1) Sharing a common goal or developing a shared goal as a first order of business; 2) establishing and maintaining good communication and clear expectations; and 3) developing a mutually-respectful and trusting relationship between the IPP clinician and DHS. This relationship and respect for each other's efforts were critical, as IPP and DHS did not always agree about how to proceed.

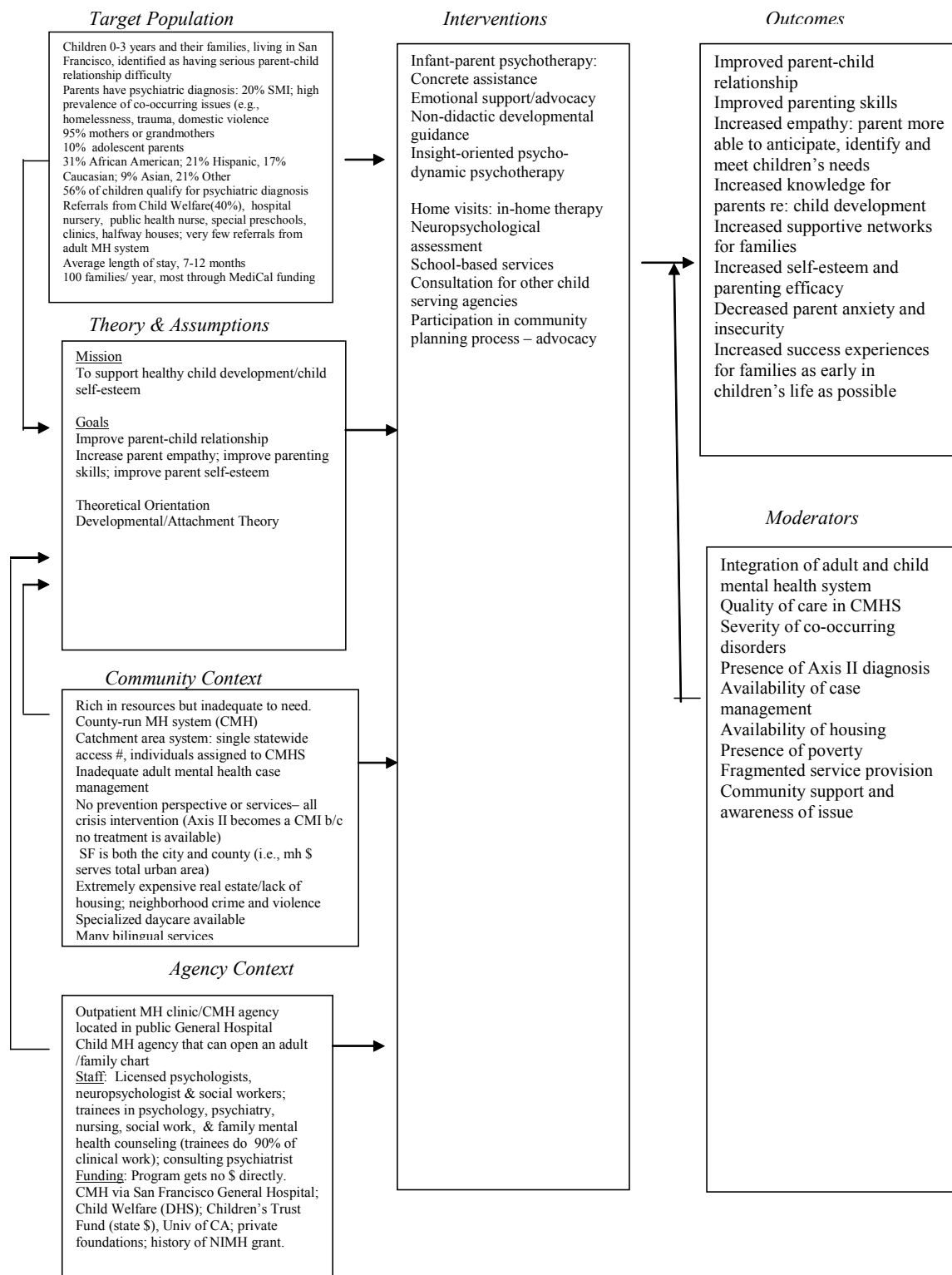
### **Challenges**

At the client level, most families struggle with finding safe and affordable housing in San Francisco. Families have limited childcare options, and respite for parent and child is costly and difficult to secure. Many families lack social supports in their communities, resulting in isolation. IPP is often challenged to create and support an array of services for families, including individual treatment, after school programs, and childcare. Maintaining IPP funding (all 18 sources!) is time consuming and limits direct family services. For trainees and staff, creating a cohesive treatment experience is challenging; there is no "normal" day, and the circumstances of families are often fragmented and challenged by economic and physical realities. Treatment needs to be continuous, responsive to the shifting needs of families and integrated with other services the family is receiving. Clinicians need support in order to tolerate the inability to bring about changes in the social and economic realities faced by the families they serve while simultaneously staying focused on the aspects of the infant-parent relationship they can impact.

**Next Steps**

IPP would like to have a therapeutic nursery to serve preschoolers who are having difficulty and their families. This would involve an expansion beyond the current population of children birth to 3 years. In addition, IPP lacks enough bilingual therapists to work with the large multicultural population in San Francisco. Finally, IPP is continually striving to enhance collaboration with other institutions and agencies in the community to exchange information about services that may be of use to the families they all serve.

## Logic Model: San Francisco General Hospital Infant-Parent Program



## **San Francisco General Hospital: Women's Issues Psychiatric Program**

### **San Francisco, CA**

#### **Program Description**

The Women's Issues Psychiatric Program is a specialized team on the inpatient service of the Department of Psychiatry at the San Francisco General Hospital (San Francisco, California). The program focuses on women's issues including pregnancy and parenting, among women with serious mental illness. Program participants receive both psychiatric and obstetrical services from a multidisciplinary team trained to address issues at the interface of psychiatry and obstetrics/gynecology (OB/GYN). Women participants can also continue joint psychiatric/OB care after discharge at the outpatient high-risk clinic (see below). The program is also a training site for students and interns in medicine, nursing, social work, and psychiatry.

#### **Program History**

The Women's Issues program began in 1985. It was originally developed "in reaction" to treatment practices for pregnant women with mental illness. According to the program's founding psychiatrist, it was common practice to stop use of all psychotropic medications for pregnant women in order to prevent any risk to the fetus. Without medication, women decompensated, needed to be "locked up," and attempted suicide at much higher rates. Women so-"treated" also complied more poorly with prenatal O/B care. The Women's Issues program was founded upon the premise that women should be educated about the risks and benefits of treatment during pregnancy, and allowed to make treatment decisions that included medication, taking into account the risk of "no treatment."

The program began as a consultation service to the OB service. Staff were recruited from both psychiatry and OB to learn about the relevant issues and develop appropriate and collaborative treatment protocols. In 1986, the program became fully integrated into the inpatient psychiatric service. In more recent years, changes in inpatient psychiatric practice driven by de-institutionalization and healthcare funding, have changed the population served by the program. This change in population has been followed by changes in focus and content. For example, referrals that originally included patients from state mental hospitals or residential facilities administered by the county Department of Mental Health, now include admissions from acute psychiatric emergency rooms, and a variety of community-based mental health providers. As a result, a larger proportion of the women referred to the program are not pregnant, and the population served by the program has shifted from primarily women with schizophrenia to women with varied diagnoses (e.g., acute psychosis, PTSD, Major Depression, Bipolar Disorder), and/or substance abuse.

The focus of the program has similarly expanded from managing pregnancy in the context of a serious mental illness to include multiple women's issues such as parenting, relationships, history of trauma, and domestic violence. At present, women are admitted to the Women's Issues Team if they are pregnant, experiencing other reproductive issues, or have a history of trauma. Many of these women are diagnosed with Borderline Personality Disorder, and the providers have developed expertise in this area. Finally, length of stay in hospital has decreased considerably since the beginning of the Women's Issues Program. Acuity on the unit has increased as a result, and follow-up care and referral to appropriate community resources have become critical components of care.

#### **Funding History**

The San Francisco General Hospital is a public hospital whose services are available to all residing in San Francisco County, California. It provides a full range of inpatient and outpatient medical services, including psychiatry, for both insured and uninsured individuals. The Department of Psychiatry is funded through the County Department of Mental Health (DMH) and reimbursement from the state health insurance program (MediCal). The Women's Issues program, as part of the Department of

Psychiatry, is funded through reimbursement from public (MediCal) and private insurance, and subsidized by DMH money to serve those without insurance.

### **Target Population**

The Women's Issues Program serves women 18 years and older with Serious Mental Illness (SMI) who are admitted to an acute inpatient psychiatric unit during a psychiatric crisis. Many women receive case-management services from the Department of Mental Health.

### **Theory and Assumptions**

**Mission.** The Women's Issues Program does not have an explicit mission statement, distinct from that of the Department of Psychiatry, which includes a commitment to gender and culture specific treatment. As noted above, the program was developed "in reaction" to highly objectionable practices and poor outcomes for women with mental illness who were pregnant. One of the program's founders defined the original mission of the program as "providing reproductive choice" and improving reproductive health for women with serious mental illness. Currently, that mission has expanded to encompass the more generalized empowerment of women with mental illness to have choice in all areas of life, including their reproductive health. For example, a weekly clinic run by a nurse practitioner for routine OB/GYN examinations is available for hospitalized women.

**Program Goals.** The primary goal of the program is to improve the quality psychiatric and medical services available for women with serious mental illness. This includes the central goal of providing adequate information and support so that women can identify priorities and be empowered to participate in the decision-making process about their own treatment and life-course. The program also aspires to enhance the relationship between psychiatry and OB services, and provide specialized training in the interface of OB and psychiatry, so that the care of women with serious mental illness is improved.

**Theoretical Orientation.** The program is founded upon a feminist psychodynamic approach that strives to demystify treatment, and encourage empowerment and collaboration. However, patients are sometimes treated against their will when providers deem it necessary for safety. The program is also eclectic in practice as needed. Treatment modalities include psychopharmacology, and cognitive behavioral models in addition to feminist principles.

### **Community Context**

**California Mental Health System.** The California Mental Health System is organized and funded at the county level. Consumers are eligible for case-management services only after they have used over \$100,000 in mental health services. Consistent, preventive care is generally non-existent. According to providers, this practice "trains people to be in crisis" (and use costly inpatient services) because resources are not available until there is a crisis. In addition, it allows potentially manageable conditions to progress to more chronic and entrenched disorders that can not be well managed even with case-management that becomes available after high-end service use.

**Community Strengths and Weaknesses.** San Francisco is rich in resources. However, organization of mental health services at the county level obscures this wealth with respect to those in need. The city of San Francisco is both a city and a county. As a city, it attracts a large population, including mental health consumers seeking increased resources. As a county, however, San Francisco is small relative to the population it must support. The proportion of poor, inner-city neighborhoods to middle class and affluent ones is high. Thus, although relatively rich in resources, supply does not meet demand.

**Mental Health Resources.** According to providers and consumers, mental health issues are deeply embedded in local economic and social issues. San Francisco has one of the highest standards of

living in the United States. There is little affordable housing available. Adults with mental illness are therefore at high risk for homelessness and substandard housing in crime-ridden neighborhoods. Substance abuse is a major local issue, and there are limited treatment facilities available. San Francisco reportedly has the highest rate of substance related Emergency Room visits in the United States.

### **Community Collaborators**

Providers on the Women's Team are familiar with community resources and the Women's Issues program has strong collaborative relationships with the High Risk OB Clinic described later in this volume, the Community Crisis Resolution Team, and the Community Case Management program. The availability of these resources in the community and the long-standing collaboration among providers allow for continuity of care and enhanced follow-up, and stability for women seen by the Women's Team in psychiatry.

### **Agency Context**

The Women's Issues Program is located on an inpatient psychiatric unit at a public teaching hospital in San Francisco. The program is fully integrated into the larger unit. Staffing consists of a multi-disciplinary team of psychiatrists, psychiatric nurses, psychiatric social workers, a psychiatric occupational therapist, a psycho-pharmacologist, and trainees across all disciplines. Pregnant women can receive both psychiatric and prenatal care during an admission. Consultation is available from all services in the hospital.

### **Program Model: Services and Interventions**

Program participants are offered all services available to patients on the inpatient psychiatric units at the hospital. They receive a comprehensive assessment and evaluation of immediate, short-term, and long-term needs, medication consultation, neuropsychological testing if needed, group therapies as offered on the unit, and discharge and follow-up planning (referral to and contact with community resources). These services are delivered on a unit that houses mostly women patients, and are provided by predominantly women providers who are trained in and sensitive to the interface of women's issues (e.g. oppression, poverty, trauma) and psychiatry. Because the hospital is a public hospital, there may be men present on the unit, and the Women's Team may work with men admitted for general psychiatric problems. Specialized groups can be arranged to address specific women's issues (e.g., parenting, domestic violence) as requested by patients. As noted above, an OB/GYN consult is often provided as women with SMI are less likely to receive adequate GYN care in the community.

### **Evaluation**

The Women's Issues Program does not collect any formal outcome data. Client progress is monitored during the inpatient stay. Individualized goals are established for the period of hospitalization and discharge. As goals are achieved, women are discharged from the program and unit. The program does aggregate data on participants' characteristics.

**Demographics.** Approximately one-third of the women are African American one-third Latino, 20% Caucasian, and 15% Asian.

**Diagnoses.** The most frequent diagnoses among the women admitted to the Women's Issues Program are Schizophrenia, Bipolar Disorder, and Major Depressive Disorder.

**Co-occurring Disorders and Issues.** Substance abuse is a very common co-occurring disorder among the women involved in the program. All women experience some co-occurring issues such as poverty, homelessness, or history of trauma or abuse.

### **A Success Story**

The Program has been very successful in raising awareness about reproductive health issues among psychiatric providers, and about mental illness among OB providers. The relationship between Psychiatry and OB/GYN at San Francisco General Hospital has been enhanced through the program's existence and cross-training of both senior providers and trainees. Providers in psychiatry and OB have become more knowledgeable about the diverse and intersecting needs of women with SMI, and are eager for collaboration across disciplines. Ultimately, this collaboration has resulted in improved care for women with SMI.

For example, a middle-aged woman of Japanese origin with schizophrenia was hospitalized after she was widowed. She initially refused a GYN exam offered by the Women's Team. However, after building trust with her providers who provided encouragement and education about the importance of reproductive healthcare, she agreed to the exam. Cervical cancer was diagnosed and treated successfully with chemotherapy and radiation. Without the diligence of the Women's Team and the availability of GYN healthcare for women admitted to psychiatry, this woman would most likely have died.

### **Challenges**

Numerous challenges confront psychiatric care for women in San Francisco. From the perspective of the Women's Issues program, providers point to a lack of case-management services for women with SMI, and poor follow-up in the community as primary barriers to success. Case-management is only provided to women after they have already become "high-end" consumers of mental health services. According to providers, this explicitly non-preventative approach increases the likelihood of psychiatric crises, and contributes to the creation of chronic mental illnesses and high-end service utilization. In addition, there is a lack of inpatient and outpatient care for women with co-occurring SMI and substance abuse disorders (i.e., dual-diagnosis), and for parenting women with their children. Programs for women with SMI who wish to retain custody of their children are "essentially non-existent." Finally, a shortage of affordable housing and other community resources add obstacles to women's mental health. All of these dynamics contribute to increased likelihood of poor mental health for women, psychiatric crises, and loss of child custody.

### **Next Steps**

Changes in the program are currently contingent on changes in funding structures. Providers agree that case-management services are inadequate and available only after a chronic illness has been established, and custody loss highly likely. Funding for preventive services and increased community-based services is critical for this population.

## Logic Model: San Francisco General Hospital Women's Issues Psychiatric Program

