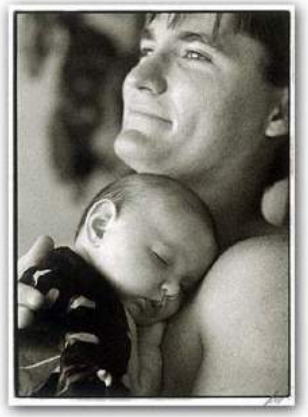
Mental Illness:
The Impact on Parenting

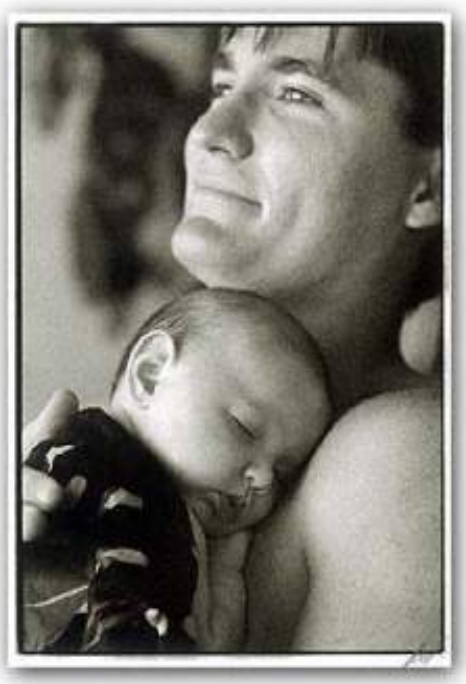


KEEPING INFANTS AND TODDLERS SAFE
HEALING THE YOUNGEST VICTIMS

JUNE 28, 2012

DR. M. CONNIE ALMEIDA, PHD, LSSP
DIRECTOR OF BEHAVIORAL HEALTH, FORT BEND COUNTY
INFANT TODDLER COURT INITIATIVE
CONNIE.ALMEIDA@CO.FORT-BEND.TX.US

The child-parent relationship is core to a child's development



ATTACHMENT

- The central theme of attachment theory is that mothers who are **available** and **responsive** to their infant's needs establish a sense of security. The infant knows that the caregiver is **dependable**, which creates a secure base from which the child can explore the world.

Attachment is an emotional bond to another person (Bowlby, 1969).

- Parents of maltreated infants often have increased risks including **poverty**, **substance abuse**, **mental illness**, **disabilities**, **violence** and **limited social support** (Larrieau, 2000)
- Maltreated infants and toddlers are at risk of developing disorganized attachment and later psychopathology
- Optimizing early child development for children in the child welfare system requires the provision of a corrective attachment experience

Interventions

- Our interventions focus on helping parents:
  - **stay connected** to their children
  - **learn about their child's needs**
  - **respond appropriately** to those needs
  - **recognize the impact of their behavior** /emotional availability
  - **make better decisions** to have healthier lives for themselves and their children

Our goal

Healthy

Safe

Happy

Does your client have?

- Trouble focusing or concentrating
- Restlessness
- Impulsivity
- Difficulty completing tasks
- Disorganization
- Frequent mood swings
- Hot temper
- Trouble coping with stress
- Unstable relationships

What is this?

- ADHD - Attention Deficit Disorder
- Fetal Alcohol Spectrum Disorder
- Substance Abuse Disorder
- Intellectual Developmental Disability (IDD / MR)
- Mental Health Disorder
  - Bi Polar
  - Depression
- All of the above

Where do we start?

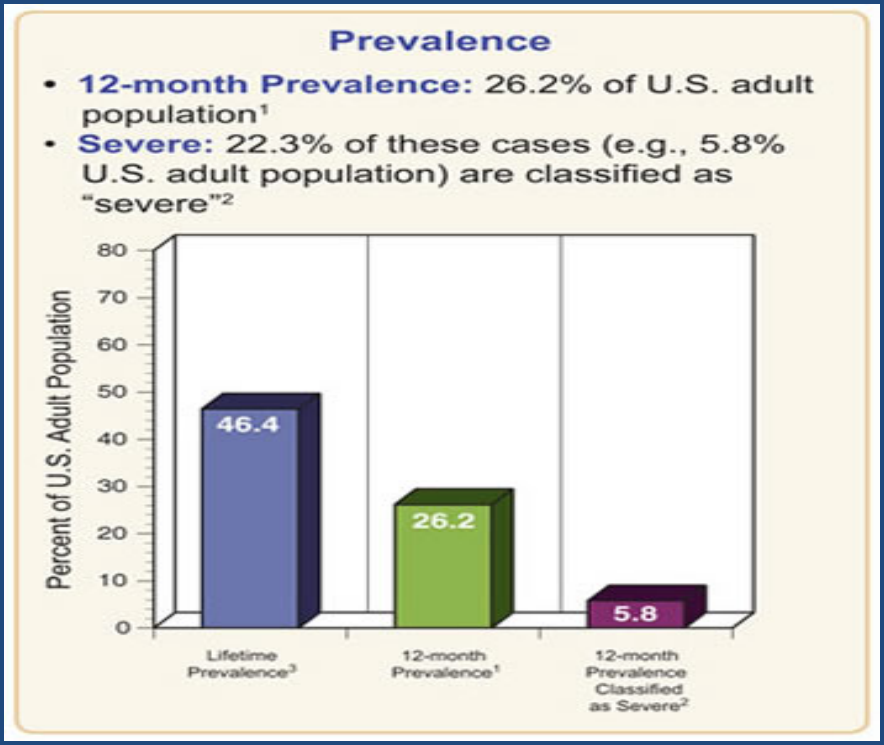
- At the beginning
  - Understanding the history including prenatal exposure to toxins, trauma, parenting experiences, risk factors
- What happened in the early years – early experiences matters
- Comprehensive assessment – mental health, substance abuse, physical health, trauma, risk factors
  - identify needs and strengths
- Identify treatment history (successes and failures)
- Engage the client/family .. ENGAGE.. RE-ENGAGE

Need to Understand Risk Factors

- Domestic Violence
- Trauma
- Insecure/ disruptive relationships
- Learning disabilities
- Abuse/ neglect
- Mental illness
- Intellectual developmental disabilities
- Social isolation
- Financial stressors

Prevalence of Mental Illness

Approximately one quarter of adults are diagnosable for one or more disorders
About 6% suffer from a seriously debilitating mental illness.



http://www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml

Mental Health Disorders

- Anxiety Disorders
  - Generalized Anxiety Disorder
  - Obsessive-Compulsive Disorder (OCD)
  - Panic Disorder
  - Social Phobia (Social Anxiety Disorder)
- Post-Traumatic Stress Disorder (PTSD)
- Attention Deficit Hyperactivity Disorder (ADHD, ADD)

Mental Health Disorders

- Bipolar Disorder (Manic-Depressive Illness)
- Depression
  - Major Depressive Disorder
- Schizophrenia
- Borderline Personality Disorder
- Adjustment Disorders – situational

Mental Disorders

- Mental Disorders are Brain Disorders
- Mental Disorders are Developmental Disorders
- Mental Disorders results from complex genetic risk plus experiential factors

- Thomas R. Insel, MD , Director of NIMH (Agenda for Psychiatry and Neuroscience presented by Menninger., April 12, 2012)

Mental Illness

- Co-existing diseases are the rule not the exception
  - Co-occurring psychical diseases
  - Multiple neuropsychiatric conditions
  - Co-occurring substance abuse/ alcohol problems

What are Co-Occurring Disorders?

The co-occurrence of a substance use (abuse or dependence) and *mental* disorders in one person

COD clients have

- one or more disorders related to the use of alcohol and/or drugs of abuse *and*
- one or more mental disorders

At least *one* disorder *of each type* must be established *independently of the other* and is not simply a cluster of symptoms resulting from one disorder

Disorders

- **Mental Illness**
  - Bi-Polar
  - Depression
  - Anxiety Disorders
  - PTSD
  - Schizophrenia
- **Substance abuse**
  - Alcohol
  - Crack/Cocaine
  - Prescription drugs
  - Marijuana
  - Heroine
  - Pain medication

Who is receiving treatment?

- Almost 50% of persons with COD do not receive treatment

4.2 millions adults with COD (SAMHSA , 2004)

- 39.8% received treatment for Mh
- 49% no treatment
- 3.7% SA treatment alone
- **7.5% treatment for both**

- Substance abuse is associated with many crimes of violence and increases rates of violence in person with mental illness.

History of Treatment

1. **Not at all**—referred out to treatment for the other problem or refused care entirely.
2. **Serial Treatment**—one type of disorder treated at a time, in separate settings.
3. **Concurrent** or **Parallel Treatment**—treatment for both types of disorder offered at the same time but in separate settings and by separate providers.
4. **Integrated Treatment**—both types of disorder assessed and treated together in specialized settings by providers possessing competency in the treatment of both types of disorder *and* integrated treatment

Falling through the cracks!

Why Integrated Treatment

- MH problems do not go away with abstinence
- Improved MH does not bring about abstinence
- Separate treatment is uncoordinated and can be counterproductive
- Neurochemical rebalancing
- “Underlying” or overlaying issues need to be addressed
- Impact on interpersonal relationships central to treatment

Evidence Based Practices for COD

- Seeking Safety (PTSD and SUD)
- Dialectical Behavior Therapy
- Modified Therapeutic Communities for person with COD
- Moral Reconation Therapy (Robinson,Ken)
- Assertive Community Treatment (ACT) with SA component
- Intensive Case management
- Staged treatment interventions
- Culturally competent services

Evidence Based Practices for COD

Appropriate intervention needs to take into consideration

- stage of treatment
- safety
- needs and strengths
- previous treatment history,
- cognitive functioning
- environmental factors

Appropriate Motivational Strategies for Each Stage of Change

Strategies that work

- Engagement
- Develop a therapeutic alliance
- Continuity/ consistency in caseworker
- Consistency
- Strength-based approach
- Indentify barriers
- Remove barriers to accessing services
- Create social supports - wraparound “supports”
- Peer –mentor support

Strategies that work

- Choice making
  - Provide opportunities for choice making - model choice making
  - Limit and structure choices
  - Allow extra time
  - Teach steps for choice making (good / bad lists)

- Impulse control
  - role-playing situations

- Communication
  - Establish eye-contact
  - Facial and body language
  - Visual cues/ prompts

- Organization / Follow-through
  - Provide tools to assist with organization and follow-through

Strategies that work

- Reinterpret behavior to take into consideration disability
- Try something different not harder
- Take care of yourself
- Ask for help

Case examples

DSM-IV Diagnosis:

Axis I: Depressive Disorder NOS
Partner Relational Problem
Marijuana Abuse, by Self-Report
Cocaine Abuse, by Self-Report

Axis II: Borderline Intellectual Functioning
Dependent Personality Features

Axis III: None Reported

Axis IV: Psychosocial Stressors: CPS Involvement, Separation from Children, Recent Relocation, Limited Support System, Relationship Issues, Family History of Abuse and Discord, Limited Resources, Substance Abuse Problems, Legal Problems of Partner

Axis V: Global Assessment of Functioning: 55 (Current)

Case examples

DSM-IV Diagnosis:

Axis I: Adjustment Disorder with Mixed Anxiety and Depressed Mood

Alcohol Abuse

Cannabis Abuse

Axis II: Mild Mental Retardation

Paranoid Personality Features (Rule Out Personality Disorder NOS)

Axis III: None Reported

Axis IV: Psychosocial Stressors: CPS Involvement, Separation from Children, Separation from Partner, Pending Employment Changes

Axis V: Global Assessment of Functioning: 60 (Current)

Intellectual & Developmental Disability: The Impact on Parenting

KEEPING INFANTS AND TODDLERS SAFE
HEALING THE YOUNGEST VICTIMS

JUNE 28, 2012

MARIA QUINTERO, PHD
MENTAL HEALTH AND MENTAL RETARDATION AUTHORITY OF HARRIS COUNTY
MARIA.QUINTERO@MHMRAHARRIS.ORG

Parents from both sides of the looking glass

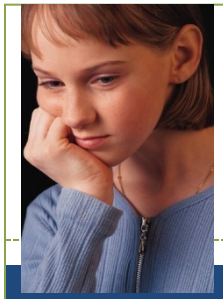
- Parents who have IDD
- Parents with children who have IDD

Terminology

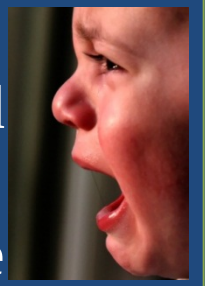
Mental Retardation "MR"	→	Intellectual & Developmental Disability "IDD" or "ID"
Autism Spectrum Disorders "ASD"	→	Autism Pervasive Developmental Disorder Asperger's Disorder
Dual Diagnoses	→	Co-Occurring IDD + Mental Illness

IDD

- Three criteria:
  - ID < 70
  - Corresponding delay in adaptive behaviors
  - Onset before age 18 (developmental period)
- Degrees of severity: Mild, Moderate, Severe & Profound
- According to the President's Committee for People with Intellectual Disabilities (2004), an estimated seven to eight million Americans of all ages experience an intellectual disability.
- IDD affects about one in ten families in the United States at some point in their lifetime.
- Prevalence rates of IDD range from 1% to 3%



ASD



- Autism Spectrum Disorders (ASD) is a range of complex neurodevelopment disorders, characterized by social impairments, communication difficulties, and restricted repetitive, and stereotypical patterns of behavior.
- Behavioral excesses such as tantrums and self injury are common
- The current prevalence rate of ASD is estimated be 1 in 88 individuals (Centers for Disease Control and Prevention, 2012).
- Recent findings:
  - One in 54 boys and one in 252
  - Estimated prevalence among non-Hispanic white children (12.0 per 1,000) was significantly greater than that among non-Hispanic black children (10.2 per 1,000) and Hispanic children (7.9 per 1,000)
  - Problem with identification?

Dual Diagnoses

- The prevalence of psychiatric disorders in people with IDD can be as much as 4 to 5 times higher than among people without IDD
- A conservative estimate of 33% is commonly cited
- People with ASD are at much higher risk (75%) of developing mental illness than people with IDD

And here in Texas

- Harris County has approximately 82,000 residents with IDD/ASD
- Statewide, over 510,000 Texans have IDD/ASD

Being a parent with IDD

- Can a person with an IQ under 70 have a child?
  - Intelligence is not a criterion for parenthood
- Impact on the child
  - Limited research
  - Without parental supports, children are at higher risk for developmental delay and behavior disorders
  - more likely to live in poverty and be in unsafe and/or unsuitable housing in low income neighborhoods (McConnell, et al., 2008)
  - Approximately 40% show developmental delays by age 2.
  - Little is known of effect on older children—one study documented lower IQ, reading, spelling and math scores, and 37% qualified as learning disabled (Feldman & Walton-Allen, 1997)

Outcomes for parents with IDD

- Are they at higher risk for abuse?
  - Not necessarily!
  - Neglect is more common complaint than physical or sexual abuse
- Children are removed more often and more quickly
  - 48% in England (2005)
  - 49% in U.S. (2001)
- Harder to restore parental rights

Professional bias?

- Examine own history and emotions around developmental disabilities
- Examine own feelings toward parents with limited cognitive ability
- Understand the law and rights of the parent with IDD/ASD
- Know available supports

Can this family be saved?

- Research on parent training supports success of specific methods
  - Understand contextual variables—how much support and how many natural resources are available?
    - Child factors
      - behavior problems, age, etc.
    - Parent factors
      - Stress, depression, etc.
    - Familial factors
      - Social support, partner support, etc.
    - Environmental factors
      - Low income, neighborhood disadvantage

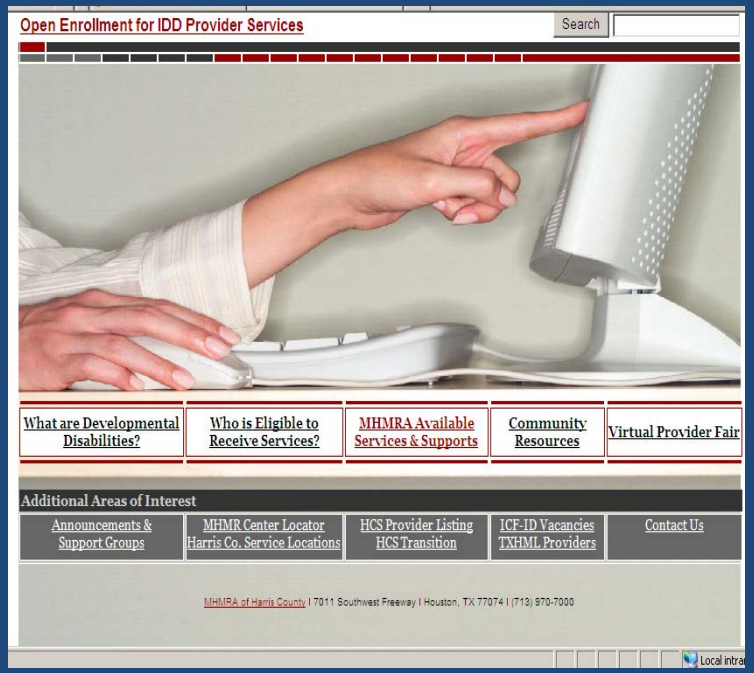
Wade, Llewelyn & Matthews, 2010

Can this family be saved?

- Intervention in the home—teaching skills where they will be needed and used
  - Skill-focused training, not concept based; e.g.,
    - Positive and stimulating interactions with child
    - Responding to symptoms of childhood illness
    - Grocery shopping, menu planning
    - Problem solving
    - Cleanliness and home safety, bathing, changing diapers, etc.
  - Use of behavioral teaching strategies
    - Modeling, repeated practice, feedback, praise, tangible reinforcement, task analysis, corrective feedback
  - Combination of written, practice, auditory modalities, verbal prompts (check reading skills!), weekly, or twice weekly
  - Generalization can be limited

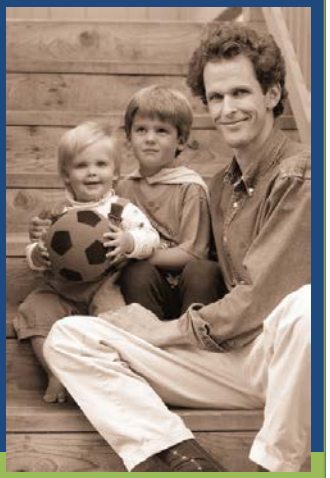
Supports for parents with IDD

- The Arc, http://www.aogh.org/
- MHMRA of Harris County, http://www.mhmraharris.org/MRSD/MR.html



Parents with children who have IDD

- Cross-cultural
- Present in all socio-economic groups



Parents with children who have IDD

- Increased psychosocial stress
- Increased physical health problems
- Higher annual healthcare costs
  - 3x higher costs for child with disability
- Lower quality of life
- Stigma & social isolation that impact self-esteem
- Spend an average of 29.7 hours per week helping with activities of daily living and other child-related supports, limiting ability to work outside of the home
- *Note: Child severity is not a major factor in parent's well-being*

Parents with children who have IDD

Stage	Considerations
Denial	But he looks like a normal baby Babies change so much Stop worrying If we don't tell, it won't be true
Anger	Dashed expectations Fear of the unknown Helplessness and lack of control Someone has to be responsible Professionals with few/unsatisfactory answers
Bargaining	Overcompensation/Guilt Change in relationship with God Good things happen to good people Try anything

Parents with children who have IDD

Stage	Considerations
Depression	Sense of finality & of great loss Support system changes Financial burdens Overwhelmed by the future
Acceptance	Coping Not necessarily happy Acquire some sense of control “Hardening” of reactions

The cycle repeats

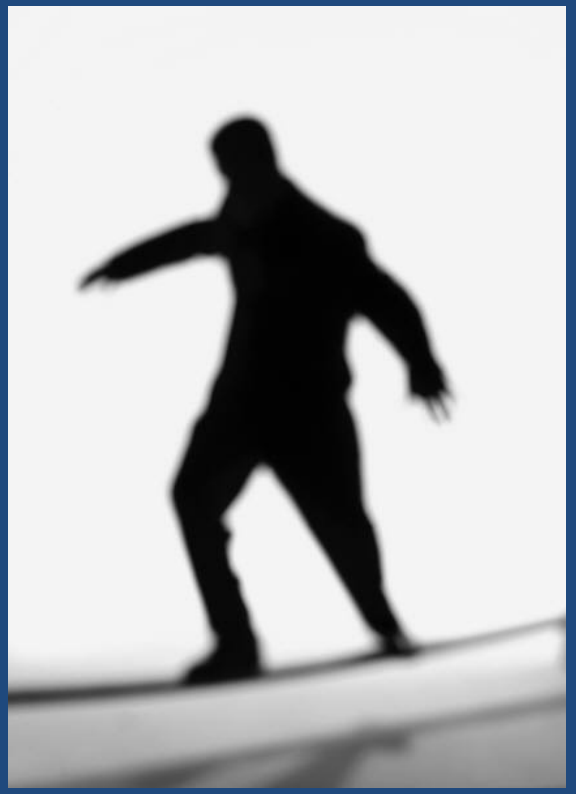
Preschool	Middle school transition
Kindergarten	Dances
Start of Special Education	Summer library program
Report Cards	High school transition
School programs	Dating
ARDs	Dances
Back to school night	Driving
Class parties	Sexual development
PTA	Graduation
Neighborhood kids	Post-graduation plans
Family functions	Relative's weddings, new jobs, etc.
	Aging parents

Siblings

Fear Loneliness Anger Resentment Embarrassment	Pressure Guilt Frustration Confusion Jealousy

Parents with children who have IDD

- Not all is bleak!
  - Balance between Threat appraisal/Growth
- Most parents describe negative emotions in relation to the child and disability, but also describe positive emotions that balance the negative experiences



Bostrom, Broberg, Hwang, 2009

Prevalence

- **50 to 75 percent** (substance abuse settings)
- **20 and 50 percent** (mental health settings)
- Co-occurring disorders should be ***the expectation, not the exception*** in any behavioral health setting.

(Source: SAMHSA's TIP 42)

The professional factor

- Research finding: Child protective services workers demonstrate more empathic responses to parents of children with IDD/ASD---even when the abuse is of serious, physical form
- Workers more often attributed child-focused reasons for abuse, versus parent-focused; i.e., the child was seen as having characteristics that contributed to their abuse
- Recommended services were more likely to be child-focused

Manders & Stoneman, 2009

The professional factor

- Recommend that workers be trained to understand:
  - Families with children with IDD do not exist in chronic state of stress and dysfunction
  - Families with children with IDD have unique stressors, but great majority of families establish a healthy balance and do not abuse their children.
  - It is essential to disentangle the abuse from the disability.
- Learn the needs of families with children with IDD and where to locate resources
- Make good network contacts and ask for help!

Needs

- Access to information and services
  - The value of Respite
- Fewer financial barriers
- Feeling of being included in the community
- Support groups

Support Groups

http://mhmraharris.org/MRSD/announcements.htm

Houston Area Respite Center (HARC): Adult Social Club	
Date	Every Friday
Time	4:00 PM - 6:00 PM
Location	Down Syndrome Resource Center 7015 W. Tidwell Building G Suite 108 Houston, TX 77092
Additional Information	The club will provide a unique opportunity for its members to practice social skills and gain self confidence in a safe, welcoming environment. It will give them the opportunity to have their own place; make new friends; to be themselves; discover new talents and goals; become leaders; make decisions, and to have fun. With guidance, the members will plan and run their club's activities and occasional outings – all the while practicing their social thinking skills. For more information and to join the club, please call 281-639-2788 or email us at harc@harc-hou.org Adult Social Club Flyer

North Houston Autism Play Group
Visions for Tomorrow Daytime Support Group: Sponsored by NAMI West Houston
El Grupo de Apoyo Community Self-Help Group
Jewish Family Services Alexander Institute Support Group
Parents as Partners in Special Education Support Group Day Meeting
Parents as Partners in Special Education Support Group Night Meeting
Parent Run Support Group supported by the Arc of Greater Houston Familias Hispanas
Recovery, Inc. Self-help Mental Health Group
Tzu Chi Support Group for Families with Special Needs
Additional Support Groups
The Arc of Greater Houston

QUESTIONS?