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RESEARCH TO PRACTICE BRIEF

Supporting Children of Parents with Co-occurring Mental Illness and Substance Abuse

When the police arrived at the home after receiving a report of domestic violence, they found 6 year old Peter alone in the family room watching television in his pajamas. No adults were present in the house, and open alcohol containers were strewn about the kitchen. Peter was taken back to the station, where he was interviewed by a child welfare worker. Peter informed the worker that he was not enrolled in kindergarten, and spent most of his time on the couch watching cartoons. Peter's file showed that he had been in the care of three different family members over the years as his mother bounced in and out of residential treatment for her substance abuse, depression, and multiple suicide attempts. No formal supportive services had ever been offered to Peter.

For nearly a decade, the Substance Abuse and Mental Health Services Administration (SAMHSA) has been advocating for integrated treatment of co-occurring mental health and substance abuse disorders, with the understanding that those who struggle with both addiction and mental illness face complex life stressors and unique barriers to treatment (1). Up to 50% of substance abusers are suffering from PTSD, and some reports show that up to 90% have a depressive or anxiety disorder of some form (2, 3). Integrating the treatment for these two types of disorders is recognition that the whole of a person is more than the sum of his or her parts. It's not enough to merely treat the substance abuse, and then send the individual for counseling (or vice versa). Instead, treatment should be holistic, and respond to the whole person's needs. What is commonly left out of the equation, however, is that according to the National Prevalence Data, over two-thirds of women with co-occurring disorders are mothers (4). While integrated treatment may respond holistically to the clinical diagnoses of the client, it rarely attends to the needs of the client as a mother, the needs of the family system or more specifically, to the needs of the children.

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http://aia.berkeley.edu

Risk Factors for Children

It is well-documented in the literature that children growing up in homes headed by a parent with co-occurring mental health and substance abuse disorders are at an increased risk for a multitude of psychosocial complications. These children are commonly exposed to ongoing stressors that can have a cumulative impact on their behavior and development (5). In fact, in a three-year longitudinal study, researchers found that the risk of child behavior problems increased with the number of areas in which the mother reported difficulties (6, 7). Unfortunately, in families with parental co-occurring disorders, multiple difficulties are commonplace.

Exposure to Violence and Trauma

Individuals with co-occurring disorders are more likely to have been exposed to violence than are individuals with either a mental health or substance abuse disorder. In fact, in a large nationwide sample, most co-occurring mothers reported having experienced violence in their lifetime (4). This abuse is commonly in the form of domestic violence. In a similar study, 67% of interviewed children who had a mother with a co-occurring disorder reported domestic violence in the home, compared to 22% of children living in a home with no mental illness or substance abuse (8). It is common for these children to witness violence and illegal activity in the home, and post-traumatic stress disorder (PTSD) is typical for both the children, as well as their mothers (9, 10). This trifecta of parental mental illness, substance abuse, and domestic violence brings with it a two to five times greater risk for: homelessness, use of food banks, lack of needed medical care, unreliable or unsafe child care, and placement in foster care of the children in the home (11).

Poverty

Over three-quarters of interviewed mothers diagnosed with a co-occurring disorder were living below the poverty line (12). Childhood poverty has been found to be a powerful risk factor for a wide range of poor outcomes in children from low birth-weight, delayed development, and cognitive deficits to poor earning power and major depressive disorder in adulthood (13).

Neglect

Neglect is a serious concern for children of parents with co-occurring disorders. Parental drug-seeking behaviors may result in inadequate or inappropriate care of the child. Children may be left alone for long periods of time in front of the television or with inconsistent supervision as parents seek their next high (3, 10). The child may be inconsistently fed and/or bathed, and placed at high risk for accidents due to the lack of parental supervision. In addition, some of the medications parents may take to combat their mental health diagnosis or substance abuse can make them lethargic, causing a lack of motivation to perform household tasks. Some parents choose to stop taking sedating medication, or may refuse it from the start, in an attempt to better care for their children. Unfortunately, in many cases, this often backfires when the parent becomes more symptomatic and less able to be present with their parenting responsibilities (10, 14).

Housing and Custodial Instability

An unstable living environment is common for children living in households affected by parental co-occurring disorders. Less than 40% of interviewed mothers remained the primary caregiver of their children throughout the first ten years of the child's life (15). In a nationwide study, 38% of children who had a parent with a co-occurring disorder reported experiencing residential instability, as defined by 2 or more residences in the past 3 months (5). While reasons for moving vary, research has shown that low-income families move frequently, generally resulting from unplanned or involuntary circumstances (16). For families with parental co-occurring disorders, these circumstances range from eviction and foreclosure to parental incarceration and institutionalization (12, 17). While these moves sometimes occur with the family unit, this special population of children tends to bounce around between caregivers, sometimes formally in the foster care system while a parent is incapacitated, sometimes informally with friends and extended family. Frequent moves tend to have negative impacts on child and family welfare, such as increased school absenteeism and a higher incidence of neighborhood problems (16). In addition, already fragile parent-child attachments are disrupted when the parent is incarcerated, institutionalized, or chooses to seek inpatient substance abuse or mental health treatment. The distress and anxiety that these children experience during periods of separation from their parents have been linked to a child's failure to thrive, depression, delinquency, and academic problems (18).

Effects on Children

Much research has been conducted on the singular effects of maternal depression, anxiety, or substance abuse on children. In contrast, considerably less research has been directed to the effects of parental co-occurring disorders on children. There are some things we do know, however, about the heightened risks these children face.

Mental Health/Substance Abuse Disorders

While healthy debate persists as to the extent of nature versus nurture in the onset of mental illness and substance abuse disorders, there is consensus that children living in households with a parent with a co-occurring disorder are at-risk on both fronts. They may be born with a genetic predisposition for substance abuse disorders and mental health issues, as well as experience daily exposure to an environment that may breed such disorders. One study found that 25-50% of children with a mentally ill parent will also experience some psychological disorder during childhood, adolescence, or adulthood (19). In a small sample of qualitative interviews, psychiatric diagnoses were found to be 1.5 times higher among children who had parents with co-occurring disorders, compared to children who had parents with no diagnosis or substance abuse only (20). A much larger study compared the outcomes of children of parents with substance abuse issues, mental health issues, or co-occurring disorders. The rates of substance abuse and internalizing disorders were highest among the children, ages 8-17, whose parents had a co-occurring disorder (2). In addition to feelings of grief, loss, sadness, anger, and depression, many children also reported feelings of anxiety and concern about possibly developing a diagnosis themselves one day (19).

Developmental Delays

These children are at great risk for developmental delays due to potential in-utero substance exposure, poor parent-child attachment, limited opportunities for appropriate child development activities, exposure to traumatic events, multiple transitions and caregivers, and possible neglect (4, 9, 12, 18, 19).

Stigma and Isolation

Isolation from peers, adults, and possible supports is common with these children, as they generally feel pressure to keep their parents' illness hidden (19, 20). If they do choose to share their situation, they are commonly met with stigma and judgment reinforcing their hesitance to reach out (20). This isolation can lead to a lack of informal and formal supports in the home, and the child feeling as if they need to care for the parent independently.

Parentification

Due to the parent's incapacity at times, many children in these homes are expected to perform household tasks that are not age-appropriate, such as caring for a younger sibling, making meals, doing laundry, and buying groceries. This phenomenon, known as parentification, further isolates the child keeping him/her busy after school and unable to relate to the care-free attitudes of peers (11, 17).

A Continuum of Services

Clearly these children could benefit from intervention services of their own. Despite that fact that research has highlighted the specific risk factors for these children as well as documented long-lasting effects of having a parent with a co-occurring disorder, there are minimal specialized services in place that take formal responsibility for primarily addressing the child's needs. Children generally only receive treatment once identified with problem behaviors, and this treatment tends to be time-limited and specific to the targeted behavior only, rarely taking into account the bigger picture. Knowing that they are at high-risk for a host of complications, an intervention at a single point in time is not sufficient to address the needs of these families. These children are living their lives in this environment, and may need various supports throughout their childhood. To support children who have parents with co-occurring disorders, the field needs a new tactic. An array of comprehensive family-centered prevention and intervention services that spans the prenatal stage through young adulthood is essential to adequately address the unique and complicated needs specific to children of parents with co-occurring disorders.

Prenatal/Postpartum Support

Offer Universal Screening

Pregnant mothers should be screened for illicit and prescribed substance use, as well as alcohol use, at each prenatal appointment. If a mother is found to have either a substance abuse disorder or mental illness, she should then be screened for co-occurring disorders. Clinicians should have supportive community referrals on hand to help mothers manage their symptoms during pregnancy, including referrals to integrated co-occurring treatment, case management, and public health nurses.

Supportive services to children affected by parental co-occurring disorders can begin in-utero. Chronic stress during pregnancy can result in atypical fetal development and decreased immune support, increasing the child's susceptibility to postnatal illnesses (21). The fetus of a woman with co-occurring disorders may also be exposed to illegal substances, as well as prescribed psychotropic medications used to alleviate maternal depression and anxiety. Working with a mother to reduce substance use during pregnancy combined with closely assessing and monitoring any prescription medications she may be on is critical to minimizing fetal abnormalities, reducing pre-term labor, and increasing infant birth weight, all of which can lead to physically, mentally, and emotionally healthier infants (22).

Provide Close Maternal Postpartum Monitoring

In-home supportive services, such as visits from public health nurses or high-risk home visitors, are especially helpful during the postpartum period.

Special attention needs to be paid to mothers with co-occurring disorders in the postpartum period. Hormonal changes that accompany pregnancy, delivery, and lactation may heighten the symptoms of a woman's mental illness, and may even bring on new psychiatric symptoms related to postpartum depression (23). This, combined with the added stress of parenting a newborn that may be especially fussy or challenging due to prenatal substance exposure, increases the risk that a mother will relapse or continue her substance use (22).

Infancy/Toddlerhood (0-4 years of age)

Strengthen Mother-Child Attachment

Evidence-based infant mental health services and home visitation programs work to increase the parent-child attachment in the home.

Substance exposed newborns often have an impaired ability to self-regulate. They tend to be fussier babies who may be difficult to soothe and have trouble feeding (24, 25). Simultaneously, a mother with a co-occurring disorder may have reduced capacity to read and respond to her child's cues, especially if she is actively using substances (12, 25). This combination can create challenges for the initial mother-infant bonding leading to poor parent-child attachment (24). In a small study, over four-fifths of infants with mothers with co-occurring disorders were insecurely attached (26). Poor attachment has been associated with a wide range of poor outcomes later in life, and linked to child maltreatment and neglect (24). On the contrary, a secure mother-child attachment can act as a strong protective factor helping to buffer a child from the multitude of risk factors and stressors described above (27, 28).

Evidence-Based Programs:

- *Early Head Start*
  http://www.ehsnrc.org/
- *Nurse Family Partnership*
  http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=88
- *Circle of Security*
  http://www.cebc4cw.org/program/circle-of-security/
- *Child Parent Psychotherapy*
  http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=194
- *Partners with Families and Children: Spokane*
  http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=163
- *Promoting First Relationships*
  http://www.pfrprogram.org/index.html
- *Healthy Families America*
  http://www.healthyfamiliesamerica.org/about_us/index.shtml

Find Family-friendly Residential Treatment Facilities
If inpatient services are needed, find a program that can accommodate mom and child (ren).

Mothering is often seen as a normalizing experience that connects women with others, and provides an individual with a specific role and purpose, as well as a source of hope for the future (4). Children are often the motivation parents need to seek out treatment. At the same time, parenting responsibilities are commonly listed as a top reason for women refusing inpatient treatment for co-occurring disorders (4). Even if a woman recognizes that she needs residential services, she frequently decides against it out of fear of losing custody of her children (4). Research has shown that facilities that provide residential care for mothers and their children have an easier time engaging and retaining women (29). Inpatient stays with mother and child (ren) also provide a unique venue for assessing parenting skills and the parent-child attachment, and providing intensive parenting interventions, developmentally appropriate stimulation for the child, and family therapy (30).

> ***"The attitude that recovery must come first and that women need their own space to recover and cannot concentrate on their recovery with children present reflects a lack of understanding of access issues, and of the fact that true recovery for a mother usually works only when it includes her children." Norma Finkelstein*** [6]

Young School Age (5-11)

Educate about Parent's Conditions
Help parents talk to their children about their co-occurring disorders, and educate the child about mental illness and substance abuse. Also, work with the parent to better understand the effects of her co-occurring disorders on her children (6).

By the time children affected by parental co-occurring disorders are in the early school age stage, they are aware that something is different in their family. This is a great time to begin educating children on their parents' co-occurring disorders. Children are still very egocentric at this age, and commonly feel they are responsible for the problems in their family (31). Knowledge is power, and children who understand that they are not to blame for the potential dysfunction in their families may not only release any guilt they feel, but also have a normalizing context for the potentially erratic and confusing behaviors of their parents.

- *The Blue Polar Bear*
  This book for children 5-7 years aims to assist workers, clinicians, and parents to introduce the issues of parental mental illness and substance misuse, explore concerns and encourage positive coping and help-seeking behaviors.
  http://www.community.nsw.gov.au/docswr/_assets/main/documents/dualdiagnosis_polar_bear.pdf

- *The Flying Dream*
  Written for children 8-12 years of age, this book can also be used with parents to help them understand their children's needs, and identify what they can do differently to assist their children.
  http://www.community.nsw.gov.au/docswr/_assets/main/documents/dualdiagnosis_flying_dream.pdf

Develop Support System for Child

Help child create a network of formal and informal supports.

Children who grow up in homes with parental co-occurring disorders appear to have limited resources to develop the skills and relationships that help buffer against the risk factors they face (32). One of the most important protective factors a child can have is a positive and stable relationship with a caring and positive adult (5). Interventions at this age should assist the child in identifying a personal support group that may consist of a combination of compassionate adults, such as aunts, uncles, older siblings, coaches, teachers, mentors, neighbors, therapists, social workers, or religious leaders (10, 20). This support group will also assist in easing the isolation and stigma the child may feel. The opportunity to talk to someone about personal feelings has been cited by these children as a simple, yet effective, way to feel more confident and supported (20).

Evidence-Based Programs:

- *Big Brother/Big Sister*
  http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=227
- *Across Ages*
  http://nrepp.samhsa.gov/ViewIntervention.aspx?id=138

Offer Support Groups

Coordinate with co-workers who are working with this population to offer skills-building and support groups for children of parents with co-occurring disorders.

For children who are struggling with isolation and difficulties relating to peers, a simple support group can be incredibly normalizing. It's also a wonderful place to help these children develop a set of skills they may be lacking, such as self-soothing, interpersonal communication, relaxation techniques, and assertiveness training (6). Since substance abuse and mental illness can break down family communication, the group leader can help the child verbalize feelings, and model appropriate expression of emotions (6).

It may also be beneficial to involve the parents in some group sessions. This structured environment can provide a safe place for families to talk about the "hard to talk about" issues, such as how the parent's substance use and mental illness affects the child (6).

Develop Safety Plan

Help parent and child work together to develop a safety plan for the child in case of emergency.

The unfortunate reality of parental co-occurring disorders is that emergency situations can and do arise that can put the child at-risk. Parental suicidal ideation or suicide attempt, active domestic violence, drug relapse or overdose, and acute psychiatric crises are ongoing realities for these children. Creating a safety plan that can be put into action in any of these situations helps protect the child and the parent (6). It can be as simple as having emergency phone numbers posted on a wall or entered into a cell phone, and as complex as written plans detailing steps the child should take in each situation the family can brainstorm. This safety plan should be revised often, and always take into account the developmental stage and ability of the child.

Encourage Family Togetherness

Assist family in identifying and engaging in recreational activities together.

In a qualitative interview of children living in homes with parental co-occurring disorders, the children overwhelmingly reported that they cherished the times their families were able to have fun together, and wished they had more opportunities to participate in normalizing family-fun activities (20). Encouraging families to get outside together on a regular basis can greatly reduce stress and infuse a sense of normalcy and silliness into an often serious and stressful family life.

Provide or Refer to Family Therapy

Interventions focused on strengthening the family can be particularly helpful at this stage.

Evidence-Based Programs:

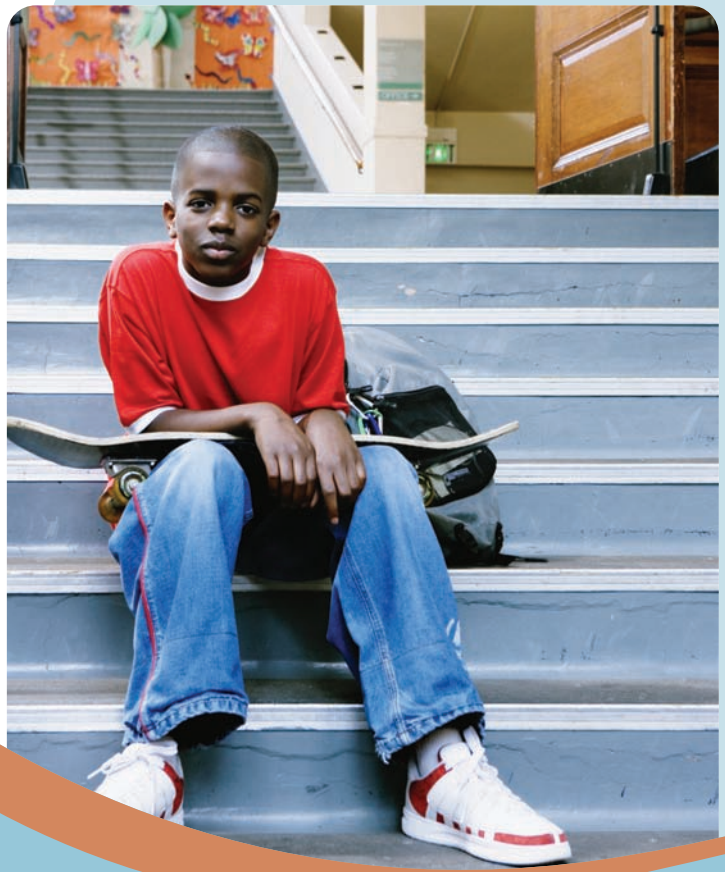
- *Parent Child Interaction Therapy (PCIT):* ***http://pcit.phhp.ufl.edu/***
- *Strengthening Families Program* ***http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=44***

Adolescence (12-18)

Many of the supports and interventions that are appropriate for young school-aged children are also appropriate for adolescents if they can be modified for an adolescent's maturity level.

Evidence-Based Programs:

- *Reconnecting Youth: A Peer Group Approach to Building Life Skills (RY)*
  http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=96
- *Coping with Stress*
  http://www.kpchr.org/research/public/acwd/acwd.html



Trauma-informed Support for Mothers

"If you don't meet your own needs, how can you meet the needs of another person?" Tanji Donald [17]

It's unrealistic to think you can holistically support a child without concurrently addressing the needs of the parent. A functional family system and optimal child functioning require that all members' needs are met. For women with co-occurring disorders, the role of trauma in parenting has to be addressed to adequately support the children in the home. One agency reported that over 60% of the women in their co-occurring treatment program had been physically or sexually abused (3). Mothers experiencing mental illness and addiction describe many of the challenges they experience in parenting as directly related to their trauma history (17). Specifically, women may: pay limited attention to the children due to a need to seek out safety (from trauma), have limited physical/emotional availability, struggle with trust issues, have a diminished capacity to empathize with the child, experience decreased intimacy with the child, lack positive parenting role models, and lack confidence in their ability to parent effectively (17). In addition to integrated treatment for their mental illness and addiction, mothers with co-occurring disorders can benefit from a multitude of ancillary trauma-informed interventions that will provide trickle down effects to the children.

Nurture Mothers

Utilize a strengths-based approach to help a mother develop psychosocial skills, such as self-esteem, self-mastery, and optimism.

Mothers with better psychosocial resources reported higher interaction scores on an assessment of parent-child attachment (27). Unfortunately, mothers receiving treatment for co-occurring disorders often describe feelings of inadequacy, low self-esteem, and doubt in their parenting ability (3).

Many of these women were never nurtured themselves, and have no conceptual framework for what a nurturing relationship might look like. Nurturing the mother is critical to helping her feel supported, while simultaneously learning how to nurture her children (17). Developing a strengths-based connection with the mother that models a positive and nurturing relationship can provide her with an opportunity to feel nurtured herself and recognize the invaluable role she plays in her child's life (3). Once a woman has the chance to address her own psychosocial needs, she is more able to take an active and positive role in learning effective parenting skills (17).

Offer Parenting Interventions

Offer trauma-informed parenting interventions and programs that provide tangible skills to participants.

Parenting interventions for this population should assist parents in understanding the impact of their substance use and mental illness on their family, and provide them with tools they can use to speak with their children about their disorders (17, 20). Many times, parents with co-occurring disorders are so distracted by their own issues, they are unaware of their children's developmental milestones, and may need assistance learning age-appropriate expectations and reactions as well as positive disciplining skills (24). Video-taping of the mother-child interaction can be especially helpful for mothers who can then review and process the tape with a supportive practitioner (15). The most effective parent training seems to be offered in the community where skills can be modeled, coached, and practiced in the setting where they will be used (33).

Evidence-Based Programs:

- *Nurturing Parenting Program*
  http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=171
- *Nurturing Program for Families in Substance Abuse Treatment and Recovery*
  http://nurturingparenting.com/ecommerce/category/1:3:5/
- *Triple P- Positive Parenting Program*
  http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=1

Assist with Basic Needs

Assess family's basic needs, and assist them in accessing needed resources.

For many parents affected by co-occurring disorders and living below the poverty line, providing adequate food and shelter for their family may be a more pressing concern than receiving treatment for addiction and mental illness (12). These families need help meeting their basic needs, such as food, housing, and clothing, as well as transportation, employment, healthcare, education, child care, and legal services (34). Providing housing assistance and needed clothing and furniture has been shown to effectively reduce the risk of substitute care placement, as well as repeated child maltreatment (35). Learning about community resources for basic needs such as Family Resource Centers, food banks, and subsidized housing lists can be invaluable to these families.

Link to Peer Support

Connect mother to a trained peer worker.

Peer mentors are effective in establishing relationships with women, providing support and encouragement, and modeling an appropriate supportive relationship (3). Peer support upon discharge from a program can also assist mothers in linking to services and developing family-friendly activities (6).

Supportive Interventions for All Stages

- *Work with parents to develop standby or temporary guardianship for their children should the parent need to be institutionalized, attend residential treatment, or become incarcerated (10).*
- *Assist parents in setting up a "medical home" for children, and ensure children are visiting the doctor regularly for well-checks, in addition to as-needed care.*
- *Build resiliency in the parent and the child by:*
  - Helping the parent develop consistent and predictable routines;
  - Linking both parent and child to a healthy relationship with a caring and competent adult;
  - Acknowledging the strengths of both the parents and the children (6).
- *Regularly conduct bio-psycho-social assessments and evaluations on all children in the home, and refer to needed services (18).*
- *Offer long-term (greater than one year) services to families affected by co-occurring disorders. They have been shown to have more lasting impact than short-term intensive services (33).*
- *Provide a multi-disciplinary integrated team to support the family including a peer worker, master's level clinician, case manager, and early childhood mental health specialist (36).*

Supportive Agency Practices

"Parents entering treatment for their own problems present providers with an unusual opportunity to disrupt intergenerational patterns of substance abuse, mental health problems, and violence through the delivery of prevention and treatment services to children along with parents" (5)

Very few agencies and organizations specifically target children of parents with co-occurring disorders. Instead, these children are accessing services at a multitude of locations. Even if an agency predominately serves adults with co-occurring disorders, a number of policies and practices can be adopted to provide comprehensive support to clients and their children. Agencies can:

- *Offer childcare services during a parent's outpatient treatment (10, 37);*
- *Integrate a parenting assessment into the intake procedure to determine if additional resources such as parenting interventions and family therapy may be warranted (9);*
- *Create policies for child visitation or co-habitation at residential treatment facilities whenever possible;*
- *Develop an emergency form that clients can complete with their case workers that describes the children in the home, chosen emergency caregivers, and special needs of the children should the parents become incapacitated for any reason (to download a sample form created by Mental Health America of Hawaii, visit* ***http://aia.berkeley.edu/media/pdf/crisis_plan.doc)***
- *Account and plan for the client's role as a parent when conducting treatment and discharge planning (9, 38).*

By adopting a continuum of care for children affected by parental co-occurring disorders, no single agency needs to be responsible for the full array of services. Instead, system-wide collaboration can occur to ensure that interventions are available and accessible at each stage of development for children like Peter. Operating in a vacuum is no longer sufficient. Supporting these children requires an understanding of the complexity of their strengths and needs, as well as a firm commitment to partner with local agencies and resources to fill in the gaps. The needs of the family affected by parental co-occurring disorders transcend neatly defined departments, disciplines, and organizational scopes. They demand the development of new partnerships, informal support networks, and a commitment to connecting systems that are not typically aligned.

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The National Abandoned Infants Assistance Resource Center's mission is to enhance the quality of social and health services delivered to children who are abandoned or at risk of abandonment due to the presence of drugs and/or HIV in the family by providing training, information, support, and resources to service providers who assist these children and their families. The Resource Center is located at the University of California at Berkeley, and is a service of the Children's Bureau.

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