Parenting With Substance Abuse and Mental Illness

FINDINGS FROM A FOCUS GROUP

WEDNESDAY, JUNE 23, 2010
ALEXANDRIA, VA
This was a collaborative project between the National Abandoned Infants Assistance Resource Center (NAIARC) and Survey Center Focus L.L.C. (SCF). SCF is located in Chicago, IL (www.surveycenterllc.com).

Copies of the report are available at the NAIARC website (http://aia.berkeley.edu).

Please direct questions about the report to NAIARC at aiarc@berkeley.edu.
Parenting With Substance Abuse and Mental Illness
FINDINGS FROM A FOCUS GROUP

Background & Purpose

A focus group was conducted in conjunction with a national summit on substance exposed newborns in Alexandria, Virginia. Participants included eleven professionals representing or associated with the following organizations/institutions:

- Cherish the Family Program: Family Central, Inc. (North Lauderdale, Florida)
- Indiana University School of Medicine (Indianapolis, IN)
- Great Starts Program: Child & Family Tennessee (Knoxville, TN)
- Idaho Supreme Court (Boise, ID)
- Reflejos Familiares Program: University of New Mexico’s Center for Development and Disability (Albuquerque, NM)
- Project Matthew (Dallas, TX)
- Family Based Recovery Program: Yale Child Study Center (New Haven, CT)
- Institute for Health & Recovery (Cambridge, MA)
- Mission Inn Program: Arbor Circle Corporation (Grand Rapids, MI)

Participants represented a range of professions (e.g., social work, academics and health care) and included program and agency directors, program coordinators, a nurse practitioner, and a physician (OB/GYN). The length of time participants had been in their positions ranged from 6 months to 22 years.

The purpose of the discussion was to understand the nature and prevalence of mental illness among substance using parents; explore parenting challenges that arise as a result of co-occurring disorders; and identify effective interventions to support parenting in these families. This report summarizes the discussion elicited by key issues raised by the group facilitator.
What is the prevalence of co-occurring mental illness and substance abuse among the populations served?

Participants estimated that as many as 90% of the substance-abusing parents they treat are living with some form of mental illness. Most of these parents are women, given the general focus of the programs represented. Post-traumatic stress disorder, depression, and anxiety were the most commonly cited mental illnesses among them.

Participants noted, however, that diagnoses are often missed or erroneous. Some parents do not receive a diagnosis because they either never sought out care and/or because drug treatment providers do not routinely assess for mental health issues. An undiagnosed/untreated mental disorder may be the trigger that initiates some women’s addiction or relapse.

“I've been working with a program that helps women involved in prostitution get off the streets and into drug treatment programs. We are assessing them for self-reported mental illness and drug use and we’re offering them treatment rather than throwing them in jail. …Our first thought was that prostitution is how they fund their drug use, but now we’re really beginning to see that it’s much more the mental illness than the drug use. That’s clearly prevalent; they feel awful because they haven’t gotten their mental illness under control.”

Other parents may be misdiagnosed or “labeled.” For example, several participants cited situations in which clients are described as “oppositional/defiant” or as having “antisocial personality disorder.” This labeling may define the woman’s behavior in the institutional setting rather than reflect a significant mental health disorder; it also can disqualify a person for treatment.

“We have a category of people who don’t get adequate assessment and diagnosis. They often get stuck with an anti-social personality disorder, or as juveniles get an oppositional/defiant, label. This is an opportunity to deny them mental health care – to say these people are untreatable. They kind of get marginalized and often don’t meet criteria for certain diagnoses.”
Participants noted other instances where a diagnosis of serious mental conditions, such as bipolar disorder or schizophrenia, can qualify the substance user for more care, although the mental illness isn’t necessarily addressed in treatment.

**Nature of Mental Illness**

Participants unanimously agreed that ongoing and multi-generational exposure to traumatic psychosocial events is at the root of psychological disturbances and substance abuse among the majority of the population they serve. One participant noted that 60% of patients have a history of physical and/or sexual abuse. Another noted that only about 30% are diagnosed with PTSD, but most have experienced trauma.

“The amount of abuse that women suffer prior to becoming addicts is huge. In our study, we’re seeing somewhere around 60% of our patients who are addicted have been physically or sexually abused. So, I want to mention post-traumatic stress disorder. That is probably the most prominent co-occurring disorder operating with substance use in pregnant women.”

“One of the ways we characterize the families, rather than as having diagnosable PTSD which speaks to a single event, is as living in pervasive psychosocial situations. There is a level of chronicity in which their traumas are really cumulative, and the way they deal with these is to treat themselves with drugs. This is more of a survival mechanism.”

These women are likely to have been exposed to large amounts of violence including domestic, neighborhood, gang-related, or while in prison. Participants noted that such a history of trauma has organic consequences in addition to profound emotional and psychological effects. Beatings resulting in loss of consciousness, concussions, and seizures, for example, paired with years of substance abuse, can lead to chronic brain disorders.

“It’s not just a poor adaption or a psychological problem. A lot of the trauma is truly organic. The patients have been knocked unconscious, they’ve had multiple concussions. I have a number of patients who are seizure-disordered with a positive trauma history. One of the co-occurring disorders associated with this is organic brain disease, and that can come from physical trauma but also from the drug itself: multiple withdrawals, multiple overdoses.”
Genetic causes also play a role, as most of these individuals’ family histories are fraught with a variety of mental and physical diseases in addition to antisocial behaviors. Examples cited include cancer, diabetes, and suicide.

“There are multi-generational problems—health problems. There are very significant rates of cancer, of many different diseases—diabetes in particular. In addition, there are a number of antisocial records including incarceration, dropping out of school, suicide—everything you would look at.”

Participants described an ongoing cycle of disorder where multiple conditions build up over time; cumulative traumas directly correlate to mental illness as well as the abuse of drugs and alcohol. Given the relationship between trauma and substance abuse, some specialists feel that it is helpful to regard substance abuse as a symptom of trauma when working with such individuals, rather than thinking of these conditions as separate entities.

“What are the greatest challenges facing parents with co-occurring disorders?”

Substance-abusing parents who have co-occurring disorders face a variety of challenges that can be complicated by any number of factors including their drug of choice, age, gender, culture and/or income.

Focus group participants stated that crack cocaine and other “street” drugs are the most likely to lead to joblessness and homelessness. Methamphetamines are associated with violent and highly charged sexual behavior, much like crack in the early 1990’s. The nature of prescription drugs allows abusers to hide behind a façade of medical necessity and “pretend through life a little” in
terms of keeping a job and family that appears to be well-functioning to outsiders. When alcohol is abused, getting treatment is usually more difficult because this type of dependency is difficult to identify, especially in pregnant women. Treatment is impossible unless the problem is detected, and few medical providers know how to treat pregnant substance users.

Social norms and ethnic culture may also impact the challenges of substance abusing parents. For example, Hispanics are more likely to care for children in an extended community, versus only relying on family support. Yet, they tend to deny or hide substance abuse or mental health problems.

“The way of living among the Latin population in my native country is a sense of ‘it takes a village to raise a child.’ Everybody participates in the raising of a child, everybody helps each other; it’s kind of a neighborhood collaboration of bringing up children. These issues don’t get addressed. Now they are immigrants here, and for them to hear that they have a mental health condition, it is a challenge because they’ve never heard of those concepts.”

“There is no chance for you to let anybody know that you’re having a substance abuse issue. So you hide that; you’d never say that to anyone. There are a lot of people in denial and even if the family knew, they would never get treatment. Nobody talks about it… there’s a stigma.”

Specific Parenting Challenges

The parenting challenges faced by individuals with co-occurring substance abuse and mental illness are emotional, financial, and logistical.

Low self-esteem and feelings of inadequacy are present in almost all of the women who participate in the programs and services represented in this discussion. Physical and emotional abuse, usually starting from an early age, suggests to these women that they are of little value. Consequently, for some, becoming a parent is confused with a longing for someone to love them; but it can also be experienced as intimidating and frightening as many of these women doubt their ability to be good parents.
“I think they have very little sense of self. They don’t have any sense of themselves as adequate, as being worth anybody paying any attention to because that’s been their experience through life. The reason that they make the attributions that they do about their children being manipulative or not obeying them is because that’s how all people treat them, so why would this child be any different? How do you give someone a sense of being worth something?”

Symptoms of depression create even more obstacles to attentive, active parenting. Parents suffering from addiction and psychological disorders, such as depression, typically have little energy. They may be unable to care for themselves in terms of personal hygiene, eating habits, and the everyday responsibilities of managing a household, let alone addressing the needs of their infants and children. In many cases, their need to procure the next “high” may take highest priority at the expense of their child/children. Consequently, children may be left alone for long periods in front of the television or have inconsistent/inappropriate contact with family or friends.

“Many of these mothers have such a difficult time engaging their children because they’re suffering from depression and having trouble taking care of their own basic needs: poor personal hygiene, poor eating habits, and really low energy. This child is placing demands that they’re struggling to meet and so they try to engage their child in TV or ask another child to care for them. That early attachment is lacking.”

Additionally, expectant mothers who are clinically depressed and taking medications for their depression may stop their pills during the pregnancy fearing the impacts it might have on the baby. Such noncompliance is often done without the consent of the prescribing physician and puts such patients at further risk of relapse and post-partum depression.

The lack of stability and consistency, pervasive among this population, also impacts the children. Parents with co-occurring disorders often experience emotional deregulation and mood swings. This, along with multiple caregivers and insidious violence, creates confusion and trauma for their children.

Moreover, few of these moms have the skill set to create or carry out any sort of life plan. This inability to plan often contributes to their becoming a parent, and many of these mothers feel no attachment to babies resulting from unexpected pregnancies.
Lack of parenting role models further contributes to their difficulty bonding with their children. It is difficult to be empathetic or nurturing if you have never been nurtured yourself. Additionally, parenting can revive painful memories from their own childhood, which can in turn trigger relapse.

“It’s a challenge for these mothers to see the world from their infant’s point of view because so much of their own stuff is put on the infant. You hear expressions about newborn babies like, ‘he’s manipulating me by crying’ rather than being able to see the world through the eyes of a child. We parent as we were parented, and when we talk about intergenerational transmission that is also true for parenting. Many of these individuals have not experienced the kind of relationship that not only nurtures attachment, but nurtures the security to be involved in the world.”

What are the barriers to providing effective parenting interventions with this population?

The lack of an experienced staff can be a fundamental barrier to successful program interventions with these families. Staff members coming out of Masters’ programs have the knowledge, but often lack the practical experience that makes for a good clinician.

Even among experienced practitioners, skill sets are different between addiction counselors, psychiatrists, and physicians, for example. Because of the variety of people involved in a patient’s treatment, sharing information would promote a more complete and accurate picture of the parent and child, as well as a better understanding of the emotional, behavioral and physical challenges. However, participants said that few programs integrate treatment for the multitude of problems these families experience. Programs delivering services are like silos and tend to only recognize the needs of their own specialties.

Substance abuse is most often identified as the primary concern with this population because there is no initial psychological diagnosis or assessment. With no diagnosis, the mental and emotional health issues that may lie at the root of substance abuse are often not identified or addressed. With such a fragmented vision, each program’s impact is limited. Therapy becomes a misguided effort of eradicating the symptom rather than the disease, a treatment that is bound to crumble when the anxieties of life become too great. If programs incorporated mental health treatments as well as substance abuse, professionals in the field believe they would have a greater impact.
“A lot of our clients have a co-occurring mental illness but are not adequately screened for it. They’re treated for their substance abuse and they’re not seeing a psychiatrist or a licensed behavioral health specialist and that’s really not being addressed. It might be addressed if they go to the [executive director] in a crisis situation but the follow-up for these clients isn’t there. They’re not being treated for mental health; they’re treated for substance abuse.”

Treatment programs must be designed to help the children, as well as the parents. There is a direct relationship between the negativity a mother feels toward herself and the way in which she parents her children that must be understood and addressed at the root. Helping mothers recognize the pivotal and tremendously important role they play in the lives of their children may help them to perceive that they are extremely valuable. With behavioral directives alone, however, teaching these individuals to become good parents and consistent, reliable caregivers is difficult. Role modeling for the parent(s) may offer a nurturing experience that these parents would benefit from both observing and experiencing.

“What is expected of parents to be ‘good parents’? There was a case in which the mother had tried for three years to regain custody. She had a learning disability, and one of the reports that was sent to court and was also the basis upon which the court decided she wasn’t able to keep her children said that during the one hour visit she had with her children once a month she wasn’t doing homework. I went back to my office and said, ‘then my mother wasn’t a good mother.’ What is parenting? Parenting to some extent is abstract.”

The fragmented nature of the funding process creates additional barriers. Funding is usually project-driven and allocated by various government (federal, state, and/or local) or private sources. Each funding source requires its own assessments and evaluations, which maintains the current segmented approach to treatment/services.
What intervention models have effectively improved parenting skills and practices among this population?

Ultimately, the focus needs to be on the children. What do they need and how do we support parents to adequately address their needs, especially when parenting brings up so much past trauma? As previously noted, parents with co-occurring disorders need to be nurtured themselves in order to increase their capacity to nurture their own children. To some extent, participants feel that the caring, honest, and genuine relationships these parents develop in treatment programs are the underlying vehicles that are truly responsible for positive changes in their lives.

“It’s the relationship that they have with their case manager or peer advocate or primary person—women in our program frequently say their case manager is the first sober friend they have ever had. It’s through that relationship that you begin to see some changes in behavior because the women do want to understand their babies; they really do love their babies. None of us ever question the love they feel for their babies, it’s the knowing how.”

“One of our patients has been very lucky in that she has not been labeled, and we have seen her improvement over time just from being with someone who is very supportive of her—respectful. She regulates herself so well now after two or three months working with the baby. She has become a better parent. She complains about everybody in the world, but she said that she’s become a better human being with us and that she’s a better mom. I would love to be less labeled and more able to do things.”

“We have to make them feel that they are treasured, so that they can treasure their children.”

The honest recognition of their strengths and genuine encouragement to develop them can help parents to grow their self-confidence and find ways to express love of their babies. Encouragement that they can be good parents is a huge motivator.
“I’m always impressed when my staff members talk about their families. It’s always about who the women are as people. Later you hear about the disorders, the violence, or the criminality. But, the genuine feelings the staff feel for them is palpable. When that’s happening, I know that’s where change begins to occur. The woman makes the change but the relationship she has with that individual staff is the vehicle that promotes that change. It’s not necessarily unmitigated niceness; it’s honesty, it’s a genuine caring for who that person is.”

“Yes we treasure you, but more than that we accept you just as you are. We want you to accept yourself. Build on your strengths that are there. We are honest, authentic and can be understood.”

Participants noted that peer mentors can be very effective at establishing relationships with these women, providing support, encouragement and motivation. It is a powerful message when they say and demonstrate, “I’ve made it, so you can make it, too.”

Participants also commented on the role that judges can play in supporting parents and holding them accountable.

“The judges are largely unhampered by all of the psychological and clinical knowledge, even all of the sociological knowledge. They really do accept them because they in some ways don’t know any better. They’re special judges in the sense that they’re committed to a long-term, ongoing relationship, and they do not see these women as victims, but as capable of being accountable. They hold them accountable with acceptance.”

In addition to the nurturing relationships of specialists, participants mentioned a variety of approaches and strategies that have proven effective among this population. Strategies include the following:

- Basic Twelve Step techniques.
- Encourage parents to perform simple acts of service for somebody else, e.g., a child, a partner, a spouse, a relative or a friend. This can help them re-pattern their behavior to look beyond themselves.
- From a list, have the parent identify a developmental task that a child has not done. Parents often cannot identify what their child has and has not accomplished. This helps parents understand which developmental milestones their child is approaching, and to take part in getting them there.
Collaboration between different programs simultaneously addressing different needs of parents and their families.

Parent and child activities that focus on the attachment and can be as simple as sitting down with the child.

Infant mental health services that provide home-based parent-infant support and intervention services to families to address parent-infant attachment and the related social, emotional, behavioral, and cognitive development of the infant.

Additionally, participants identified the following program models that they employ to address the needs of parents with co-occurring disorders.

**Treatment Programs and other Adult-Focused Models**

**Seeking Safety**
http://www.seekingsafety.org/

Seeking Safety (SS) is a manualized, integrated treatment for individuals with a dual diagnosis of PTSD and Substance Abuse Disorder (SUD). Seeking Safety focuses on the needs of both PTSD and SUD by emphasizing stabilization and safety from self-destructive behaviors and trauma reenactments.

*Developed by: Lisa M. Najavits, Ph.D, Professor of Psychiatry, Boston University School of Medicine, Lecturer, Harvard Medical School*


**Hazelden Co-occurring Disorders Program**
http://www.bhevolution.org/public/program_overview.page

The Hazelden Co-occurring Disorders Program is a comprehensive program that provides integrated treatment services for people with non-severe psychiatric disorders that co-occur with substance use disorders. This integrated treatment approach helps people recover by offering both mental health and substance use services at the same time and in one setting. Practices include motivational enhancement therapy (MET), cognitive-behavioral therapy (CBT), and Twelve Step facilitation (TSF).

*Developed by: Hazelden Foundation*
**Matrix Model**
http://www.hazelden.org/web/public/matrix.page

The Matrix Model is a proven effective, evidence-based protocol that has been used in the treatment of over 6,000 cocaine and 2,500 methamphetamine addicts. It’s a ready-made intensive outpatient program (IOP) that any treatment center can implement.

*Developed by: Richard A. Rawson, Ph.D., UCLA Integrated Substance Abuse Program and Michael J. McCann, M.A., The Matrix Institute on Addictions*


**Stages of Change Model**

The Stages of Change Model was originally developed in the late 1970s and early 1980s by James Prochaska and Carlo DiClemente at the University of Rhode Island when they were studying how smokers were able to give up their habits. The SCM model has been applied to a broad range of behaviors including weight loss, injury prevention, and overcoming alcohol and drug problems, among others.

*Developed by: James Prochaska and Carlo DiClemente at the University of Rhode Island*


**Tackling the Tough Skills**

http://extension.missouri.edu/tough-life-skills/

Tackling the Tough Skills™ is a fun, innovative and highly interactive life skills curriculum that helps hard-to-reach adults or teens prepare for success in work and life. Along with basic life skills, it addresses self-esteem, responsibility, and social interactions. It’s also being used in the workplace to teach soft skills to employees.

*Developed by: University of Missouri Extension*

**Child or Family Focused Programs**

**CDD Home Visiting Professional Development Team**

http://cdd.unm.edu/homevisiting/

The CDD Home Visiting Professional Development Team provides training and technical assistance to the Children, Youth and Families Department (CYFD) Home Visiting programs
across New Mexico. Core and advanced practice trainings are provided to home visiting staff with a focus on a relationship-based, reflective approach using the New Mexico Association for Early Childhood Mental Health (NMAECMH) Competencies for Culturally-Sensitive, Relationship-based Practice Promoting Early Childhood Mental Health as a guide. Home visiting supervisors are also supported through monthly reflective supervision calls from the professional development team to assist their efforts in providing a parallel reflective supervision experience to their home visiting staff. The team also coordinates and facilitates quarterly meetings for home visiting supervisors, which include the CYFD home visiting program manager, to help support the home visiting initiative.

Developed by: University of New Mexico Center for Development and Disability

Note: One of the represented programs employs this model using a team that includes a relationship-based case manager, developmental services, and primary care or family doctor.

**Family Based Recovery**
http://www.ucfs.org/services/Community_Behavioral_Hlth/fam_recovery.shtml

Family Based Recovery (FBR) is an intensive and comprehensive in-home program for families who have co-occurring caregiver substance abuse and an infant (birth to two) who is at risk of removal or poor developmental outcomes. It is designed to address both the parent and child relationship in a developmental context and to provide reinforcement-based substance abuse treatment for parents who are active users. The FBR team is composed of a supervisor, two clinicians, and a family support counselor. FBR has been replicated in five sites throughout Connecticut.

Developed by: Yale Child Study Center

**Child Witness to Violence Project (CWVP)**

The Child Witness to Violence Project (CWVP) provides trauma-focused clinical intervention to children age 8 and younger who have been exposed to domestic or community violence. The intervention requires the active participation of at least one parent and is focused on addressing the traumatic experiences of the child within the context of the child-parent relationship. The intervention incorporates principles of Child-Parent Psychotherapy (Lieberman, Van Horn, et al.), which has been empirically validated for children under age 6, and Trauma-Focused Cognitive Behavioral Therapy (Cohen, Mannarino, et al.). Components of the intervention include advocacy and case management, parent guidance, along with dyadic and/or individual psychotherapy. Services are primarily outpatient and office-based.

Developed by: Boston Medical Center
Promoting First Relationships (PFR)
http://www.pfrprogram.org/
Promoting First Relationships (PFR) is a prevention program dedicated to promoting children’s social-emotional development through responsive, nurturing caregiver-child relationships. PFR staff train service providers in the use of practical, effective strategies for promoting secure and healthy relationships between caregivers and young children birth to three years of age. Features of the training program include: videotaping caregiver-child interactions to provide insight into real life situations, giving positive feedback that builds caregivers’ competence with and commitment to their children, and focusing on the deeper emotional needs underlying children’s challenging behaviors.

Developed by: Washington University Center on Human Development and Disability

Nurturing Parenting Program
http://www.nurturingparenting.com/home.php
The Nurturing Parenting Program is a family-centered initiative designed to build nurturing parenting skills as an alternative to abusive and neglecting parenting and child-rearing practices. The long term goals are to prevent recidivism in families receiving social services, lower the rate of multi-parent teenage pregnancies, reduce the rate of juvenile delinquency and alcohol abuse, and stop the intergenerational cycle of child abuse by teaching positive parenting behaviors. The Nurturing Parenting Program targets all families at risk for abuse and neglect with children birth to 18 years.

Developed by: Stephen J. Bavolek, Ph.D., Family Nurturing Center, Inc.

Strengthening Families Program (SFP)
http://www.strengtheningfamiliesprogram.org/
The Strengthening Families Program (SFP) is a nationally and internationally recognized parenting and family strengthening program for high-risk families. SFP is an evidence-based family skills training program found to significantly reduce problem behaviors, delinquency, and alcohol and drug abuse in children and to improve social competencies and school performance. Child maltreatment also decreases as parents strengthen bonds with their children and learn more effective parenting skills.

Developed by: Karol L. Kumpfer, Ph.D., psychologist, associate professor at the University of Utah, and former director of CSAP.
What additional resources might help these programs better support the parenting needs of this population?

Participants agreed that more funding and integrated approaches among programs would be invaluable in supporting the needs of parents with substance abuse and mental illness. The windfall of funding that was allocated to social services in the early 1990’s allowed for great advances, but a lot of the progress is deteriorating due to limited funding in recent years.

“I think we have to bring the early childhood developmental services world together with the behavioral health world so we can work together, because the other part of the equation is the development of the child. How can we support that child and make them more available to being parented?”

“Our population doesn’t have the funds to pay $150 for a session. The changes are only going to happen through politics, if we educate legislators, senators, and the people we put in power to make decisions for us.”

“Our behavioral health Managed Care authorizes exactly two visits a month. I do get concerned that we have to think carefully about all of the things we think are so important… and how is that going to get funded?”

“One of the things we need to deal with is to move away from the American sense that you give them an intervention, they’ve got to get better, and that’s going to be the end of it. This is not the way it is. This is life-long. How can we see that there are supports all along the way?”

Related to the integration of systems and aspects of care, leaders in the field also feel that better training for new social workers would improve the efficacy of treatment. Exposing students to in-home visits while they are in school could better prepare recent graduates when they enter the treatment field.
Conclusion

Clearly, based on the collective experience of participants in this focus group, mental illness is common among substance using parents (mostly mothers, in this case). Multi-generational exposure to traumatic events is pervasive and at the root of psychological disturbances among many of these women. Their mental illness and substance abuse disorders, along with their basic needs, must be addressed concurrently and persistently in order to help them become adequate parents. Moreover, these women typically need to be nurtured and parented themselves to enable them to provide nurturing care for their children. Thus intensive, multi-disciplinary approaches are needed and must be sufficiently funded, and well integrated or coordinated. Numerous promising and evidenced-based practices exist to address both the co-occurring disorders and related parenting challenges. These practices must be validated through additional research and implemented by experienced staff with the capacity to establish caring relationships, which ultimately lie at the heart of the healing process.