

**DEINSTITUTIONALIZATION:
THE UNPLANNED PARENTING
PARADIGM**

By

Shannon Nancy Skogstad

A Thesis submitted to the Faculty of Graduate Studies
In partial fulfillment of the requirements for the Degree of

Master of Social Work

University of Manitoba
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ABSTRACT

This thesis examines two major unanticipated consequences of deinstitutionalization; one, the unexpected rise in the number of children born to mothers with mental illness and two, the continued resistance of the mental health system to address the lack of services to these mothers. Despite deinstitutionalization and the philosophy of integration, stigmatization and stereotypes of mentally ill women have remained entrenched by both the child welfare and mental health systems. These entrenched attitudes have had an impact on the willingness to accept that mentally ill women may want to and be able to parent their children. As a result, research and the development of appropriate services for these mothers have been almost nonexistent in Canada. A literature review reveals that the United States has begun to address this gap in service provision. The research questions for this study were developed from similar questions asked in one study conducted in the United States.

Using a triangulation of research methods, this study begins to examine the needs of mothers with mental illness in Winnipeg. First, a telephone survey of twenty-four social service agencies providing services to mothers and children was conducted. This survey

established there were no specialized parenting services for women with mental illness in Winnipeg. Second, three focus groups composed of child welfare, mental health and support workers working with mothers with mental illness, were facilitated to examine what they feel they need in order to provide services to these women. Finally, ten mothers with mental illness were interviewed to learn what they thought was needed in order to successfully parent.

The results of this research indicate that the child protection and mental health systems have contradictory mandates that will pose a challenge when these agencies begin the necessary collaboration to provide interagency support for this population of mothers. Mothers with mental illness expressed fear that their children would be apprehended because of their illness, and due to this fear many mothers withheld pertinent mental health information from their psychiatrists or any professionals that may have been working with them. Mothers with mental illness also reported they felt a need for a more comprehensive, stigma free service that would include specialized parenting programs, respite, counseling services and 'friendly visitors' to end the isolation. This research confirms that the situation in Winnipeg mirrors that of the research thus far - there remains a gap in service for mothers with mental illness.

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I dedicate this thesis to my inspiration, Nicole Thomas. Nicole is a role model for all young women who experience mental illness and want to parent. I would also like to acknowledge Nicole's parents for their dedication to Nicole and Emmit. Without their sacrifice, Nicole and Emmit would not continue to be a family.

I thank my daughter Kristal and son Sasha for the sacrifices they had to endure over the years while I continued my education. Finally, I thank my partner Katrina for her continued support and encouragement over the years.

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CHAPTER ONE

OVERVIEW OF THE STUDY

Working within the mental health and child welfare systems exposed me to many clinical and organizational challenges related to working with mothers who live with a mental illness. In fact, several women I worked with expressed a need for some kind of a program that would support them in their parenting role and not just focus on their illness or assume they are “crazy” and unable to parent.

My interest in this topic emerged from observations of mothers living with mental illness interacting with the existing child welfare system. While attempting to coordinate services for mentally ill mothers, I noticed a lack of available information and resources for these mothers. There clearly appeared to be a “gap” in service when working with mentally ill mothers. The “gap” in service not only affects the successful parenting abilities of the mentally ill mother, but the formulation of successful intervention plans by the service providers from both the child welfare system and the mental health system.

For example, one mother reported being sent to a parenting program by Child and Family Services and feeling uncomfortable, as she was unable to talk about her fear that the “voices” may return. Symptom management for this woman is an important component of parenting effectively. As she stated to me, “Could you imagine the look on the other mothers faces if I started to talk about

my schizophrenia?" Although this woman felt she learned some skills at this class, she also felt alone, as she could not discuss things that were important for her well being, such as identifying and monitoring for symptoms of schizophrenia. Another topic this woman felt she could not discuss was the side effects from the medications that often left her feeling ill thus affecting her energy level for parenting. There are many unique factors mothers with mental illness face each day while parenting. This particular woman is on a medication, which requires a blood test every week. Child-care is an issue when she travels many kilometers to the hospital by bus for these tests. This is but one of many complex issues that arise for mothers parenting and living with a mental illness.

Another woman with whom I worked reported that she has had a long antagonistic relationship with Child and Family Services. She felt that the child welfare system had no idea how to deal with her diagnosis of mental illness. Although she has recently voluntarily transferred permanent custody of her child to the child welfare agency, she was unable to make this decision until the mental health worker systematically aided her in making this important decision. A rarely utilized team approach involving the child welfare system and the mental health system enabled this mother to feel empowered in her difficult decision. Although the child is going to be adopted, the adoption is open and mom will remain involved with her child - a successful conclusion for both the mother and the child.

Historically, institutionalized women were not considered as candidates for parenthood. (Gamache, Tessler, & Nicholson, 1995). Unfortunately, these

women are still considered to be poor candidates for parenting and remain at risk of losing custody of their children through divorce, or by being removed by the child welfare authorities. Women living with severe mental illness are often advised to abstain from sex, use contraceptives, or have abortions if they become pregnant (Apfel & Handel, 1993).

The implementation of the Health and Mental Health Reform Policies within Canada in the 1970's moved people living with mental illness from an institutional to a community based service model (Wallace, 1992). Although the current rhetoric of mental health reform encompasses the concept of holistic, comprehensive, community care, a literature review reveals that most programs remain antiquated in their ideologies and approach to the rehabilitation of women living with mental illness who have children or are planning to have children.

Social work training and practice is based on a belief that all individuals should be able to live meaningful lives in their communities and access support services and resources that are needed and wanted. Strengthening community resources has and will always be an increasingly important role for social workers in promoting health and reducing the risk and vulnerability of at-risk groups. Mothers living with mental illness are individuals who should be able to live meaningful lives in their communities. Motherhood is traditionally an important social role and one that some women living with mental illness, with support, in recovery, can and do attain.

Ristock and Pennell (1996) provide a detailed view of what needs to be assessed and the considerations that ought to be addressed before going into

any sort of exploratory research. They connect the theme of empowerment with research in the following way:

Empowerment as an approach to community research means thinking consciously about power relations, cultural contexts, and social action. It is an approach to building knowledge that seeks to change the conditions of people's lives, both individually and collectively. It involves consulting or collaborating with diverse individuals, groups and communities as part of the process of illuminating people's lives and social issues. Fundamentally, it is a research that is 'committed to identifying, facilitating or creating contexts in which heretofore silent and isolated people, those who are "outsiders" in various settings, organizations and communities, gain understanding, voice and influence over decisions that affect their lives'. ...In the history of the feminist movement, the primary means of empowerment has been women's telling of their own stories.

This research is aimed at elucidating problems mentally ill women face when they enter the parenting phase of their lives. The research involved asking the mentally ill mothers what they feel they need in order to parent successfully, thus giving a voice to this population of women.

It is from within this context that this researcher developed the following research questions:

1. Are there any parenting support services in Winnipeg that have been developed specifically for mothers living with mental illness?
2. How do mothers living with mental illness experience existing parenting services and what do they see as necessary to support their parenting role?
3. How do the mental health and child welfare professionals feel about the current parenting services for mothers who are mentally ill? Do they feel they have the knowledge and programs necessary to work with this population of parent?

In order to respond to these questions exploratory research was conducted using the following research methodologies: telephone interviews, focus groups, and one-to-one interviews. The research identified the needs and expectations of all parties concerned. A descriptive summary of the research built the knowledge and information to lay the foundation for interventions designed for mentally ill mothers.

Upon undertaking a literature review it became evident that there is a lack of research related to mentally ill mothers and their parenting. Most literature on this topic is American, and although it may have some applicability, there is a glaring omission of Canadian content for services developed which target mentally ill mothers and their children. This research is intended to contribute to the limited body of research available within a Canadian context.

CHAPTER 2

REVIEW OF THE LITERATURE

This chapter provides an overview of some of the theoretical and practical research to date that has examined issues encountered by mothers with mental illness subsequent to deinstitutionalization.

Existing Literature on Mentally Ill Mothers

Historically due to institutionalization, pregnancy among women living with mental illness was assumed an unlikely event. In fact, through forced sterilization and the removal of children at birth it became impossible for mentally ill women to become mothers. According to Oyserman, Mowbray and Zemenchuk (1993), "this situation has substantially changed, due to the increase in community rather than hospital-based services; increased awareness of the rights of individuals with severe mental illness; and a rehabilitation policy focused on enabling persons with severe mental illness to carry on adult tasks such as having a job, maintaining family connections or raising children" (p. 189). Miller (1992) argues the mental health system failed to recognize that deinstitutionalization would lead to an increase in pregnancy among women with severe mental illness. There has been a dramatic increase in pregnancies among women living with mental illness, with no specific planning on how to address the unique needs of this high-risk group of women (pp. 170-176).

Nicholson and Blanch (1994) note that adults diagnosed with mental illness do experience normal desires to form intimate relationships and to raise children. Although women with severe mental illness are currently quite likely to

be mothers, most literature remains focused on their children, all but ignoring the parenting experiences of the mothers themselves (Anthony, Cohen & Farkas, 1990; Kuehnel, Liberman, Storzbach & Rose, 1990; Manitoba Health, 1996; Mowbray, Oyserman & Scott, 1995; Nicholson & Blanch, 1994; Schwab, Clark & Drake, 1991; Wallace, 1992). Wallace (1992) contends, "the often difficult, long-term psycho-social (as opposed to medical) supports for mothers with long-term disorders and the underlying stigma of long-term mental illness, have perhaps resulted in the very few attempts at research and treatment/support programs for people with long term disorders" (p. 5).

The guiding image of the mental health service system into the new millennium is 'recovery' from mental illness. According to Anthony (1993), recovery, "...involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (p. 22) and embraces the belief "...that any person with severe mental illness can grow beyond the limits imposed by his or her illness" (p. 23). The recovery vision acknowledges that mental impairments create significant functional limitations. Deinstitutionalization created a need for community support systems. These support systems need to recognize the impact of mental illness upon mothers with mental illness and require services beyond symptom management. This includes treatment, crisis intervention, case management, rehabilitation, enrichment, rights protection, basic support, and self-help. This process involves redefining the illness in the person's life and integrating the experience of mental illness to the point where it becomes only one aspect of life. Anthony (1993)

identifies recovery as a consumer-based task, which professionals do not control. Recovery involves the presence of people who believe in and support the consumer. Recovery occurs in spite of the episodic nature of mental illness because recovery changes the frequency and duration of symptoms. Anthony contends recovery is not a linear process. It is a process, which is dynamic and includes growth as well as setbacks. Frequently, the consequences of illness, including dysfunction, disability, and disadvantage, are more difficult to recover from than the illness itself.

With the seemingly endless bed closures in Manitoba and the government's commitment towards more community-based service provision, Anthony provides very valuable information for service providers. The concept of "recovery" as defined by Anthony is a common philosophy among mental health organizations and professionals. Although deinstitutionalization has occurred, institutionalization remains internalized for many of the chronically mentally ill, who, as a result may be lacking in paid work experience, basic living skills, social skills and the ability to function within their community. Because of this, unemployment, homelessness, discrimination, and poverty are common. Anthony asserts that remaining focused on the illness serves to perpetuate the hopelessness felt by consumers. This is a very important point for service providers to understand because recovery is not a linear process and symptoms may reoccur. We must remember this in order to facilitate consumers continuing in the recovery process rather than dwelling on any setbacks. Furthermore, in order that we as professionals support mothers with mental illness to participate

in the recovery process, child welfare agencies, as well as mental health agencies must have an in-depth understanding of this concept of recovery. Recovery is a dynamic process and requires a long-term commitment of support for the consumer. In order to facilitate a program with a commitment of having mentally ill mothers remain with their children this concept of recovery is paramount. We as a society would not think of alienating a woman living in remission from cancer when the cancer reappears. Perhaps the most important point made by Anthony is that recovery is the consumer's journey and that the task of the professional is to facilitate the process.

A study commissioned by Manitoba Health and conducted in Winnipeg by the Women and Mental Health Working Group (1996) identified that mothers with mental illness have no specific programs related to parenting and suggested one reason for this "gap in service" is that mental health literature has not addressed the issue of gender. Moreover, the mental health system has historically minimized the role of women as parents in spite of the fact women living with mental illness are more likely than men to have parenting responsibilities and are at high risk of losing their children specifically because of their illness. In fact, the working group found most literature which concerns itself with mothers is focused "either on the general clinical picture of women who suffer postpartum psychiatric disorders or on outcomes of children of deviant mothers" (p. 7). In addition, mental health professionals rarely, if ever, address a mental health consumer's concern about children. Coogan (1993) agrees, citing similar results from a study conducted with 25 women. The women, ages 25 to 64, were interviewed to

ascertain their specific service system needs, their relationship needs and whether or not their respective service providers were meeting their relationship needs. The results indicated that the women had relationship needs, as well as child-related needs and more often than not, these needs were not being met. In addition, the women reported high rates of sexual violence, sexual discrimination, and stigma due to a "mental label".

Catherine Medernack, the Consumer Consultant for an earlier study commissioned by Manitoba Health and conducted in Winnipeg (1996), states "There is a fundamental truth that must be acknowledged in order to consider the reality of mental illness - that mental illness and the associated stigma are great equalizers. Once people have a psychiatric label, they are generally relegated to a separate, genderless, asexual subspecies of 'CRAZY ITS' "(p. 11). There is a long-standing assumption, tied to cultural fears and the stigma of mental illness, that women with psychiatric disabilities are not fit parents.

Although, it is evidence of abuse and neglect, not mental illness, which legally defines a parent as unfit, the link between mental illness and child abuse is a foregone conclusion for many. According to Joanne Nicholson, Assistant Professor at the University of Massachusetts, "The assumption is made that a person would have to be 'crazy' to abuse a child, therefore, some people assume that all parents with a mental illness abuse their children" (1996, pp. 67-68). The assumption that mentally ill parents are more likely to abuse/and or neglect their children is simply unfounded. Studies (Justice & Justice, 1990; Melton, Petrila, Poythress, & Slobogin, 1987; Nicholson, 1994) have shown that few abusive and

neglecting parents are psychotic. In fact, Melton et al. (1987) determined that as few as 10% of the abusive and neglecting parents are psychotic. While some studies have shown that some parents who abuse and neglect their children may have a psychiatric diagnosis, mental illness has not been conclusively identified as the cause of the abuse and neglect (Egami, Ford, Greenfield, & Crum, 1996; Whipple & Webster-Stratton, 1991). Because psychiatric disorders are rarely confirmed or evaluated in abuse and neglect studies, it is difficult to determine the representative nature of selected findings and the significance of certain disorders (e.g., posttraumatic stress disorder) relative to other forms of distress. A study conducted by United States Department of Health and Human Services showed that, "while substantiated abuse and neglect complaints quadrupled in Massachusetts from 1986 to 1993, the cause was not an increase in mental illness but a rise in drug and alcohol abuse and unemployment" (Riechmann, 1996). Yarbrough (1997) contends mentally ill mothers "are still considered to be poor candidates for parenting and are at risk of losing custody of their children through divorce or through removal by the Department of Social Services (DSS), or are urged to voluntarily give their children up for adoption" (p. 7). Birthmothers reported they felt their families and mental health professionals, were unwitting agents of societal norms, and exerted considerable pressure on them to give up their babies (Sorosky, Baran, and Pannor, 1978). In one study conducted by Weinreb and Murphy (1988), seven of the eight birthmothers reported they were dissatisfied and disappointed with the services provided by helping professionals. As one woman stated, "If I could give any advice to mental health professionals,

it would be to tolerate and understand the enormity of the experience...Surrendering a baby is real event with real and profound feelings and is not a derivative of other issues. There needs to be literature and workshops that help therapists recognize that it is an event worth focusing on” (pp. 23-36).

Other studies show the mental health system is not the only group of professions feared by mothers who are mentally ill. One woman in a study conducted by Wallace (1992) cautioned,

... never should a single mom, a mentally ill mom, approach the SRS, (Social and Rehabilitative Services)¹ without having bona-fide, credible legal advice. They are not user friendly. That is number one. Number two, document everything, because believe you me, they will, and it doesn't come to the same animal. Number three; always be prepared to lose your children. What I was looking for was an advocate, someone well versed in mental illness, particularly manic depression. ...I will say that my worker had no idea what manic depression was. ...SRS had provided certain treatment goals that were inappropriate for a manic-depressive... (pp. 14-15)

A second woman in the same study explained that what really aggravated her when being hospitalized for suicide attempts during her pregnancy was when “everyone was really mainly worried about the baby, which was good, but I kept telling them, I needed to be worried about too ...because she's not going to be OK, if I'm not OK” (pp. 14-15). It is not surprising that Wallace (1992) reported that some women with severe mental illness are advised to avoid having children altogether, whether it be by abstaining from sex, using contraceptives or having abortions. The prospective mentally ill mother remains characterized as unfit by many.

¹ The name of one child welfare system in the United States.

Penfold and Walker (1986), discuss past psychiatric theories that commonly attribute family problems to the "bad mother". A "bad mother" fails to develop appropriate relationships in the family and is considered as unwilling or unable to meet her children's needs. The most blatant example given of a "bad mother" is the theory of the 'schizophrenogenic' mother who is "presented as domineering, nagging, hostile (Arieti, 1965), and ill (Bateson, Jackson, Healey & Weakland, 1956). Penfold and Walker (1986) note that historically, mothers of autistic children were described as "self-centered and cold (Despert, 1951; Kanner, 1943), annihilating and totally uncaring" (Mahler, 1952, p. 12). The authors note that although both these illnesses are known to be biochemical in origin, the old psychiatric theories are not forgotten.

Penfold and Walker (1986) contend psychiatry functions as a social regulator primarily because of psychiatry's unrecognized inter-relationship with social systems. They suggest that psychiatry participates in women's oppression, locating the problem within the individual woman and obscuring the subtle effects of powerful social structures. They argue, "Psychiatric theories often reflect and reinforce long standing beliefs about women's status and role, contribute to her devalued status, blame her for her difficulties, minimize violence against her and suggest that her behavior should be shaped so that she can conform to the traditional role" (p. 9).

Ehrenreich and English (1978) argue that motherhood has historically been institutionalized and prescribed by experts. They see this prescription as changing with the political and economic times. The authors particularly note the

point in history when children were freed from child labor in factories and placed at home with their mothers. They came under the observation of the child-raising experts, who had no material help to offer, only a steady barrage of advice, warning, and instructions to be followed by each woman in her isolation. It is from this time in history, the authors contend, that any perceived failures of the child have been linked to their 'pathological' mothers. A mother-blaming pattern developed and became firmly entrenched throughout the decades. Ehrenreich and English (1978) contend this child raising science came to view the "mothers not only as the major agents of child development, but also as the major obstacles to it" (pp. 184-185). Moreover, they insist, motherhood is an all-encompassing culturally defined institution that applies across all race and class lines. A mother is objectified - heterosexual, married, chaste, and self-sacrificing. Nowhere within the historical context of Ehrenreich and English's book, For her own good: 150 years of expert's advice to women, was there shown to be any flexibility afforded to women to accommodate the special needs some may require in order to parent. The prescription for motherhood is all encompassing crossing all abilities and disabilities, rich or poor, single or married.

The historical treatment within the societal institutions, in particular, the mental health and child welfare systems, have been less than ideal for all women. Notions of what behaviors constitute motherhood are firmly entrenched in social policies, which subtly form the social 'control' function in our societal institutions. Past and present, unintentional and intentional stigma, abuse, race, class and gender bias are the key variables to consider when working and

developing interventions with a group of women – especially a marginalized group of mentally ill women.

Women with severe mental illness are now more likely to become parents, yet, while the prognosis for rehabilitation and recovery has greatly improved, attitudes have not significantly changed. Miller (1992) notes there has been “a failure to assist with family planning, failure to recognize worsening mental health during pregnancy, inadequate planning for child custody, lack of access to service and omitted pelvic examinations” (p. 170).

In addition, the Women and Mental Health Working Group (1996) found there are gender differences in mental illness although the reasons for these differences are not always clear. Examples of gender differences include “women being more likely than men to receive psychiatric services¹, women experiencing ‘higher rates of abuse, more types of abuse and more severe abuse than the general population” (p. 2).

Nicholson, Geller, Fisher, and Dion (1993) conducted a study that reflects the lack of services available to families who are trying to parent young children and have at the same time, a serious mental illness. Nicholson et al.’s study, although conducted in the United States, substantiated the 1980’s research (Gerstein, 1984; Heseltine, 1983; Trainer & Church, 1984, Nelson & Earls, 1986), which concluded community services for mentally ill consumers tended to be fragmented and inadequate.

It is important to understand the difference between illness, symptoms and

¹ From 1995 to 1996 women made up approximately 60% of all provincial mental health service recipients in Manitoba.

side effects of psychotropic medications as well as symptoms of mental illness before assessing a mentally ill mother as neglecting her child/ren. An individual's ability to parent may be compromised by issues having to do with their illness rather than poor parenting skills. In such cases, specific symptom management training may be necessary to compensate for the symptoms and/or correlates of the mental illness itself. An example is the impact of mental illness on social functioning and parent interaction (Oyserman, Mowbray, & Zemencuk, 1993). For example, one of the typical symptoms of schizophrenia is a diminished capacity to respond to subtle social cues, especially non-verbal communication (Beels, 1981). Similarly, psychotropic medications can affect an individual's spontaneity and/or their physical expressiveness (Lieberman, Massel, Mosk, & Wong, 1985). Therefore, the mother living with schizophrenia who appears not to be responding to her baby's subtle clues may be in need of skill development rather than an assessment that she is neglecting or not bonding to her child. Once the impact of various symptoms of the illness and side effects of the psychotropic medications are identified, compensatory strategies for symptom management and relationship improvement can be developed.

Some clinicians contend that women with serious mental illness should avoid becoming pregnant because of the potential effects on the children or on the mother from the psychiatric medication taken or withheld during pregnancy and the postpartum period. However, there is a substantial body of literature regarding the side effects of psychiatric medication taken at those times which shows that the risks depend on the type of drug and when taken. Other studies

(Cohen, Sichel, Dimmock & Rosenbaum, 1994; Haynes, 1994; Cohen, Sichel, Dimmock & Rosenbaum, 1994; Pastuszak, Schick-Boschetto & Zuber et al, 1993; Rosenblatt & Rosenblatt, 1992; Mowbray, Zemencuk, & Oyserman, 1993; Miller, 1992) demonstrate that concerns regarding psychiatric medication should not automatically preclude pregnancy. Tucker (1994) contends that it is up to the mother and her treating physician to weigh the risk of an untreated psychiatric disorder against the risk of taking psychotropic drugs.

Other clinicians fear that pregnancy itself, or the postpartum period, will have adverse consequences on women's mental health. Some studies (Cohen, 1994; Cohen, Sichel, Dimmock & Rosenbaum, 1994; Pastuszak, Schick-Boschetto & Zuber, 1996; and Sichel, Cohen, Dimmock & Rosenbaum, 1993) do show that psychiatric symptoms can worsen and women can even risk the development of mental illness during pregnancy or the postpartum period. Conversely, pregnancy has also been shown to be "a time of relative protection from emergence or relapse of a psychiatric disorder" (Cohen, Sichel, Dimmock & Rosenbaum, 1994, p. 284).

Mentally ill women have also been discouraged from parenting because of the alleged effect of their mental illness on children, including behavioral and developmental problems. Some studies (Keitner & Miller, 1990; Patterson, 1990; White, Nicholson, Fisher, & Geller, 1995) on the children of parents with mental illness, especially depression, have revealed that the children have a full range of problems, including psychological and academic difficulties as well as health problems. However, other studies (Keitner & Miller, 1990; Keitner & Miller, 1990)

reveal that the problems derive not from the mental illness per se, but from circumstances resulting from the effects of their mental illness, such as poverty, family chaos, poor communication, and long term separation caused by their parents' hospitalization. Joanne Nicholson (1996) agrees stating that her extensive work with mentally ill mothers across Massachusetts has convinced her that "a person's ability to be a successful parent has less to do with diagnosis, and more to do with resources and support" (p. 66).

A study conducted by Nicholson and Blanch (1994) reflects the lack of services available to families who are trying to parent young children and have at the same time, a serious mental illness. Nicholson and Blanch sent out questionnaires specifically requesting information about mentally ill mothers who had children of preschool age. The State Health Authority Managers responded to the following questions about service in their state: (1) Are there residential programs for chronically mentally ill women and their children? (2) Are there programs that formally assess parenting skills? and (3) Are there outpatient services available that specifically focus on parenting skills? The study revealed that only two states, Nebraska and South Dakota, assessed parenting skills in any public sector rehabilitation services for the mentally ill. A second phase in this study involved obtaining similar information from program contact persons identified by state mental health authority managers. Written program descriptions and materials such as pamphlets that were supplied to clients were requested, as well as any other descriptive information available. Sixty-nine programs, from 19 states, responded in 1990 and 1991. Only 9 of 69 programs

focused on the specific needs of the mentally ill parents and/or their children. Moreover, goals were generally stated as the prevention of child abuse and neglect and the prevention of out-of-home placement, which suggested a child welfare orientation. Once again, the focus was on the child rather than incorporating the parent's needs. Of the nine programs, only two, the Madre Project in Shreveport, Louisiana and the Community Counseling Consultants in Clinton, Missouri, focused on the rehabilitation of the parent with mental illness (Nicholson & Blanch, 1994, pp. 109-119). The Madre Project in Louisiana is a residential program for women with a dual diagnosis of serious mental illness and substance abuse and their children. Here, parenting training is provided in the context of a comprehensive daily living skills program. The Community Counseling Consultants in Missouri is a community mental health center. Services are delivered from within the center, under the psychosocial rehabilitation component and case management unit. It is here that mentally ill women are taught skills related to parenting, education, child development, communication and negotiation, as well as, home maintenance and housekeeping.

Zemencuk, Rogosh and Mowbray (1995) conducted a study to find out just who these mothers living with mental illness are, how they function in the parenting role and their specific parenting needs. They interviewed forty-eight seriously mentally ill women in state facilities who ranged in age from 17-50 years old and had at least one child under the age of 13. The results indicated that the majority of women experienced risk factors that would be expected to

compromise any woman's parenting abilities. For example, they were of low socio economic status (SES), poorly educated, not married, had few social supports, had multiple hospitalizations, and had generally given birth at an early age. It was also noted that their current hospital treatment did not address any parenting needs. In fact, only a minority of treatment plans for these women even mentioned their children. In spite of a lack of acknowledgment that these women had children, it was discovered they had parenting skills that could have been supported and strengthened.

Another study by Wallace (1992) examined the implications of a psychiatric disability on women who parent. Using an interview format with three psychiatrically labeled women who were mothers, Wallace identified some commonalities of their experiences. According to Wallace, "...women with mental illness are at great risk of losing their children to adoption or foster care" as a result of "...a blanket assumption, tied in with our culture's fear and stigma around mental illness that women with psychiatric disabilities are not fit parents" (p. 32). This was clearly the case for the women interviewed who all felt that:

a) Their contact with the mental health system and child welfare system left them particularly vulnerable to losing their children making it unsafe to ask for assistance with parenting when they knew they needed it.

b) There was a dichotomy between taking care of the mother and taking care of the child in spite of the belief by the consumers that the health and well-being of the two were

intrinsically connected.

c) The label of mental illness tended to obscure an assessment of parenting ability and the focus becomes accumulating enough data to terminate parental rights (Wallace, 1992, pp. 31-32).

Wallace (1992) includes in her discussion some recommendations for systemic changes that would provide more support for women with chronic psychiatric disabilities in their parenting role. These include: recognition by mental health workers of the inadequacies of the current system and the need to advocate on behalf of consumers; increased education on reproduction, sexuality and contraception; increased and flexible community supports; the reformation of policy concerning the termination of parental rights; and increased participation of consumers in the planning of all of the aforementioned.

Wallace's (1992) article raises some very valid points. However, it could be questioned whether her recommendations are transferable to practice. The issue of mothers with chronic psychiatric illness is an area, which, is under-researched. Wallace contends this omission is indicative of a systemic disregard of women's health issues in general. She asserts that myths, fears and stigma still pervade our current views on mothers with mental illness and, that as professionals we need to distance ourselves from this and assess individual cases on an individual basis. Furthermore, she states there is a dichotomy between the needs of mothers and the needs of child(ren). Given the social climate described by Wallace, this is inevitable. Child protection workers are

mandated in law and are held accountable should a child be left in a situation that later proves to be unsafe. While Wallace suggests alternatives to placing the children of psychiatrically diagnosed women in care such as providing intensive in-home supports, this may be difficult to provide due to our current fiscal climate that embraces restraint in all areas of social service spending. Although Wallace calls for mental health workers to advocate on their client's behalf, one would wonder if this could happen without some systemic change specifically in regards to attitudes and myths towards mental illness. Finally, the women interviewed by Wallace were white, middle-class women who were committed to a parenting role, were able to articulate their feelings and perspectives and, at the time of the interviews, were managing their illness. As this sample included only three mothers, it would be impossible to generalize these experiences to those of all other psychiatrically disabled mothers.

More work is necessary in order to develop comprehensive treatment plans for specific mental illnesses. Motherhood can be an important rehabilitation opportunity for women with serious mental illness. However, it can also present grave hazards to women and their children - an issue that neither the mental health system, nor the child welfare system, can afford to ignore any longer.

The challenges faced by mothers living with mental illness require services that address generic parenting issues, e.g. behavior management and limit setting, as well as issues specific to managing an illness and parenting with a disability. Interventions need to be developed that match the learning styles

and interpersonal skill levels of the parents. Most of all, interventions must be developed that are "user friendly" and considered relevant to the mother living with mental illness. Nicholson (1996) notes that "parents might be more inclined to seek support from providers and programs not directly attached to the social service agencies charged with identifying child abuse and initiating legal proceedings" (p. 67). The fear of losing a child may prevent a woman from disclosing a pregnancy or parenting difficulties. Moreover, once a child is removed from the home, a mother's motivation to manage her illness may subside.

Existing Programs for Mothers with Mental Illness

To date, in the United States there has been some development of interventions and programs to accommodate mothers living with mental illness. Mary Ann Zeitz (1995) describes an innovative primary intervention program, which was developed in 1976, named the Mothers Project, offered in Chicago, Illinois, by the Thresholds' Psychosocial Rehabilitation Center. The Mother's Project, under the direction of Zeitz, offers its services to mothers with mental illness and their "at risk" children between birth and age five. The Mother's Project is program funded and operated jointly by the Department of Mental Health and the Department of Children and Family Services (DCFS). One piece of the mandate that is shared by both organizations is to work collaboratively "in the best interests of the child". Furthermore, the program assumes a child advocacy position that recognizes that the child is best cared for within the context of the child's own family. Although in Canada, the mandate for child

protection organizations mirrors "best interests" "criteria, the mental health organizations remain silent on children's interests.

Zeitz (1995) advised that participation in this program is either voluntary or court ordered and referrals are made from professionals in the community who assess the child's development to be at risk because of parental psychopathology. Therefore, the program works in collaboration with a number of inpatient and outpatient facilities.

Zeitz (1995) describes the essential feature of this treatment model as a holistic, case management system, which treats the family while focusing on the mother and child. Comprehensive services are offered which are agency, or center-based, as well as community-based and home-based. Of central importance is the recognition of parental mental illness and its impact on the family. The center-based program offers full psychosocial rehabilitation services to the parent including specialized groups such as a Mother's Therapy Group, Child Development Classes, Infant Group, Medication Attitudes, Parenting Skills, Family Milieu, Stress Management and Goals Group. In addition, there are therapeutic nursery services for the child. Moreover, each participant is offered a comprehensive program which includes employment, housing, social life, education and physical health while seeking to reduce unnecessary psychiatric hospitalizations.

Zeitz (1995) contends that the comprehensive services offered by the Mother's Program are cost effective when compared to the cost of hospitalization. For example, some mothers enter into this program with as

many as fifty prior psychiatric hospitalizations and often have no further re-hospitalizations during their three years of participation. According to Zeitz, (1995) for the entire agency, the average number of hospitalizations prior to participation in Thresholds is 6.9. Once entering the program the re-hospitalization rate of members active in the program is 15 per cent, as compared to the national average of the re-hospitalization rate of 35 per cent. According to the Mental Health Task Survey (1994), the cost to the state of Illinois would exceed \$8,000,000 for specialized substitute care for each year these children remain in foster care in Cook County alone (Achenbach, Howell, Quay, & Conners, 1994, p. 3). Historically, these children remain in long term foster care in the state of Illinois with a poor prognosis of reuniting with their families. Within Thresholds, with its holistic focus on psychosocial supports for families, the prognosis for the reunification of children with their families is much better. Zeitz presents a convincing argument, both financially and psychosocially, for the need for programs such as the Mother's Project. The program as described by the author is flexible and able to meet the families "where they're at".

The benefits of a more cost-effective delivery system extend far beyond the fiscal savings. How does one measure the cost to the family and the child in terms of repeated separations that may be unwarranted and could be avoided with adequate supportive services? In the Zeitz study the rate of hospitalization post program was not identified. From this study one could question whether child and parental outcomes were demonstrated by means other than the cost

analysis.

Another innovative project is the Emerson Family Project, a housing program developed in New York City for mental health consumers and their families. I personally visited this project in Brooklyn, New York, on July 25, 2002. Elizabeth Miller, the Program Director, and Denise Wharton, Program Director, gave me a tour of the project then agreed to answer any questions I might have. The project consists of 38 one and two bedroom suites with kitchens. There are 22 single units and 16 units dedicated to families that are currently intact. The single units are for parents who are working towards reunification with their children. The apartment complex has staff assigned to it twenty-four hours a day. The program provides permanent housing, case management and rehabilitation services. Service also includes counseling and coordination of mental health services as well as on-site crisis intervention. There is coordination of adult and child health care along with prevocational and supported employment skills training. The staff coordinates special needs services if needed as well as the education services for adults and children. Parenting skills programs and childcare are offered on site. For those who require it there is substance abuse counseling. Finally, the staff is trained to teach clients how to maximize state entitlement as well as teach rehabilitation skills for independent living.

The referrals for this program come from homeless shelters, transitional mental health programs, hospitals and other housing programs for individuals with mental illness. To qualify for admission, the parent must have a mental

illness as well as a history of homelessness. The person can also have a history of substance abuse but must be stable and drug free. Applicants pass through a two-stage interview process to make sure they understand the program and are appropriate for it. The individual must have custody (or be in the process of getting custody) of one or two children who may range in age from birth to eight years old. Clients are accepted from anywhere in New York State.

According to Yves Ades, director of New York's Institute of Community Living, single parents with mental illness are particularly vulnerable to homelessness (Leeper, 1998). In finding themselves homeless, people with mental illness who have children also find themselves childless as the welfare system identifies them and the tendency is to keep the children apart from the parent. Ades contends "it was not easy convincing the New York State Department of Mental Health - as we are providers of services to adults- to let us bring in the children...But we finally convinced them we would provide support for both parents and children" (Leeper, 1998, p. 4). The Emerson Family Project supplies the case manager and skills training and the rest of the support is facilitated through linkages with other agencies.

Latanya, a three year Emerson resident and single mother of two had both schizophrenia and substance abuse problems. She felt "having my kids back was a boost to me to get my life together" (Leeper, 1998, p. 12). Latanya is leaving the center soon. She notes, "The way you come to Emerson is not the way you go out" (Leeper, 1998, p. 12).

The Emerson Family Project is particularly enlightening as the focus of

this program is less on the illness, which cycles in and out, and more on stabilizing a person's daily life. As children are an important factor in women's lives, the program sought a solution to the dilemma of children placed in and out of care or in the worst-case scenario, being made permanent wards. The project is ground breaking in that it was developed in recognition that mentally ill parents want and need their children.

The Parenting Option Project (POP) is an innovative model for the development of rehabilitation strategies for parents with psychiatric disabilities (Yarbough, 1995). The University of Massachusetts Medical School (UMMS) Employment Options, Inc. (EO, Inc.), a clubhouse psychiatric rehabilitation program in Marlborough, Massachusetts and the Massachusetts Department of Mental Health (MA/DMH) formed an alliance to work together to describe the experiences of parents with psychiatric disabilities, identify their needs, and develop new rehabilitation techniques. Participatory action research is being employed to develop the following: (1) an education and skills training curriculum for parents with psychiatric disabilities; (2) a goal-setting and assessment tool for parents and their helping professionals; and (3) an evaluation of the Development Project.

The three-year grant allows UMMS, POP and DMH to identify the needs of parents with mental illness, establish a parent support group in six Massachusetts Clubhouses, and create a model curriculum for establishing parenting education programs for parents with mental illness. In addition, to aid in the research the grant also created four transitional employment positions for

clubhouse members.

Yarbough (1995) reports that focus groups related to the POP program have been conducted which provided the opportunity for mothers and mental health case managers to identify the needs of the mothers, as well as issues which may have an effect upon the parenting of the mothers. Both the mothers and the mental health case managers indicated that services for mentally ill mothers "were often irrelevant or not well integrated, with little attention paid to what parents want and need" (p. 8). For example, they felt that existing programs were often inappropriate or uncomfortable to attend for parents with psychiatric disabilities as they felt the content was oriented toward "normal" parents or parents' known to be child abusers. In addition, the existing programs are perceived as based on traditional clinical or early childhood educational models, which were developed for parents without disabilities. The mentally ill parents concluded that they felt the existing parenting programs were unresponsive to their unique needs. To date the program components developed include 24-hour support, home visits and a parent support group. In addition, staff supervises visits for parents who do not have custody of their children.

The Mother and Infant Development Program in Washington, D.C. "is a hospital-based, clinical program that focuses on the psychiatric needs of mothers and the prevention of psychopathology in their children. The mother-infant relationship is enhanced through a model of dyadic psychotherapy. Treatment is provided by therapists and treatment teams, working to help mothers achieve

clinical goals” (Nicholson, 1996, p. 67).

The Peanut Butter and Jelly Preschool in Albuquerque, New Mexico “meets the needs of children at risk and their parents who are mentally ill, who abuse substances, and who possibly abuse or neglect their children. Parent training and education occur in conjunction with therapeutic early intervention for infants and preschoolers. Home-based living skills’ training is provided to parents and their children through the Supported Living Program. The Family Intervention Program provides rural outreach to young parents. The Peanut Butter and Jelly staff includes teachers, other helping professionals and consultants” (Nicholson, 1996, p. 68).

Ashbury House is a federally funded supported housing demonstration project for mothers with mental illness and their children in San Francisco, California. Mothers retain custody of their children while they receive mental health services. The goals of the Ashbury House program are to stabilize at-risk families and provide an alternative to institutional care for mothers and children. Adult services include crisis stabilization, group and individual counseling, substance abuse interventions, vocational planning and work placement, parenting classes and support system development. Children receive attention through childcare services, groups and other activities (Nicholson, 1996).

The Mental Health Association of Orange County funds a project in Orange County, New York named the Invisible Children Project. This project accepts families where the parent has both a serious mental illness and young children. The entire family is seen as the client. Four apartment buildings have

been renovated to supply affordable housing to this population. The Mental Health Association staff are "on-call 24 hours-- and are called at all hours for help in dealing with hospitalizations, courts and other situations" (Office of Mental Health News, May, 1994, p. 10).

The Crystal Run Village is another project funded by the Mental Health Association of Orange County. The Crystal Run Village "is a non-profit organization which has begun a supported housing program for the families. Program staff and Mental Health Association staff review each case monthly, and work on solving system problems" (Office of Mental Health News {OMH}), May, 1994, p. 10).

Jane Patterson (1998), a social worker at the Queen Street Mental Health Centre in Toronto, writes "There is a recognition in the literature that people who have a mental illness and are parenting have needs that are missed" (p. 14). One specific area of concern cited as being problematic is the lack of formal access child welfare workers have to the mental health system thus rendering them powerless to provide proper services to the rising population of people parenting with mental illness. In addition, often the child welfare workers are expected to monitor mental status even though they are not trained to do so.

In an attempt to build bridges between the child welfare system and the mental health system, as well as create a working partnership between groups with similar policies, Alice Broughton of the Queen Street Mental Health Centre, organized an informal coalition. The group includes the Metro Children's Aid Society, the Catholic Children's Aid, Jewish Child and Family Services, Native

Child Welfare Agencies, along with people from the Clark Institute, Queen Street Mental Health Centre, Toronto General Hospital and a private psychiatrist. From this initiative, a proposal emerged to develop a Family Case Management Team. This team brings together individuals from the child welfare and mental health system thus enabling parents to link up to the professional help they need to manage their mental illness.

Paterson presents a convincing argument for the development of formal links between the child welfare system and the mental health system. Neither system is trained to holistically work with parents who have a mental illness. For example, if a child welfare worker is teamed up with a mental health worker, the mental health worker will help them recognize the signs and symptoms of mental illness and how that affects parenting. Therefore, the child welfare worker can determine how to address the specific parenting concerns brought about by illness and the mental health worker can identify symptoms and strategize how to deal with the symptoms. In essence, all parties involved benefit from the working relationship. Service systems that are working together to enhance an intervention will benefit both the parent with mental illness and the children being parented.

One dilemma to beware of is that with shrinking funding, child welfare may begin to rely on the mental health system to “monitor” risk to the child and the mental health system may rely on the child welfare system to monitor mental status. Therefore, any formalized amalgamated case management must be aware of the risk presented by the fiscal constraints of the past ten years, which

leave both mental health and child welfare workers with large caseloads and limited time.

Paterson's ideas of case management between the mental health and child welfare systems confirm there is a need for a protocol or agreement in order for the two systems to work together in a holistic way in order to meet the needs of both the mentally ill parent and their children. A dilemma that may arise is that the child welfare system is a mandated service and mental health services are not. A client's right to privacy is one issue with which to contend with. For example, the confidentiality of the participant of a mental health agency is more important than all but the mandated child welfare concerns. It is common knowledge that in Manitoba a participant receiving mental health care must be willing to share their health information. Should they decide not to share this information, their wishes are honored. This is different with child welfare services, which are mandated to request relevant information about a client with a child considered in need of protection. What the child protection agencies and the mental health agencies may not agree upon is what might be considered relevant information to share.

The final model identified here is Kidder Place, located on the east side of Vancouver. Kidder Place is an apartment building owed and operated by the Vancouver Mental Patients' Association. There are 11 suites, five one-bedroom units which are home to Single Independent Living clients and six two bedroom suites which are operating as an independent living program that provides safe, affordable, stable and supported housing to single mothers living with a serious

and persistent mental illness. A family cannot enter this program if either mom or child requires inpatient care or twenty-four hour supervision. A trained mental health outreach worker schedules appointments, Monday through Friday during regular hours, which supports the mentally ill resident's well being. There is also an emergency phone service for after hours. A mother is able to access parenting support and learns symptom management. Referrals for this program are accepted through Mental Health Residential Services, the British Columbia Women's Hospital, Mental Health Care teams, doctors and psychiatrists, and self-referrals. The overall goal of this program is to support a mother living with mental illness in the community in order to keep the family together.

One important factor gleaned from the literature review is that when service plans are developed for individual clients - adults or children- without considering family needs or constraints, services may be duplicated, fragmented, or considered irrelevant, thereby not wanted or followed by the participant.

Parenting is a very important and legitimate life role for women living with mental illness. As demonstrated by this literature review, there has been relatively little research conducted on the needs of the mothers living with mental illness in Canada. American research dominates the literature. It is my intent to address this gap in Canadian research by conducting exploratory research with a needs assessment component and to describe some of the expressed needs of the mothers living with mental illness in Winnipeg.

Perhaps from this research a negotiating process with social service funders can begin and as a result of the negotiations, policy, programs and

interventions be developed to include the expressed needs of the mothers with mental illness and enable more of them the opportunity to parent their children successfully.

Summary of the Literature Review

The authors who researched the needs of mothers with mental illness have identified that there was a serious omission in the planning of services post deinstitutionalization for this population. Those responsible for the planning of services did not envision women with mental illness assuming a parenting role. The research read demonstrated that the mental health system treats the "individual" in isolation all but ignoring their roles and relationships in life. For example, when a woman seeks assistance for mental health concerns she is rarely questioned about children or family. Nicholson (1993) found that "fewer than one-third of states routinely collected information about the parenting status of women in their care" (p. 485).

With improvements made to psychiatric medications, women with mental illness were now able to conceive and have children. The system did not anticipate this; therefore, many mentally ill women are having their children apprehended at birth. Services for mothers with mental illness and their children are extremely fragmented if there are any services at all.

This research highlights the fact that there is little to no coordination between the mental health and child welfare systems. There is a lack of Canadian research on the topic of mentally ill mothers parenting their children and in Canada, only one housing program in British Columbia that targets

mothers with mental illness was identified.

The needs of mothers with mental illness have been under-reported, under-serviced, and rarely documented in Canada. The impact of this omission has resulted in one group of citizens in Canada being denied the services and supports they are entitled to in order to successfully parent. Chapter 3 discusses the methodology of the research.

CHAPTER 3

METHODOLOGY

Researcher Bias

Ristock and Pennell (1996) wrote "In the context of research, the old feminist slogan 'the personal is political' means that we must start from the personal and indicate the ways in which our own locations and identities as researchers inform and shape the research process" (p. 67). My 'personal' situates me a white, middle aged, feminist woman who has a well-paying management job as well as my role as being enrolled in the Master of Social Work program. The mothers I interviewed had an average income of under \$15,000. At the time of interviewing the participants I was first a front line mental health worker, then changed jobs to become a front line child protection worker. Both these positions placed me a position of 'power over' the participants.

Kirby and McKenna (1989) referred to Westergaard and Resler's (1979) definition of power where they agree:

...real confusion can arise if the term 'power' is used only when speaking of dominance that subdues opposition, while dominance that is "legitimized" by lack of opposition is spoken of as "authority". Not only does the word authority "convey a misleading notion of dominance less absolute and more beneficent than "power", but 'no control could be firmer and more extensive than one which embraced the minds and will of its subjects so successfully that opposition never even reared its ugly head

(p. 34).

It from within the aforementioned understanding of 'power as authority' that I acknowledge my position within the research process. Ristock and Pennell (1996) aptly note "[n]ot acknowledging the researcher's power as 'discoverer' can be as disabling and patronizing for research participants as overestimating that power" (p. 71).

My position as researcher situated me as the person with power/authority. I had intimate knowledge of their personal struggles. I was perceived as the person who might be able to assist them in having a 'voice' in any future programming that might help them meet their needs as mothers; and for others the person who might be able to help them regain guardianship of their children. Therefore, I was committed not to 'speak for others', but as one "who can and must speak out for others" (Ristock & Pennell, 1996, p. 67). This power position also extended to the focus groups and in particular with the Level 3 support workers. I had arranged to give a presentation on parenting and mental illness following the Level 3 focus group interview. I was perceived as the expert and inherent in the 'expert' role is power/authority.

As stated earlier my initial interest in this subject began while working front line for both a mental health and child welfare agency and discovering there were no services specific to mentally ill mothers and their children. It is my belief that having front line experience in both mental health and child protection services places me in a unique position to understand and comment on some of the issues raised in this study.

Introduction

This research is exploratory as there is little literature on this topic in Canada. The methodology used was primarily qualitative. The information was gathered through telephone surveys, focus groups, and individual interviews. Multiple research methods were used in order to understand the context of this exploratory investigation from different points of view. Qualitative research methods were chosen for their strength in gathering information on a topic about which little is known. They are particularly effective during the initial exploratory phase of inquiry (Padgett, 1998). This study was designed to capture the “experiences” of mothers with mental illness and create meaning from it. Kirby and McKenna (1989) refer to this type of methodology as a “methodology of research from the margins”. They write, “Methods from the margins must focus on describing reality from the perspective of those who have traditionally been excluded as producers of research” (p. 65). As the intention was to examine the needs of the mothers living with mental illness, as well as the needs of the service providers, inherent in the research result is a needs assessment. When talking about a needs assessment “researchers often mean finding out what people require to meet some standard established by some experts” (Abbey-Livingston & Abbey, 1982, p. 15). The purpose of this study was to examine not only what the needs of the child welfare system and mental health system were, but to inquire and record what the mothers living with mental illness felt they needed in order to parent successfully.

Ristock and Pennell (1996) refer to this as "Grounding the Research" and define this as "ensuring that the study remains based in the research participants' realities" (p. 103). Feminist researchers use the terminology of "working from the margins" when including the 'voices' and 'real life experiences' of the women themselves. Kirby and McKenna (1989) explain that "in researching from the margins we are concerned with how research skills can enable people to create knowledge that will describe, explain and help change the world in which they live" (p. 17). In addition, Kirby and McKenna (1989) ascertain research from the margins is not research on people from the margins, but research by, for, and with them" (p. 28). The telephone questionnaire, as well as some of the questions for the mentally ill mothers were designed to discover whether or not there is a gap in parenting services and supports to mothers living with mental illness in Winnipeg. The overall goal of this research was twofold. First, this investigator wanted to add to the Canadian content of literature examining the needs of mothers living with mental illness, and second, provide research from which specific parenting programs can be developed for, and with input from, mothers living with mental illness. This research gives a voice to the forgotten women who have seen deinstitutionalization.

Research Design

Both qualitative and quantitative research methods were employed to glean the information necessary to answer the research questions. Qualitative and quantitative methods are not simply different ways of doing the same thing. Qualitative research focuses on specific situations or people and its emphasis is

on words rather than numbers (Maxwell, 1996). "The qualitative method emphasizes the depth of understanding and the deeper meaning of human experience that are used with the aim of generating theoretically rich observations" (Friedman, 1998, p. 4). Although the quantifiable research component is rudimentary and responses have been used descriptively, it is fundamental for this research project. This researcher hypothesized that there were no parenting services specifically for mothers with mental illness and their children in Winnipeg, Manitoba. The quantifiable component of the phone survey was used to verify this researcher's perspective by counting the number of organizations that provide parenting services specifically to mentally ill mothers.

Fenow and Cook (1991) suggest that combining research methods, "sometimes termed 'triangulation' (Denzin, 1978; Jick, 1979), permits researchers to "capture a more complete, holistic, and contextual portrayal..."(Jick, 1979, p. 603). Ristock and Pennell (1996) agree stating triangulation uses "multiple methods in order to obtain a more thorough coverage of a subject by viewing it from different angles. This can be achieved in two ways: by using different methods for different questions about the same topic, or by using different methods to explore the same set of questions" (p. 51). Triangulation by data source refers "to the use of different types of data as a means of corroboration" (Padgett, 1998, p. 98). Exploring and describing all the data collected will give a holistic richness to the research.

A benefit to triangulated methods is that this researcher "personalized" the data collection. For example, the population samples involved in this research

are diverse and the data collection method appropriate for a mother with mental illness may not be appropriate for the busy executive of a child welfare or mental health agency. In addition, what might be considered an appropriate data gathering tool for the busy executive may not be the best method for the child welfare and mental health service providers who may want some 'moral support' as they relive their work experiences with mothers with mental illness.

This researcher chose qualitative methods in order that the experiences of mothers with mental illness and the experiences of service providers working with them were heard, understood and can contribute to future planning and programming. Padgett (1998) states qualitative "studies are emic, capturing the respondents point of view rather than etic, seeking to explain from the perspective of an 'objective' outsider" (p. 8). Therefore, this research study would be considered emic in that the intent of the study is to make sense of the experiences of mothers living with mental illness and the social service providers who work with them.

Research Questions

The questions this research was developed to answer are as follows:

1. Are there any parenting support services in Winnipeg that have been developed specifically for mothers living with mental illness?
2. How do the mental health and child welfare professionals feel about the current parenting services for mothers who are mentally ill? A related question was: Do they feel they have the knowledge and programs necessary to work with this population of parents?
3. How do mothers living with mental illness experience the existing parenting services and what do they see as relevant to support their parenting role?

The research process was conducted using a triangulation of the data and was completed in the following manner:

- The first research question was answered by a telephone survey of organizations offering parenting groups as well as groups which work with the mentally ill (see Appendix A for telephone survey questions). The organizations were chosen out of the Winnipeg Contact Book¹. They were also chosen because this researcher knew that the selected agency worked with women and their children. Thus, the sampling method was purposive.

- The second question was answered by conducting three focus group interviews (see Appendix B for questions). One focus group was held with mental health professionals, another with child welfare professionals and the last was held with Level 3 support workers. To obtain the sample for the focus groups, this researcher first obtained permission from the proper authorities and then posted signs in their workplace. Volunteers then called this researcher and made a commitment to attend the focus group.

- The third question was answered by conducting ten interviews with mentally ill mothers. The definition used to identify a mentally ill mother was: a mother who had a formal diagnosis of mental illness (see Appendix C for interview questions). The sample was recruited in the following way: First, mental health and child welfare

¹ A booklet produce yearly by the United Way that lists all the programs and agencies in Winnipeg as well as Manitoba.

workers handed out pamphlets explaining the research to mothers with mental illness; and second, as women volunteered, they told other women who volunteered giving rise to what is referred to as a “snowball” approach to sample selection. The women were given a choice of where they would like to meet for the interview and choices ranged from their homes to my office. Each woman was given an honorarium of twenty dollars for their time.

The purpose of descriptive research is to describe and provide us with a higher level of knowledge. Marlow (1993) explains that “descriptive research can provide important fundamental information for establishing and developing social programs, but it is not primarily concerned with causes” (p. 25). A descriptive summary of the research completes the study.

Data Collection

This researcher incorporated three methods of data collection. The three methods were; 1) a telephone survey of twenty-four social service agencies; 2) three focus groups of social service providers who work with mothers with mental illness; and 3) ten in-depth interviews with mothers with mental illness.

The telephone survey contained the quantitative measure component and was focused on community-based social service agencies that were deemed likely to work with mentally ill mothers. This was a brief survey, five questions in total, and it was undertaken only to substantiate the underlying assumption of this research: there are no parenting programs in Winnipeg that provide services specifically to mothers with mental illness. The method of choosing the sample

was what is known of as purposeful sampling. A purposeful sampling is a “sampling in which people with particular characteristics are purposefully selected for inclusion in the sample” (Grinnell and Williams, 1990, p. 309). For example, for the purpose of the telephone survey all the individuals spoken to were employed in agencies that work with mothers and children in Winnipeg, Manitoba. The telephone questionnaire established that there are no specialized parenting services for mothers with mental illness as well as providing an overview of service currently offered specifically to mentally ill mothers in Winnipeg (see Appendix A). Three of the questions were slightly modified from those originally developed by Blanche and Nicholson (1994) and used in similar research conducted in Massachusetts. The modification was asking the interviewee to expand on the questions; for example, asking them if they saw a need for a specialized parenting program if they did not provide one. The social service agencies targeted for this survey, included services listed in the Winnipeg Contact Book that provided services to mothers and children. In addition, the sample included mental health providers who worked with mentally ill women.

The researcher identified herself and asked to be connected to the appropriate person in the agency about answering the questionnaire. The researcher explained the research project and how the results would be used. There was a verbal informed consent obtained before interviewing. The informed consent, congruent with ethical standards of the University of Manitoba’s Ethics Committee for telephone interviewing, was read and clarified with the agency respondent. Permission from each respondent was recorded. The respondent

was given an opportunity to ask questions and when completed, thanked for their participation. Twenty-four organizations were contacted for the phone surveys. The answers to the five brief quantitative questions were documented. This section of the survey verified the number of present services or programs specifically designed for mothers with mental illness in Winnipeg.

The questionnaire's three open-ended questions read as follows:

- Does the agency have any specialized programs that formally assess parenting skills of mentally ill mothers.
 - If yes, what is the nature of the service?
 - If no, do you see a need for a specialized service?
- Does the agency provide any specialized programs that directly focus on parenting skills for mentally ill mothers.
 - If yes, what is the nature of the service?
 - If no, do you see a need for a specialized service?
- How could their agency, and/or the network of family agencies best meet the service needs of mentally ill mothers and their children?

Answers to these three open-ended questions were transcribed for future analysis.

Three focus group interviews were conducted in order to collect data from the service providers working with mothers living with mental illness. The focus group interviews had specific questions that generated discussions to determine whether key informants who work with mentally ill mothers felt they have the

resources and skills to develop appropriate interventions (see Appendix B). Separate focus groups for child welfare workers, mental health workers and a group consisting of support service providers, were conducted. Rubin and Babbie (1997) contend "in a focus group, a small group of people (some recommend 12-15 people; others recommend no more than 8) are brought together in a room to engage in a guided discussion of a specific topic" (p. 573). Focus groups were chosen as they provide a group perspective relative to the research on the issue and the group can compare experiences and encourage each other to openly discuss concerns.

The samples for the three focus groups were chosen by contacting the various identified managers of a child protection agency, a mental health agency as well as an agency that provides respite to families. This researcher requested permission to hold focus groups at each of their respective worksites during a lunch hour. A sign was posted as to the time and topic and this researcher provided a contact phone number in case a potential participant had questions. The researcher conducted the focus groups over the lunch hour in order that the respondents had the choice of remaining anonymous to their coworkers and supervisors. One benefit to participating in the focus group discussion was that the agency, as well as the participants, were offered the opportunity to receive a summary report on the final research results. The posters requested that the workers who chose to participate would have experience in working with mentally ill mothers. As indicated, the sample approach is purposeful, in that the workers and volunteers would have to have worked with mothers who are mentally ill and

work for an agency that works with mothers and children. Both the mental health and Level 3 support workers' focus groups had eight participants. The focus group for the child protection workers had six participants.

The researcher introduced herself to the participants, distributed the informed consent forms, reviewed the informed consent form, and asked if there were any questions while they were signing their forms. The participants of the focus groups were given a copy of the questions for discussion as well as time to review them and reconsider their participation. The participants were then provided an opportunity to write their names and addresses down in order to receive a summary of the research. This researcher indicated her commitment to honoring each member's confidentiality and anonymity in so far as being identified in the research report. As well, an expectation for confidentiality and non-disclosure among members of each group was discussed and agreed to. The focus groups were audio taped and a summary of the discussion was composed.

The final method of data collection employed was ten standardized open-ended interviews (see Appendix C). Standardized open-ended interviews are used when "you want to ensure all interviews are conducted in a consistent, thorough manner-with a minimum of interviewer effects and biases. ...The standardized open-ended interview consists of questions that are written out in advance exactly the way they are to be asked in the interview" (Rubin and Babbie, 1997. p. 392). Although the questions were standardized, often the mothers would add comments and introduce topics which were not related to the

questions.

The participants for the interviews were chosen by non-probability sampling because not all the people in the population would have the same opportunity of being selected for the sample. The method of non-probability sampling employed was what is known as availability or convenience sampling. This is where the first mothers with mental illness who were available and willing to participate were included in the study (Grinnell & Williams, 1990). This type of sampling was necessary, as mentally ill mothers are not always willing or able to participate in such a study. The sample was chosen by posting signs in relevant agencies describing the research and requesting participation in the study. In addition, a request was made to social service providers from the child protection agencies, mental health services, and support services to pass on the request for participation in the research to possible subjects. Additional participants were obtained when one person in the study told another individual about the study and they agreed to be interviewed. This reflected a snowball approach to sampling. The sample was restricted to mothers who had a psychiatric diagnosis and were currently parenting children under 18 and/or had recently lost custody of their children by either apprehension or voluntary placement within the last three years. A pamphlet with the qualifying information was given to all people who recruited the sample. The posters as well as the pamphlets had the qualifying information on them.

The interview format included a non-identifying demographic page that included questions on age, diagnosis, partnership status, education level, and

services currently used (see Appendix C). Confidentiality as well as anonymity in reporting was assured and informed consent forms were reviewed and signed. The purpose of the interviews was to provide a "voice" to what mentally ill mothers felt they needed as far as service provision, and if receiving service, how relevant/appropriate they felt the services were in meeting their needs. The interviews were taped and transcribed.

Data Analysis

This researcher utilized a case study methodology for the analysis. This is one form of qualitative analysis. Creswell (1998) describes a case study as a ...qualitative research method, which studies a 'bounded system' with the focus being either the case or an issue that is illustrated by the case (or cases). ... A qualitative case study provides an in-depth study of this 'system' based on a diverse array of data collection materials, and the researcher situates this system or case within its larger 'context' or setting (p. 249).

The 'case' selected for study has boundaries, often bounded by time or place, and for the purpose of this research, the time is the time period after deinstitutionalization and the place is Winnipeg, Manitoba. A case also has interrelated parts that form a whole. The interrelated parts are: the mothers with mental illness; the agencies which were surveyed, and the focus group participants. Hence, the case to be studied is both 'bounded' and a system'.

This study is referred to as an 'instrumental case study' in that it focuses on a specific issue (deinstitutionalization) rather than on the case itself. The case

(mentally ill mothers, focus groups, and telephone surveys) deals with the issues faced by mentally ill mothers, and data was gathered from the mothers themselves, focus group interviews with professionals relating to this population and a telephone survey. These methods are a vehicle to better understand the issue (Stake, 1995). This researcher simply stated the facts about the case as were recorded from these key informants and this is referred to as the "description". This description was the first step in analyzing the data in this qualitative case study. This phase of the case analysis is referred to by Stake (1995) as the 'narrative description' and is evident in the story-like script used when describing the findings. Within this narrative description, patterns began to emerge. A pattern is an aspect of data analysis where patterns were established by searching for an association between two categories. This researcher was able to find the patterns in advance of the narrative by first clipping out each question and placing the answers in their respective "answer piles". After reading the answers to each question, this researcher was able to write potential categories on the margins of the answers. For example, if a person mentioned 'stigmatization', this word was written in the margins.

Following the description of each case this researcher was then able to analyze the data for specific themes. This was completed by combining the information into clusters of ideas and providing details that supported the themes. Stake (1995) refers to this element of the research as the 'development of the issues'. Once again, this investigator uses the example of the concept of stigmatization to illustrate this point. A number of the women discussed

stigmatization, the word was written in the margins and the details surrounding this 'stigmatization' became the support for the theme.

Once the issues, or themes were developed, a 'Cross Case Analysis' was conducted. Stake (1995) explains that a cross case analysis applies to a collective case where the researcher examines more than one case. In this study, the word 'case' as it is used in this context refers simply to the groups of informants. It involves examining the themes across the cases to determine themes that are common to all cases. The transcripts from the telephone survey questionnaire, the focus groups, and the mentally ill mothers were examined for common themes. Once again 'stigmatization' is used as an example of a theme. The transcripts show that many of the mentally ill mothers discussed issues around 'stigmatization'. Stigmatization had also been marked as a theme in the focus group transcripts as well as the telephone survey transcripts. Stigmatization, then, was a theme that emerged from all cases.

The only quantitative analysis utilized was the yes/no answer questions to determine whether or not there were organizations providing parenting programs specifically for mothers with mental illness.

Reliability and Validity

One needs to consider the reliability and validity of the measures as well as reliability and validity of the design. Data collected may be valid and reliable but the validity of results occurs only if the sampling is adequate and there are no biases within it. According to Ristock and Pennell (1996) "validity pertains to methodology and signifies the degree to which the research design yields

findings that provide an accurate picture of reality (Morawski, 1994) and are therefore generalizable beyond the research sample" (p. 49). Validity is also described as "the integrity and value of research; achieved through accountability both to the participants and to those who will be affected by the outcome" (Ristock & Pennell, 1996, p. 50). Bell (1993) contends validity "tells us whether an item measures or describes what it is supposed to measure or describe" (p. 65). In other words, "For our research to be valid, we must be able to say that what we describe is recognized by the research participants as so (Kirby & McKenna, 1989, p. 36).

Kirby and McKenna (1989) stated, "Reliability refers to the trust or confidence we have when speaking about the description and analysis of our data" (p. 35). They contend that in order for the research analysis to be reliable, the description must truly represent what was found; the description or analysis must be depended upon and the research participants should be able to see their experience in the research report.

Based on these arguments, one can conclude the telephone survey questions that have yes or no answers are both reliable and valid. For example, one question on the survey asks whether or not the agency provides specialized programming for mentally ill mothers and their children. The response was not subject to any changes, therefore, the question measures what it was intended to measure - whether or not the agency provided specialized programming for mothers with mental illness and their children in Winnipeg. Therefore, the data collected should be, by definition, both valid and reliable. However, reliability for

the open-ended questions might fluctuate depending on who responded within the organization surveyed. Due to the fact that it is unknown if all relevant agencies had been contacted, the results may not be generalizable to all the agencies in the city of Winnipeg.

Although the sample sizes of both the focus groups and mothers interviewed were small, the research design helped ensure they both have validity. The interviews and focus groups were taped and transcribed thus eliminating researcher bias in summarizing the data. An issue, which may have had an effect upon the validity of the data collected from the interviews with the mothers with mental illness, was whether she was at the time of the interview in crisis or having difficulty with symptom management. The same factors could also affect the reliability of the data. Therefore, the sample of mothers was restricted to women who were currently able to participate in the study. On the other hand, it is this population of mothers with mental illness that may be actively parenting; therefore, they may be more able to readily identify current social service or resource needs. The generalizability of this study to all mothers with mental illness who are currently parenting their children was limited by the sample size. However, the data collected likely reflects important perspectives that could be expanded upon in future studies.

Patti Lather's (1991) articulation of three types of validity is useful to understand. The first type of validity is called construct validity. Construct validity is explained as recognizing and confronting "the theoretical traditions within which we are operating and be willing to challenge and change them; in

other words, it demands flexibility in the research design (p. 50). Mothers with mental illness who were interviewed often had “stories” to tell which often led to longer than necessary answers to the researchers standardized questions. However, by being flexible this researcher learned more about the issues mentally ill women experience around parenting.

A second type of validity is face validity, which is defined as being related to construct validity in that “its purpose is to ensure that your work makes sense to others. It is achieved by checking your analysis, descriptions, and conclusions with at least some of the participants in your research; this is the kind of ‘reality check’ that is part of reflexivity” (Ristock & Pennell, 1996, p. 50). As this research is exploratory in nature there is no analysis per se – only a descriptive write up of the research. However, this researcher did ask a mother with mental illness to read the questions asked in the interview and suggest changes if she felt the questions were not relevant or offensive.

The final type of validity noted by Ristock and Pennell (1996) is termed catalytic validity which “is achieved when participants, and the broader community affected by the research, feel energized or re-oriented in some way by the project” (p. 50). Many mothers with mental illness who participated in the research expressed a sense of importance for their participation in the study. All ten of the mothers asked for a summary of the research and more than one offered to sign consent forms which would allow this researcher to use their real names. This researcher declined this offer and explained that the research design and informed consent forms had passed through the University of

Manitoba's Ethic's Committee and changes would delay the research process.

Both the focus group participants and the telephone survey participants expressed support for this research. All the participants who were involved in the focus groups and telephone surveys asked for a summary of the research results. This researcher also received a call from a mental health agency that had heard of the study and asked that they be forwarded a summary of the research results and also considers presenting the research at a meeting of workers and mental health consumers they would hold for this purpose. The broader community definitely appears to have been affected by this groundbreaking research.

Limitations of the Study

Discord remains among researchers about the usefulness of qualitative research. However, many supporters of this method consider it a valuable resource, particularly in exploratory research (Maxwell, 1996; Fonow and Cook, 1991; Ristock and Pennell, 1996).

The research study in its entirety was carefully designed to ensure internal validity, meaning that the conclusions drawn from the data are actually produced from the interviews and surveys. As it is this researcher's bias that there are no appropriate services for mothers living with mental illness, this researcher carefully formulated non-leading, open ended questions and topics for discussion by the mothers living with mental illness and the focus group participants.

A further limitation to this study is that it is restricted to mothers, not fathers, living with a mental illness. The literature reviewed stated that most

single parents who have a mental illness and have custody of their children are women. Therefore, this researcher chose to explore this population exclusively. Another study at a future date could be conducted which would investigate fathers with mental illness.

A further limitation to this study lies in the fact that this researcher only speaks English; therefore, the study was restricted to respondents who speak English. The inability to speak another language restricted the research to English speaking folks or immigrant women who can speak English fluently.

Reliability may be problematic if someone should try and replicate the interview results with the mothers with mental illness. The interview process itself may have changed the individual's perception of their experience. Therefore, a future researcher could possibly receive different answers from the respondents once they had the time to rethink their perceptions.

The participants in the study volunteered to participate and were assured they could drop out at any time. This researcher believes that all the participants were as honest as they felt they could be about their experiences considering some of them were interviewed during the time this investigator was working for a child protection agency.

Another limitation of the study is that the sample sizes were small and not necessarily generalizable to the larger population. This is why it would be important to involve a larger population of mentally ill mothers to participate in a study of this nature. A data collection method that might prove to be valuable would involve placing surveys in doctor's offices in order to identify, and hear

what more of the mothers with mental illness feel they need in order to parent their children.

The mothers with mental illness who participated in the study were well enough to be interviewed, and this may not be reflective of the mothers who would be served by specialized programming. On the other hand, this may be the very population who are able to parent their children.

A voice that is missing from this research is the children of mothers with mental illness. Perhaps further research could survey adult children of mentally ill mothers and ask, how in retrospect, they felt living with their mothers when they were growing up and what services they felt would have benefited both them and their mothers.

CHAPTER 4

RESULTS

In this chapter, findings from the telephone interviews will be presented first then findings from the three focus groups will be discussed and finally, the results of the interviews with mothers with mental illness will be presented.

Results from Telephone Survey

Twenty-four agencies were contacted and participated in this survey. Although all respondents agreed to participate in the survey, most were interrupted during our conversation. There were five questions and the yes and no portions of the survey were readily answered (see Appendix A). However, this researcher found that most of the respondents gave brief answers to the open-ended questions. The majority of the respondents frankly stated that they had not thought about specialized parenting services for mothers with mental illness and would need more time to think about what this service would look like.

The following questions were asked and the most common themes were included in the results. The definition of a mother with mental illness for the purpose of the survey was a mother who had a 'formal' diagnosis of mental illness.

The first question asked whether they provided services to mothers with mentally illness. Six organizations stated they did not think they had any mothers with mental illness within their groups and eighteen organizations stated they did have mothers with mental illness in their programs.

Question two asked if their respective agencies provided any specialized

residential services for mentally ill mothers and their children; all twenty-four of the respondents stated they did not provide any specialized residential services for mothers with mental illness and their children.

The third question asked if they had any specialized programs that formally assess parenting skills of mentally ill mothers, and if they answered no, did they see a need for a specialized program? Once again, all twenty-four agencies responded they did not have any specialized programs that formally assessed the parenting skills of mothers with mental illness. Twenty-one respondents felt there should be some kind of specialized service; however, most were unclear about what that service should look like. Two respondents said they did not think that there needed to be a specialized service and one respondent stated she did not know. The following responses are examples of the typical responses received: One response came from an Executive Director of a parenting program who stated:

I believe there is a need to assess the parenting skills of mentally ill parents as well as other parents who may be experiencing difficulties with parenting. We just don't have the room in our facility to add any more programs.

Other participants in the study viewed mental illness as a disability and they agreed with the following woman who explained she felt there is "...a need for a specialized service because severe mental illness is a disability which is different than other disabilities". On the other hand, some of the respondents felt mothers with mental illness simply needed services "to provide the mom with support". Two interviewees concluded this question in agreement "that they, (meaning mentally ill mothers) could simply "use the existing services".

Question number four asked if the agency provided any specialized programs that directly focused on parenting skills for mentally ill mothers and if they did, what the nature of the service provided was. Twenty-three respondents stated they did not have any programs that focus on parenting skills for mothers with mental illness. However, one representative of an agency reported they had a specialized program for mentally ill parents. She explained:

The service is open to medically or self-diagnosed parents with mental illness. The program does not directly focus on parenting skills; however, if the member of the group chooses parenting skills as a topic to be discussed, then parenting skills are discussed. The group picks the topics for the meetings. The main purpose of the group is to provide support for mentally ill mothers. It is more of a peer group support and is not a therapy group.

In other words, this was not a specialized parenting group for mothers with mental illness. The respondents who replied "no" to the question were asked if they saw a need for specialized parenting programs for mothers with mental illness. Fifteen of the respondents indicated they thought that mentally ill parents have special parenting needs. The consensus was that "... mentally ill people have special needs that ... could not be met in a 'regular' parenting group".

Five respondents felt there needed to be more support for mentally ill parents. The most typical response to the question about what supports were needed was summarized by one respondent who concluded:

There needs to be more supports for mentally ill people. They need more social support. This might be done by referring to appropriate services, for example, to counseling services or mental health groups.

Two interviewees indicated they would need to think about this further before giving an answer and one respondent thought mentally ill mothers could join existing parenting groups. Another simply said, "Mentally ill people may parent differently than other parents".

The fifth and last question asked the respondents how they thought their agency, and/or the network of family agencies could best meet the service needs of mentally ill mothers and their children. Overall most respondents to the telephone survey agreed that someone should develop a parenting program for mothers with mental illness. One person stated, "We need services specifically for mentally ill mothers". Another stated that she believed that agencies "need to create more "individualized" services for mentally ill mothers". Other people agreed, however, felt it was necessary to "...create a network and lobby for the money to develop specialized parenting programs for mentally ill mothers".

Another respondent stated and others agreed that:

Each agency needs to be able to identify women who are struggling with mental illness and then there has to be accommodation, or a place for these women to go in order to deal with their special parenting needs.

Other respondents had similar views and two of these responses are reproduced below:

- Winnipeg needs an agency that can provide, in-home supports, assistance with housework and childcare. There also needs to be counseling provided to mentally ill mothers who may be dealing with many unresolved issues. There needs to be support groups for moms, partners and children. There needs to be residential services that provide supportive living arrangements for moms and children.
- There needs to be a specialized parenting group for mentally ill mothers and they need to provide childcare while the mom is

participating in the program. I think that daycare has to be available for anyone who is mentally ill in order that they have the energy to parent for shorter periods. I don't think the programs should be therapy oriented. I think either the criteria should be medically or self diagnosed mental illness. Many people never get a formal diagnosis, yet are able to say they are "depressed".

Another participant stated:

There needs to be more people trained who can run specialized parenting groups for mentally ill moms and their children.

Two respondents agreed this research on the parenting needs of mentally ill mothers was important and needed to be completed. One participant concluded:

The research into this topic needs to be completed. Referrals for the groups can come from the hospitals, psychiatrists, and family doctors. I think this is a project that is worth doing and will save lots of money in the end.

The general sense this researcher got when speaking with the respondents to the survey was that they were very busy with their own programs and did not see this as a project they would be interested in developing. However, most respondents agreed that this would be a worthwhile project even though, all but one agency, had never thought of a specialized parenting program for mothers with mental illness before.

One organization in this sample offered a specialized parenting program to mothers with mental illness in the form of a support group that is not specifically a parenting group. However, the spokesperson for the organization clarified that should this group choose a 'parenting' topic, it would be added to the next agenda.

In summary, these results indicate general support for future specialized parenting programs.

Results from Focus Group Interviews

The focus group interviews were audio taped and transcribed. The answers from the interviews questions were cut out and placed into answer clusters. Next, data from the interviews was analyzed for common clusters of themes as well as unique experiences. The numerous themes were presented in the form of a dialogue. A detailed description of the focus group's discussion follows in order that most of the opinions be documented.

Child Protection Professionals

Six child protection workers attended the focus group for the child welfare staff. These workers included two of each of the following: intake workers, crisis response workers and family service workers. Therefore, the background experience of respondents was quite broad. When asked about their experiences working with mentally ill mothers and their children one worker began to describe a myriad of experiences and the other workers agreed and added their comments.

The most common theme expressed by the child protection workers was how closed they found the mental health system. One child protection worker stated:

My experience with working with a mother with mental illness is the mental health system itself is a very closed system...It becomes problematic when you're working with moms on an emergency basis. When you walk into a home and you know there is mental illness, but it is an issue in terms of voluntary services, if a person tells you that they are depressed then you get treated for depression, but if they choose not to have the services of mental health.

Another mental health professional agreed:

I think that's one of the biggest issues we face, the release of information. We don't have it. The mental health worker won't provide you with it unless the mom signs a release of information, but if the mom is extremely mentally ill, most of the time they won't. So how do you get that information in order to work successfully with the family? Or perhaps, there is no way that this mom should be parenting.

Other focus group respondents began to share their stories. One worker told the story of a client:

... in her late 30's and she had two kids. I didn't have access to her records, like she hadn't been to anybody, but she had been assessed as a child, as a minor with mental illness and I had no access to any information from her childhood or her youth when she was growing up which was impacting on how she was parenting now.

Tragedy was not uncommon to workers who had been in the field a long time.

One worker explained:

One woman was very seriously mentally ill, we found that out after the fact, and that was a real tragedy, we didn't have the information, the hospital refused to give it to us. Consequently, she killed her child.

Another theme identified as a barrier to working successfully with mothers with mental illness was the lack of willingness among the clients to accept mental health help from anyone. All of the workers agreed that at one time or another they had worked with clients similar to one worker who stated:

If a client would be willing to accept mental health information so that we could work cooperatively, it would be successful.

These responses reveal the child protection workers were concerned about the lack of cooperation with the mental health system and the stigma felt by mothers when it comes to the sharing of information. They believed that this lack of information has led to at least one child fatality in the past. The child

protection workers all agreed that they believe the mental health system needs to be more responsible in dealing with such cases, especially where the mother was diagnosed with severe and persistent mental illness.

The child protection workers wanted to share their stories with this researcher. The following stories are reflected below:

- Well her kids came into care and she refused to go for a mental health assessment which I was asking her, or rather the agency requested so that she could get her kids back, but she refused, so for a year and a half this went on where she just wouldn't go for an assessment, I mean, even the courts couldn't force her to go, so she ended up getting her kids returned to her, because the agency didn't have any proof that she had a mental illness because she wouldn't go for an assessment – and we couldn't get the information that would have helped from when she was a child.
- One thing we can do is an Abuse Intake Form and fax it to the police. They'll phone and say the alleged offender has no history of sexual assaulting children, but you might be interested in knowing that 5 years ago s/he 'killed a baby'. And the charge was stayed and there was no conviction. Now I think that's a very informal arrangement and the police are breaching their own protocol.
- I have a case right now where the mother is in the psych ward of the hospital and is also active with child abuse.

Most of the child welfare workers agreed there is a high risk to children's well being when information of past mental health concerns, as well as stayed charges are not shared with them. Currently the workers reported they have an informal arrangement to obtain some information however, they would not disclose 'their source'. They reported that, overall, they are never sure if they are going to get the information.

Several workers spoke of the problems related to mental illness and dual diagnosis; that is having the mental illness along with an addiction. They spoke

of the difficulty they had in trying to make useful intervention plans because they just could not get a sense of what was going on.

- We deal with many parents who are diagnosed with depression and many mothers are at some point diagnosed by their family doctors and put on some sort of medication but their issues are compounded with chemical abuse on top of it. There is a lot of pill taking that's going on, lot of administering of medication....
- In terms of people, you know, you know they're depressed, they're getting medication from their doctors opposed to their combining it with drinking or pot, so you know they're self medicating at times and everything is just going all over the place and we can't sort out what is what.

The child protection workers then began exchanging stories as to how to get information from the psychiatrist. The following response indicates a preferred method for getting information:

...when you get these moms and you write the psychiatrist, as long as they have a psychiatrist, or their doctor, a formal letter saying these are the concerns, is this mother capable of parenting their children, are there any concerns that the children might be danger, they have to answer, They have to respond because if anything happens they will be hung out to dry. So they will respond, (but) they won't give you that much information.

Another woman then added that she had been counseled by a child abuse police officer on ways to get information from the doctor or psychiatrist. The police officer suggested:

...that one of the things that police do to get that information or to get (patients) admitted in there, if there is a general mental health risk, is they'll take the client to the Health Sciences Centre or they'll contact the psychiatrist and ask for information and if they don't release it they will say, if it's at the hospital, can I have your name and your designation here in case anything happens. ...I need to document that I tried to have this client admitted. I think we have all tried that. Sometimes you have to be a little bit forceful.

One worker contemplated reasons why mothers with mental illness would not want to admit they had this illness to child protection workers. This worker appeared to be quite knowledgeable in mental health issues. She stated:

There still is such a stigma attached to being mentally ill, are not going to admit to that anyway. Because that can be very threatening in terms of like, can I look after my kids? And we still continue with all the myths of mental illness and we as professionals in many ways carry that out in practice by not, by not asking the questions, because we don't want to upset anybody, and we don't want to offend anybody but if we do then, what do we do with the information? We are dealing with so many women with depression and so many women that out of their own fear don't go to the doctor.

All the workers nodded their heads in agreement.

The child protection workers were then asked what their experiences were like working with outside social service providers when trying to access, what they had assessed as, appropriate resources for a mother with mental illness. The most common theme among the child protection workers was their inability to convince mothers to get a formal psychiatric assessment and if they were able to convince a mother to do so, the lack of available resources to actually get the assessment done. One worker explained and the other five child protection workers agreed:

It's easy to get an appointment for a child though, you can get an appointment for the child at the hospital for an assessment, but not for the mom or including the mom and a lot of the moms blame their kids and say well, my problems are the kids, but a lot of the children's problems might stem from the mom too, and she is not diagnosed either, but then they focus on the child and their acting out.

The child protection workers also believed that the mental health system does not work with them and the consequences of this lack of working

collaboratively often results in the children in these families remaining in unhealthy families. One worker contended:

There's an issue of working collaboratively and I don't always find it comes from mental health (worker) because it's usually the psychiatrist behind the mental health worker. You ask for a parent child assessment and that isn't going to come any day because there are only a handful of psychiatrists and they are full, busy people, just like the rest of us; but it is problematic in terms of helping care for kids and making the determination whether the child can remain in the family, and many, many kids remain in anguished families, and take on a lot of the mental illness of the parents, some of it hereditary, some of it has been learned behavior, and I just feel that not a whole lot gets done.

Another child protection worker stated that she found the hospital difficult to work with because she felt they were inconsistent in their treatment plans and this led to her having a very difficult time in making plans for this woman's children. She stated:

I find it very interesting though, (working) with somebody that is mentally ill, cause there is a fine line in what decisions they can make and what decisions they can't make, ... I had a mom last year who was taking her little one out with no clothes on to the phone booth, and someone noticed it and called it in. Then when she got into the hospital they became very protective as to how far she could make decisions around the child, and when she couldn't make a decision and that could change day to day. So it becomes very hard in talking service and plans for that child. I find working with the hospital, in terms of dealing with someone mentally ill, a very interesting experience to say the least.

Once again the child protection workers expressed their frustration at trying to work with the mental health system. They found the hospital staff inconsistent with their 'mutual' client, giving mixed messages around her ability to make parenting decisions. The workers also expressed disappointment over the

shortage of psychiatrists that led to long waiting periods for mother/child assessments - if they were able to get an appointment at all.

The next topic discussed was whether the child protection workers felt that their agency had provided them with enough training to work with mentally ill mothers and their children. All six of the workers said they did not receive any training on working with mothers with mental illness. The following responses clarify this fact:

- No, we didn't get any training.
- The agency doesn't give us any training, like give us a list of mental illnesses, symptoms, what to watch for, what to look for.
- You know, if you think back to competency based training there is nothing. You know, for kids there is that small piece but for adults there is nothing. But they certainly don't teach you how to work with adults.
- No, but if you go into a house that is very dirty, some people might think, oh this home's very dirty, and some people know that this is an indicator of depression, whereas someone who knows nothing about mental health might not know that this can be an indication of depression.

One worker did not think they needed training to work with mothers with mental illness:

I don't think you really need it (training) though. If somebody has a mental health problem, it's not very hard to tell. I don't think you need to diagnose that issue.

It appears this worker may not have fully understood the question, in that her response focused more on diagnosing mental illness rather than ongoing work with a mother and her children.

The social workers admitted they do not get training in how to work with mentally ill mothers. It appears that what knowledge they do have they acquired on their own.

This researcher then asked the child protection workers if they thought, mentally ill mothers and their children might have different service needs than that of mothers who are not mentally ill. The workers were divided on this question. Two of the six workers felt that it would be next to impossible for child protection workers to learn the "individualized" service needs for all disabilities.

One worker explained:

The thing is, around general parenting, some parenting is better than no parenting at all. I don't know that we can just keep breaking, breaking, breaking, [read fragmenting our services] to meet everybody's special needs. All people, or most people who attend court ordered parenting groups have issues like that anyway, so it's like, do you have a group for every special little group?

The other worker who agreed with her seemed to waiver somewhat on the value of specialized training:

I don't think they should have a group for every special group but I can see where it would be more acceptable to talking about an alcohol problem rather than the TV talking to you.

Another worker admitted that:

...if they [mothers with mental illness] don't fit in our little box, our little parenting group box, they have nothing [no parenting groups to attend] and they don't go to anything.

Another woman thought there should be a service for helping kids to understand about their mentally ill parents. This researcher informed them that there was a group for children to help them understand their parent's mental

illness and the Schizophrenia Society offered it. Once again, during this conversation the topic of the role of the mental health agencies arose:

...There is also the community in terms of mental health services; they need to come up with some support. I don't think it's always contingent upon this agency [child protection agency] that they need to meet everybody's needs. Mental health gets a big block of cash flow from the government.

All of the child protection workers at the group agreed with this statement. They went on to discuss shortcomings of mental health agencies when it comes to working with children. One worker noted that if a mother has to be admitted to a crisis unit and there is no one to take care of her children, the mental health workers call Child and Family Services. The worker stated she was annoyed because she felt that they could at least try and arrange some kind of crisis plan that would include the care of children in the event of hospitalization.

...It's like they [mental health workers] call us right away if their client has to go to the hospital or crisis unit and there is no one to take care of the children. You would think they would try and figure something out ahead of time so the kids aren't so traumatized.

Three of the other child protection workers agreed that the same thing had happened to them in the past and that they had thought this was a "natural" separation of services - child welfare for the children and mental health for the adults. They then began to discuss their assumptions and wondered why they would think this way, particularly if there were no child protection concerns brought forward other than mom having to go to the hospital because of her mental illness.

One child protection worker expressed anger that she was the one who has to make the hard decisions about apprehending children from mentally ill parents she knows are unable to parent and she was the one who sat and helped them through their grief:

I guess in terms of mentally ill mothers and children, the ones I've always struggled with is when you have to remove their kids and say they are not in a position to parent. Umm, and some maybe never be able to parent. ...It's me sitting up with the mom who just smokes one cigarette after another. No mental health worker would come to sit with her and go through the grieving process.

When the child welfare workers were asked if they thought that the services currently available to mentally ill mothers and their children provide for their special needs, the response was unanimous – 'no'. The child protection workers spoke of having to leave children in situations they believed might be dangerous because they could not obtain a psychiatric assessment on their mother. One worker informed this researcher that:

...if we have a family where we feel the children are at high risk because of mental health issues, in order to access service, we go through the whole waiting process. You end up leaving children in dicey situations, which is in conflict with our mandate.

Once again, the child protection workers pointed out the need for a more accessible mental health system.

The final question asked the child protection workers if they had anything they would like to discuss that they would see as helpful to this research. A few of the workers admitted they have a difficult time working with this population of parents. One worker even likened working with parents with mental illness to "trying to make sense out of insanity" and went on to describe feeling like

sometimes she never quite knows how to assess the situation after spending time with some of the mothers. Other workers agreed and one admitted to the group:

I think part of my problem is my own attitude towards mental health issues; I walk out of a home and say to myself, what a wing nut. I don't want to walk out of a home with this attitude so I am looking for some education. I want to walk into a home looking for a mental health issue, not a wing nut.

Comments from other workers were:

- I come out of there thinking, give me some alcohol. It takes every sense that I have in order to try and determine what are they trying to say, what does that mean. Sometimes it's like making sense out of insanity.
- ... In reality, I don't know those resources for mental health. You know what I mean, I know you can go to the adult crisis unit, I know you can phone them, I know you can talk to them, I know you can phone KLINIC, do you know what I mean. ... You can send them to the hospital, but unless they're going to commit suicide at that moment, at that time, or they're going to kill the doctor there, they let them go, they're fine.

The final discussion of the focus group involved the service separation between the adult and youth mental health systems. One worker summarized the conversation:

What I see as relevant is why is the service separate [referring to Adult and Youth mental health], why does the Adult only see the adult and the Youth only see the youth. Can't there be some sort of family connection, or therapy, like why is this kid like this, what's his mother like, instead of looking at them separately and isolated.

There appears to be a gap in service coordination between the adult and youth mental health systems.

In summary, the child protection workers were concerned they did not have the training necessary to work with mothers with mental illness. The workers understood that mothers with mental illness needed a more specialized case plan, however, without training about mental health issues specific to this population of mothers, they were ill equipped to develop these specialized case plans. Furthermore, child protection workers work in a stressful environment and have large caseloads with which to contend. These workers would need a lot of training in order to provide specialized case plans for mentally ill mothers. At least one of the workers in the focus group felt overwhelmed at the prospect of learning mental health as well as child welfare practices.

The child protection workers also found the mental health system closed to sharing information about clients they had in common. This is understandable when one thinks about the mandates of the two systems. Child protection professionals are mandated to gather all the information necessary to make the determination that a child is not at risk of abuse or neglect. On the other hand, mental health professionals are mandated to keeping the mental health information they have about a client confidential and many of their clients are parents.

Mental Health Professionals

Eight mental health professionals attended this researcher's focus group: two intensive case managers, two community mental health workers, three program of assertive community treatment (PACT) workers and one hospital psychiatric nurse. This researcher first asked them their experiences working

with mentally ill mothers and their children. One of the key issues that emerged was 'who' was their primary client. All eight workers agreed that they felt torn about their loyalty to their clients, who were mothers, and the mandated rights of their children. Occasionally they had to make difficult decisions that required them to uphold their mandated position of reporting any suspected child protection concerns. One mental health worker summarized the conversation:

I guess for myself I feel that I am just dealing with the moms, the kids are just there so it feels, ummm, I feel disconnected in what is going on with the kids, but you also feel this responsibility that you may need to report if something is going wrong, or I know, I feel that the moms are always worried that you are going to contact Child and Family Services. They are aware that you have this responsibility and so they give you the least amount of information about what is going on for the kids, so that you don't have to do something. I also don't think that moms think that you might have other options than CFS. It feels like you are only working with the mom, it's like you are working with the half when you should be working with the whole.

Another worker and carried the conversation a little further stating:

As a mental health professional, you usually get to work only with the identified patient.

A third worker joined in and quipped that because of the expectation that they work only with the mother:

...you may feel like you want to know as little as possible about the kids.

All the mental health professionals agreed that they felt somewhat uncomfortable when children were involved. As one worker noted:

That's the dilemma, who is your client? Often times the mother desperately want to raise the child, it's a conflict of interest, because you know that that baby, it may not be the best for the child, but your advocating for your client, it gets uncomfortable.

One respondent spoke about a situation where her client's child was apprehended. She had supervised visits that turned out to be disastrous because:

There are a lot of restrictions on the contact and (it was) very, very structured. ...and they can't deal with that much structure and that in the end, (this) ends up destroying any relationship they might want to have with the child.

When asked what their experiences were working with outside social service providers, one woman responded with this success story:

...one that sticks in my mind, is a young woman who was 18 or 19 when she got pregnant and the whole system, everyone thought she wouldn't be able to have the baby, or even carry it to term, let alone parent. The baby is now 6 months old and she is doing quite well. She has lots of supports and lots of supports were put into place. Natural supports and professional supports, although some of the natural supports were a dual edged sword, they were good in many ways, and in some ways quite harmful. But in the end they backed her up.

Another respondent spoke of having a good experience working with Child and Family Services, which led to her client being able to remain in her children's lives:

I've had some positive experiences with Child and Family. In one situation although the children had been apprehended permanently, the children were in foster care Monday to Friday, then mom had them weekends. We would meet monthly just to make sure everything was coordinated, and keep an eye on how things were going and I felt that was quite good.

One theme shared by all the mental health workers was the education they had to provide to other service providers because of the stigma related to mental health. One worker stated she felt like she spends a lot of her time educating service providers about mental illness. Because of the stigma she

ends up taking a strong advocacy role which she described as fighting an 'uphill battle'. She explained:

Because there is such a limited awareness of mental health issues by other service providers that are working with the kids, I end up usually taking a very strong advocacy role, an educational role and fighting a lot of stigma.

Other related comments included the following:

- There is a real stigma about mental health issues. Case management is difficult especially when dealing with the different mandates. The mandate of Child and Family services is looking out for the best interest of the child and most mental health mandates look at the individual and do not address the children's needs or interests.
- There is a conflict of interest. The Mental Health worker wants Child and Family Services to monitor---and vice-versa, and both systems become reluctant to get involved with the family. Child and Family is reluctant to get involved unless there are problems, so in a preventative way I have found them reluctant to get involved.
- I think C&FS has to overcome the stigma and look at prevention rather than apprehension all the time, and in the rural areas in situations where a mom has to go to the Crisis Stabilization Unit or the hospital, what do you do with these kids if C&FS isn't involved prior, and C&FS is not involved with the family, it's like 'why weren't they involved prior, if you saw this coming'? Child and Family Services only get involved when a child is at risk, which is their mandate. That's a struggle with C&FS, they do child protection, and have little opportunity for prevention.

The mental health focus group respondents then began to discuss the need for education, for everyone, including health care providers, about mental illness. They indicated that only by education could some of the stigma around mental illness begin to be addressed. Some comments made about educating people about mental illness included:

- I think we need to also talk about the fact that we need to educate people about mental illness: some people, there are some people who still believe that no one who has a major mental illness should be a parent, that's an automatic rejection, ...I think that some people need education.
- Even the people who are in the health care profession, even the doctors are like, the minute they are even contemplating a pregnancy, it's like no way, this shouldn't happen.

Another worker complained that she found it difficult coordinating services with the hospital staff when her client was in the hospital with a pregnancy-induced psychosis. She explained:

... she had a pregnancy induced psychosis so they delivered the baby and the psychosis remained. And I think there was a lot of need for role clarification in regards to what it was the outside agencies were going to be doing with the mom, while she was going to be in hospital with the baby, and what the staff would be doing. There wasn't a lot of communication. It was like this is what we are going to be doing and the staff would implement it, but not a lot of input as to how that would actually work on the acute care ward. ..so it made services sort of choppy for everybody and I think everybody got their backs up a bit because no one really knew ...how to work together. ...maybe meeting with the staff and saying this is what our plan is, and what our goals are. ...how can we do this together to make it easier for everybody and to support the mom and the family?

The focus group respondents then began discussing the reactions of the mothers whenever they hear the name Child and Family Services. All of the workers agreed that clients were afraid of being involved with Child and Family Services because they thought their children would be apprehended. One worker explained:

I think that it is a really common reaction when moms hear C&FS, right away that means my kid is going to be apprehended, they don't see them as support. So it's a difficult role to play as well because you wanting to provide enough information to your client and say you know, it doesn't have to be that scary, it's not always that way, and yet, you know, there is that potential. I just had to do that the other day, I

wanted her to be informed about what Child and Family could and couldn't do, but I also wanted her to be aware because at this point the kids, you know I mean, I don't think C&FS would have apprehended the kids but she is really struggling and we are looking at what resources could we plug in. So instantly I thought of Family Centre and Child and Family Services, ... the two games in town and it's sort of like I wanted her to know that if she chose C&FS they have a different role than Family Centre because they have the authority to apprehend.

All the workers agreed that C&FS were good in crisis situations. One respondent expressed this in the following way:

Child and Family Services are very good in crisis situations. A lot of the work I have done has been crisis work and when I have been working with families that have been in a crisis, they've been very good in responding and very quick to respond, and very helpful, when you didn't know what to do when mom got in a crisis

This worker acknowledged calling C&FS when her client went into crisis and she had no one to take care of her child. She did not think, nor did the other mental health workers think, that they should be expected to attempt to coordinate emergency care, in advance, for this woman's child.

When asked if they felt their respective workplaces had provided them with enough training to work with mentally ill mothers and their children, they answered with a unanimous 'no', just as the child welfare workers had. There were various explanations why they felt they did not receive any training to work with mothers and their children. Some examples of their explanations include the following:

- We don't have any moms with children in the ----program yet. There aren't any programs for moms and children, I know when I was taking my psych nursing training, a mom with children was a non-issue. We talked about the illness; we talked about the treatment, but nothing really about this. I think the big part about our training then was that there weren't the new anti-psychotics,

whereas more women are having children now, whereas 50 years ago, it was totally discouraged, well part of that was cultural too.

- A lot of the research has been on women who have postpartum depression/psychosis, not on the pre-existing mental illness of the women.

One worker then brought up stigmatization again. She felt that it was because of the stigmatization of the mentally ill, that people remember the bad press when it comes to mothers with mental illness. This worker stated:

I think part of the stigma we are talking about, lately in the press, it's always the tragic and horrific stories about mothers with mental illness, that kind of taints everybody – mothers who kill themselves and their children or entire family, and that's not the norm, and I think that's what is tied into that stigma.

The aforementioned statement appeared to prompt another concern from one of the mental health professionals. She stated she had been subpoenaed into court without being taught the proper protocol or what she was qualified to say. This worker stated:

...I've had the experience of being subpoenaed into court with a single mom and we are not taught, we have no guidelines in the program whatsoever, you know, how to react when you are called as a witness, and what we're qualified to comment on in terms of parenting; if your doing home visits and do observe mom, that needs to be clarified for all of us working in mental health.

The other respondents agreed, expressing fear that they too could be faced with a similar situation because they provide home visits to mom as it is easier for them to go to her than for her to come with the children to them. They reported there were not any accommodations provided at their workplaces for children should the mothers have to bring them with her. Their workplaces do not provide any change tables, toys – nothing! In fact, they stated they do not

have any car seats should they agree to accompany mom to an appointment and she has young children with her. The mother as a rule does not own a car and therefore, she does not have a car seat either. Workers reported borrowing their friend's car seats or using their own for such occasions.

The one last statement the mental health workers left this researcher with was:

Case management has to be carefully planned and there needs to be special programming and understanding for the mothers who are mentally ill.

In summary, the most common theme presented by the mental health focus group respondents was that of stigmatization. Overall, they felt they spent a lot of their time educating other service professionals about mental health and they reported feeling frustrated at having to provide this education on a full time basis.

Another theme presented was the frustration of the workers when working with mothers and children because of the inherent "individualized" nature of the mental health system. The workers reported their respective workplaces made no provisions for children should they come to an office appointment with their mothers. The mental health workers felt torn between working with the mothers and the competing 'best interests' of the children.

The respondents expressed ambivalence about their past work with Child and Family Services and most agreed they were helpful in a crisis. The crisis they mostly discussed was when a mother had to be admitted to the hospital,

and there was no one to care for the children, Child and Family Services would make alternative arrangements for the children.

Level 3 Support Workers

Eight Level 3 support workers from a Winnipeg agency that provides in home services to mothers and their children agreed to participate in a focus group. The Level 3 support workers' focus group was the most culturally diverse group of the focus groups. Approximately one third of the group came from a minority background. When asked what their experiences working with mentally ill mothers and their children one worker immediately began to describe one situation with which she had worked:

I was with a lady with bipolar and she was in bed for almost a year. People have a hard time understanding why she's in bed, like she must be lazy or they can't see it, so they don't have the empathy for her that she needed. So in the end when she started getting up and getting on with things, getting reinvolved with the children and that, she was really grateful to me for being there for her and we developed a really close bond.

This worker recognized the assumption some people make when a person is depressed and unable to get out of bed. She remained nonjudgmental while supporting her and never gave up hope for this woman's recovery. This worker also relayed what she cited as a not so successful story next:

Another time I was working with a family; she was severely depressed; that didn't end too well because she ended up overdosing when I was there.

The worker stated that she was traumatized after this happened and felt she could not go back and work with the woman without always wondering if she was going to overdose again. Another worker was placed in the home.

Another respondent spoke of her role in supporting a mother who ended up losing her children into foster care. She explained:

I had an experience where the mom ended up losing her children. It was very sad, she was very delightful, I don't know ...I didn't know what kind of mental illness she had, she never mentioned it to me, but ah, she, they were trying for quite a few years to stabilize her. She had gone through shock therapy that she shared with me, so it was very severe. ... but she had issues with anger too and she was taking it out on the children. And eventually I felt it was part of my role, which was tough, to help her to let go of the children and prepare her for them leaving. ... and that was scary because she talked a lot about suicide and having nothing left. ...so we worked very hard in trying to get her involved in some of the resources in the area. She did start to go out to church, that was one of the things she wanted to do. She was an AA member. At least there was a little bit in place for when the children were gone. ...we talked a lot about how bad she was going to feel when the children left. It was tough, tough on me too, to go through that. Someone had to walk her through that. I don't know how she's doing; I just hope they're all well. I had to break up a few fights with her, she would smack the kids, right in front of me. You know, she just couldn't help herself.

As this support worker spoke her voice broke and you could tell she was having difficulty reliving this experience. The rest of the group was supportive to this worker after she told her story. They validated her feelings, reassuring her that it must have been hard to work in this difficult situation and that the woman was lucky to have her.

This researcher found this group to be quite knowledgeable about mental health issues. For example, the group understood how cyclic mental illness could be. They accepted the fact that they may close a case because the mom is doing well, then three months later have to reopen the same case because the symptoms reoccurred. One worker stated in a matter of fact way:

...Stress also brings on symptoms that will trigger an episode, so it's not even their fault. And we accept that fact that families will need to come back for service.

The workers had many stories to tell and described both successful and unsuccessful, outcomes. Most of the success stories were similar in how they would support their clients who found it difficult to get out of their beds. All the support workers reported that they did not try to get them out of bed; they looked after the house and the children. In each story, the clients eventually were able to resume their role in the home.

One support worker described a situation that involved a woman who had flashbacks from childhood:

I was working with a lady who had flashbacks from child sexual abuse and she became severely depressed and she was doing a lot of self-mutilation. ...She was exposing a lot to me, it was hard to sit there and not freak out, to sit there and listen, to let her know that it was the people's fault and not hers. ...I was with her for about three years. We helped get her into counseling at Laurel Centre and things started getting better.

The support worker reported that for three years she worked with this woman even though a times she found it very emotionally draining. During these three years, the agency she works for helped find resources for her client to work on her childhood sexual abuse and things eventually did begin to get better.

The support workers were then asked what their experiences were when working with outside social service providers. The overwhelming theme in answering this question was they felt Child and Family Services did not support them. In fact, one of the support workers who had been working with one of her families for over a year reported that she had never met the Child and Family

Services social worker who was also working with this family. She stated she felt like she was doing the case management. She gave an example of contacting the children's school when they children were struggling. She explained:

I worked with Child and Family Services for a number of years, so I understand how busy they can be, but I always found that a lot of the support work that I did, this isn't a put down kind of thing, but I was out there doing the work. ...there was lots of times I didn't ever meet the social workers. I would be trying to call them, I needed to get in touch and it would be a year sometimes, and I had never even seen their face. ...and I would be writing all this stuff and never getting a response back. It was a bit frustrating because I felt like I was doing a social work job, I was contacting people, I was contacting schools, you know if the children were having difficulty in school, going into the school and talking with them. And it's not a put down for them because I realize how overwhelmed they are at times and there's been a lot of changes at Child and Family, and the resistance that they get from clients and the community, but at the same time it has got to be something better, cause it's really frustrating being a support worker and you're just run off your feet, like I could have worked 24 hours a day, and there were times that I did night shift, and the kids aren't sleeping, and you have another shift the next day.

The workers all agreed that at one time or another they had mutual clients with Child and Family Services and not once did the social worker ask to meet them. Some of the respondents did meet the social workers but this was an accidental meeting because the social workers would arrive at the house to see the client and they (i.e., the support workers) just happened to be there. Even when this happened, at no time did the social workers ask about how things were going.

The support workers spoke of the fact that there was never a shortage of work and sometimes they simply could not do any more. One worker stated:

I had a family, I was in contact with Child and Family because they were involved and I spoke a couple times with their social workers, and I phoned Macdonald Youth Services a couple of times over the two years. How did I find all the services? ... With Child and Family I was working 5 days a week and as much as I loved this family, I couldn't

keep going, and they needed to replace me, cause nobody here could go, there was a waiting list. Child and Family ended up getting someone to work in the home twenty-four hours a day. She would be there after school and overnight, which was good because the children, they needed consistency and I think that was wonderful that it worked out just before I left.

This support worker did not question the amount of service this woman was receiving to maintain the children in the home. In fact, after two years of working with this family five days a week, she was pleased the client received twenty-four hour in home support services, so the children could have consistency.

Another support worker then expressed concern around her observation that mothers were being medicated, yet not receiving any therapy to go along with the medication. She stated:

With mental illness and medication, I think it's a medication and therapy thing. I think I see a lot of women or men, go to their doctor and get medication and this is supposed to be the magic pill. ...the therapy is not done, either because of waiting lists or because people are just looking for whatever, some are looking for a magic pill to make everything all right.

The other support workers agreed. The respondents were asked if they felt their agency had provided them with enough training to work with mentally ill mothers and their children. Almost all of the workers felt they had access to enough resources to do their work. They also expressed that they felt supported by their supervisor. The following comments were made:

- Supervisors are really good, you know, you call them with a problem, like if you don't know what to do and I just call the supervisor and they put me in touch with whoever and whatever I need.
- I think we have enough training, I think we have enough support, cause if you have a problem or an issue, you just phone.

- We also have a little resource room that we can access at any time too, if we are looking for specific information and if it's not there we check with the supervisor.

One support worker felt working with mentally ill women is "... a learn as you go experience. Every home is different every person is different". Another respondent summed up the discussion this way: "I don't think you could ever have enough training, but we do have to work too". When the support workers were asked if they thought that mentally ill mothers and their children require different services than that of mothers who are not mentally ill, most of the workers thought that mothers with mental illness had challenges that other mothers did not. This was indicated by the following response:

A mother who is dealing with a mental illness is more complex than a mother who requires help with five kids and twins, so to speak.

Another support worker cautioned:

Absolutely, yes some they require different service, for some, it depends, for schizophrenia yes, for postpartum or bipolar, maybe not, it all depends on the individual.

Other workers then agreed that each case is so different and the services provided should be based on each individual case. A support worker who had not commented on this topic began to speak:

I say 'no' to the question. ...I was just thinking of someone who is clinically depressed and might have their social work degree and be a wonderful parent with skills, or a childcare worker who is struck with a mental illness. Now maybe the illness might impair them from proper childcare, but sometimes it may not, so you know this mother that I worked with, she's a wonderful mother. Now that she's in hospital she might need help, but when she's back home she needs support but she doesn't need parenting classes.

Another respondent added:

I guess someone with schizophrenia or borderline, or the more severe (diagnosis), who maybe shouldn't have conceived in the first place, because they couldn't care for the child might need special help but hopefully it's temporary, but when they're in for depression or bipolar, hopefully they will get their meds right and then they'll be on their way.

This statement indicates that at least one support worker thought that some women with mental illness should not have children.

This researcher asked the support workers if they thought the current services available to mentally ill mothers and their children provide for their special needs. The answers varied for this question. However, most agreed there was a gap in service for mothers with mental illness. Gaps in service were indicated by the following comments:

- I think there should be more programs that deal with the family as a whole, I don't know what, but if you talk with one person you're getting their opinions of what's going on, but on the whole family you would get a more rounder, opinion of what is actually going on in the home.
- There are no services that I know of that work with both mom and the children.

Another worker stated that she felt that there is a lack of service because of limited funding:

...A lack of funding is just creating such a need out there for more. But where do you get the money for it?

And once again the topic of stigma arose:

I have something whirling around in my mind, and I'm not that familiar with this topic, but there used to be sort of a stigma against mental illness. Diagnosis, I seem to be in a lot of homes where you think, 'is this mental illness here? Have they been diagnosed? Of course you want to suggest for them to see their doctors and you are flagging things, but at the same time I mean, I'm asking you, is there a lot of diagnosis? I am not seeing a lot of the mothers that have been

diagnosed or they're not telling me. ...women might not tell us because of the stigma.

This support worker is questioning why mothers, whom she feels are struggling with their mental health, are not getting the proper medical care she thinks they need. Or, as she so perceptively stated, "they're not telling me".

This researcher ended the focus group by asking if there were anything, they would like to add to this research. The one and only comment involved the lack of involving the husbands, if they had one, in the treatment plans.

I think we often fall into the trap, of doing our communicating with the mom and there is this dad out there, that goes to work everyday or something, and [we] really don't involve him.

This researcher found this group to have the most compassion about the plight of the mothers with mental illness. The predominant theme of this group was their understanding that mentally ill mothers, who lay in their beds all day, are not lazy, but sick. The group agreed that many outside workers expect these women to get up and look after their children and the house, and they are simply not able to do this. The group as a whole reported success, although sometimes it literally took years, of supporting mothers, in order for them to be able to resume their parenting roles.

Another theme, which emerged is the lack of communication between agencies that had mutual clients, most particularly between themselves and Child and Family Services. The support workers reported working extended periods of time with mutual clients and never meeting the assigned social worker from C&FS. There were no service coordination meetings held to discuss roles. The support workers expressed mentally ill women could benefit from having

specialized parenting programming, especially if it involved the entire family. However, they wondered where the funding would come from for such a program.

This researcher had earlier stated that this group of women was the most knowledgeable of mental health issues and had shown the most 'compassion' towards the mentally ill mothers. In retrospect, one wonders if the patience shown by the support workers towards the mentally ill mothers who did not want to get out of bed for months, was facilitated in part, because their mandate was not 'therapeutic' per se. The work of the support worker was to care for the children and sometimes the home. It is easier to support mentally ill mothers staying in bed if one is not expected, internally or externally, to produce some sort of 'therapeutic outcome'.

Results Of Interviews With Mentally Ill Mothers

Ten mothers with mental illness were interviewed for this research. They varied in age from 29 to 44. Eight of the ten mothers were Caucasian and two had two different ethnic backgrounds. Nine of the ten mothers interviewed were on their own with the children either because of being single, separated, or divorced. One mother remains married. The children ranged in age from two to twenty-nine years. Six women had full custody their children, three shared joint custody, and one woman did not have custody of her children. The average income level of the ten women was below \$15,000 dollars. Four of the ten women had less than a high school education, two women had completed undergraduate degrees, one had attended trade school, and three had

completed high school. Eight of the ten mothers were living on welfare and the other two were employed professionals. Nine of the ten women had a primary diagnosis of depression or bipolar. Only one woman interviewed had a diagnosis of schizophrenia.

When asked if the mothers felt they were ready to parent at the time they got pregnant, six of the ten women felt they were not. When asked what they felt they could or could not do, five women stated they thought at that time they were too young to parent. Three mothers felt they could do nothing, and one woman was not sure why she could not parent but she knew she was not ready. When asked if they felt ready to parent now, five mothers felt they were, three even now thought they were not ready to parent and two mothers were unsure.

All ten mothers were currently involved with the mental health system at the time they were interviewed, however, only one of the mothers reported she was involved with the mental health system at the time of the birth of her first child. A wide variety of mental health services were reported to be utilized by the mothers. One interviewee was involved with The Canadian Mental Health Association - Options in Support and Housing, four had Community Mental Health workers, two were involved with Intensive Case Management workers, and one respondent had a psychiatric nurse therapist at the Health Sciences Hospital. Three were involved with Laurel Centre, one mother was working with the Elizabeth Fry anger management options, and all but one interviewee had a psychiatrist. Eight of the ten women have used either Sara Riel or The Salvation Army Crisis Stabilization Unit. One woman reported using Seneca House, which

is a consumer-operated Safe House. Three women reported they did not like the location of, and felt afraid of the people using, The Salvation Army Crisis Stabilization unit. One woman said she found the people running the unit wonderful, however, she felt unsafe, particularly with one of the clients. She reported:

It's a really nice place and they are very nice people there, but there are some different people there. I didn't feel safe, there was just one guy in particular; he was really creepy, every time I went to smoke, every time I went into the little room, he would just show up. And that didn't give me a very good feeling.

Often a mother was involved with more than one of the aforementioned services. In fact, one mother felt overwhelmed with all the services involved and reported:

I was involved with a Community Mental Health worker for a little while, but I had so many people looking after me that I said that's enough.

When asked what was the most helpful service they received from the mental health system there were a variety of responses:

- I think when, the most helpful was when I would crash, they were there to help me get through it. Like at least to have someone to talk to, somewhere to go where I felt safe.
- I would have to go even on two: CMHA and Laurel Centre. ...because the counseling I received there has always been there to help me cope and help me understand when things are normal or not normal; whether my fears are realistic or something I am doing to myself again. ...CMHA taught me that life is more than sitting in the house, go out and look for a job and find one.
- The worker at CMHA... reporting it (calling Intake with concerns) to Child and Family Services. ...Lots of people would say to me that was the worst thing that could have happened in the whole world. ...but, look at little Eric¹, that is the most important thing here.

¹ Name changed to protect the identity of the mother and child.

- A worker at the Canadian Mental Health Association, and I am not just saying this, but I don't think just everybody would have done what this worker did for me. ...I mean, she helped me meet basic needs, basic living needs, finding a wonderful place to live. I couldn't have even hoped for a place like this. I mean advocating for me with the system, which I was unable to do. I could barely leave a message, before, I would call my worker after hours if I had a problem and leave a message. So advocating for me, you know, special needs which I have...and talking to me like a real person, taking me out for coffee, that relaxed me, his worker validated me in a lot of ways that a lot of people haven't.
- ...the support, feeling supported and teaching me where to go.

Four of the ten mothers found counseling to be the most helpful service when dealing with past issues.

When asked what was the least helpful service they had received from the mental health system five of the ten mothers reported feeling like the psychiatrist was not listening to them and one woman articulated that for her:

The least helpful was going to see the psychiatrist every week, and then once a month, it just felt like, I felt like this is bullshit. He would sit there and it didn't really feel like he was listening, so you didn't really connect with your psychiatrist.

Another mother spoke about how she felt ignored by her psychiatrist and invalidated as a parent by her social worker during a stay at the hospital:

I would have to say my stay at the Grace Hospital. All that did was turn me off and make the problem worse. ...My psychiatrist talked to me for ten minutes, twice and I was in for a week. ...I asked the social worker to make arrangements to see my kids, because I wanted to talk to them, I wanted them to know I loved them and it was important. ...Nothing was done, I did not see my kids, ...it was hard. And then when I got home, they were gone, and I didn't know what kind of damage was done.

A mother reported she did not think that her mental health professional understood how important her children were for her and remembered:

Being told I have to detach myself from my kids, so how do you detach so that's what, she's having a hard time dealing with me because I am saying, I don't know how to detach from my kids, I live for my kids, that's all I've got going for me, sort of, you know?

The literature review revealed that mothers who participated in the research reported that they felt that being a parent was not validated by the mental health system. Some of the mothers interviewed by this researcher reported they felt the same.

Three of the ten women stated they were satisfied with the services they received from the mental health system. When asked what services they thought the mental health system could provide that would help them as a parent, six of the ten mothers felt that having someone on call to contact regarding day to day child care issues as well as having respite care for the children would have helped them a lot:

- ...having someone safe to touch base with about basic day-to-day needs. ...there is nothing really out there for when you say I'm really not feeling good, I need someone to be with the kids just to relieve some of the pressure that I am feeling.
- ...if I'm having a bad couple of days or a bad week or something, that I would have some kind of support out there that could sort of just, step in, like the Family Centre of Winnipeg, on an emergency basis. ...but Family Centre does not provide service on an emergency basis.

One woman wondered if there could be special groups where:

...you would have a set curriculum, where you start off getting to know each other, then the therapist talks about different illnesses and different, you know, symptoms, and explaining to everyone that this is not something to be ashamed of, it's something you have, and want to learn how to manage it.

Another woman spoke of being in a Taking Charge group and not knowing if they understood depression: She stated:

...they know me as a single parent, they don't know me as depressed. My counselor knows I am depressed, and there is a second person who knows about my depression, but I don't want them to know that I have this problem. ...I don't tell them that I was depressed and I don't tell them that I was in the hospital.

When asked why she does not want them to know about her depression she reported feeling more comfortable talking about parenting issues when she participated in a group at Seven Oaks Hospital.

Six of the ten mothers reported being involved with Child and Family Services (C&FS) at one time or another. Most of the services provided by C&FS were reported to be focused on child protection rather than on early intervention or support. One mother did report having reunification services after her child had been apprehended, two women had been provided with homemaking services when they had to be hospitalized, and one woman reported being involved with the Adoptions unit of Child and Family Services when two of her children were placed for adoption. She reported that she voluntarily placed her first child for adoption and Child and Family Services apprehended her second child at birth. She explained:

...the first child, yes and that was for adoption, I was too young, that was my decision, and I wasn't going to get any help from my family anyway. ...and the second child was apprehended the day after she was born. ...I had a very bad delivery. ...I had two blood transfusions, my daughter and I almost died. The next morning the nurses came in, the doctors came in, the interns came in, the baby came in, everybody is in the room, I told them to get to hell out of here, and somebody heard me yell from the hallway and reported me to hospital services. Child and Family Services apprehended my daughter and they put her up for adoption.

Another woman was confused about why Child and Family services took her second child. She explained:

...it wasn't until the time that I bumped my head that they got involved. I don't know why that they came and took Rorie¹, I had someone that was competent taking care of him. Even though I had a concussion, they took him into care. ...I guess they didn't trust the person that was living with me. ...and then my ex came back and started crap, he was only in care for the weekend and we got him back.

Child and Family Services became involved with a third woman when she was married to a man who was abusive to both her and the children. She told this researcher:

...he was very abusive, he lost his parental rights to the children, the court took them away. ...I testified against him. ...he can't have any children in his care because he went on to have more children and he abused them too. He broke our oldest child's leg when she was just six weeks old, that's how they (C&FS) became involved.

Another woman disclosed a similar story of abuse:

...in court they had said that I had to go through parenting courses, so I went through the parenting classes. They wanted me to get anger management. I said I'm not angry about anything. I need some counseling, I need some help here, nobody's willing to do anything to help me feel better about myself. I've been abused, I've been told I'm a piece of garbage, that nobody would ever want me, I've been physically abused, sexually abused, and mentally abused by my husband and nobody would do anything to help me, to deal with all that. ... they gave him custody of the kids, they told him that they were going to give him custody, that they weren't going to give the kids back to me.

A third woman explained she also tried to get help from Child and Family Services. She wanted counseling for her children and herself because of abuse.

The help she ultimately received was the children were eventually apprehended:

1 Name changed to protect the identity of the child.

...the oldest one was seven at the time and she was very angry and upset that her father wasn't around and she began acting out. I went to Child and Family Services and said, listen, I really need some help, I need help to try and explain to her that it was not her fault that her father left. I needed counseling for her, I needed counseling for me, I needed counseling for my son, cause he was smart, he knew, he would see my ex husband beating me, he would come and hold me and say mommy, it's ok, it's ok, and then I don't know exactly what happened, but one day Child and Family Services came into my house and took all my kids. ...they said I was neglecting them, that someone had called and said I was abusing them, neglecting them, not physically abusing them, but verbally and mentally abusing them. ...and I said like how am I doing this, I'm showing the children that they are still being loved, they're getting food, they're getting loved, they're being taken care of, they've got clothes, they've got formula, they are not short of anything. ...and then you people just come into my house and rip them out of my arms, like what's going on here. No one ever, ever, explained.

Four of the mothers with mental illness found the most helpful service provided by the child welfare system was the homemaking services. One mother remembered:

- They had someone come in five days a week to help me learn how to be a mother, but to them they used me as a example, on film to show young moms, young teens how to parent. They told me I was overqualified as a mother, but if I wanted them for another six months that was ok. I thought why not, that gives me a little rest with a newborn and I was sick at the time. I had to have my gall bladder out and I had cancer. I got help for a whole year.
- The most helpful? It was when a homemaker, actually to help me clean and keep things up...she was very straightforward and honest with me, she was very supportive, we got close.
- When I had a severe migraine and had no one to take care of the kids. I called Child and Family services and they came right away so I could go to the emergency ward for help. I was in such pain, I will never forget how they helped me at this time.
- Having a worker come to my house that I could talk to about my son. I found it helpful when I had the worker who spent time with me. ... I felt so alone until then.

Another woman reported that the tangible things she received from Child and Family Services were the most helpful. She stated that she really appreciated having taxis which were provided to her because of physical difficulties. She had attended parenting classes, however, did not find them helpful to her. She also reported being grateful for the homemakers who were provided to her because of her physical illness.

These respondents reported the least helpful service provided by Child and Family Services was the not the service per se, but the feeling of being judged, not only by the child protection workers, but the support staff sent to them by Child and Family Services. One mother reminisced:

Sometimes I felt like I was being judged. Like when I would tell the worker that sometimes I didn't have the energy to attend parent/teacher interview, I kind of felt the worker was judging my parenting and not understanding how I was feeling at the time. I sometimes wonder if you have to have depression in order to understand depression, or at least have some knowledge of it.

Two other women expressed a similar complaint:

- They are very judgmental, they always say the child comes first and all that, well, I never got to come first, I raised my daughter for seven years, no problems, now its just like shoot first and talk later, they didn't give me no help, no nothing. ...they don't listen, they just shoot first and ask questions later.
- I felt judged, and I felt bad because I had done everything I could possibly do for my children to protect them, I've been back and forth to court with my ex-husband. I hear from him every three years, he just keeps going.

Child and Family Services were thought of as providing service to the children but expecting mothers to be able to fix their own problems. An interviewee illustrates stating:

They were supposed to help me cope with the abuse, they didn't help me cope with the abuse, all I got was taken out for lunches, my daughter got therapy, I didn't get dick! ...They kept saying do this women's group stuff...I said no, I don't want to hear their problems, and I've got my own problems. I wanted one on one counseling.

For another respondent the least helpful service she received was when she attended a meeting with her workers and they indicated to her that they didn't think she could handle the baby on her own. She was currently living with her parents after ending an abusive relationship with the father of the child. She said they told her:

...'that we are going to have to take it slow because we don't think you can handle it'. Oh ya, they told me because my ex was the primary care giver when we were together. ... I told them that he was drunk everyday, I was really upset at that meeting, I sat there and balled my eyes out, they didn't explain anything to me. They just basically said we don't think you can handle it—without giving me a chance. What hurt [me] was, they believed him [a drunk] over me.

The aforementioned mother had gone to this appointment alone. Her parents had advocated for her and apparently, there had been some confusion over what had been stated. It appeared the workers had said they wanted to move slowly but not in the context this mother had understood. This is one reason why it is essential for mothers with mental illness, especially schizophrenia, to have an advocate attend these types of meetings.

When this researcher asked the mothers with mental illness if they thought that there was anything the child welfare system could do for them as a parent, the first response involved educating the child welfare workers, as well as others, about depression. This mother said:

...I see a lot of stigma when I find I need to get help. ..I feel that it's used against me, I also feel like I can't really be honest about how I'm

really feeling with things because it can get turned around, like 'Oh you feel like this, can you parent your children?' You know the other thing is I get people saying to me 'How could you try to kill yourself when you have two beautiful children? ...it's a common question. I think, there needs to be a lot more public education, a lot more.

Three of the six mothers who had contact with the child welfare system felt the child welfare system could not help them at all. Three referred to the system as punitive and another two mothers agreed they were at the point they didn't "want anything to do with them".

All six of the mothers who were involved with Child and Family services had some idea why they had become involved with them in the first place. Most of the mothers placed the blame for involvement outside themselves. However one mom noted, "Everyone knew that I drank; I wasn't the picture perfect kind of mother to have a kid".

When this researcher asked the mothers with mental illness who would look after their children in order for them to attend treatment appointments, four of the ten mothers stated that their mothers make themselves available in these situations. Three of the women said they hired a babysitter, one attended appointments while her children were in daycare, and another asked a neighbor to look after the children.

When asked who has helped them the most with their parenting responsibilities, four women stated their mothers have helped them the most; one also reported her ex-husband had helped her. This particular woman replied "My parents, and my ex-husband. If something is needed I ask, and I never used to, I would just put up and shut up. Now I ask if I need something". Another

woman reported that her adult daughter was a help and one mother stated that Child and Family services had helped her most with her parenting responsibilities.

When asked who would take care of the children in the event they had to be hospitalized, five women stated they could rely on their mothers. Two stated, "It switched back and forth between mom and my husband", two hired babysitters, and one called Child and Family Services because she had no one to call. Another woman stated she would not go to the hospital if she were sick because she has no one and she would be afraid her children would be taken into care.

All ten mothers interviewed reported that they worried their children would be taken away from them. When asked why they felt this way, one mom replied:

...I felt that I couldn't provide for them, I couldn't care for them, I had no energy, the last time I was hospitalized, before that, I felt very distanced from them because I thought that they were going to take them away, so I didn't want to be hurt so I just kind of backed off, I didn't spend as much time with them as I would have liked.

Even the mothers who did not have C&FS involvement reported feeling afraid their children would be taken away. They had no specific reason for their fears other than feeling that their mental illness would be held against them.

This researcher asked the mentally ill mothers what they needed in the way of support in order to successfully parent? The responses varied and included the following:

- Well, you know what I think perhaps, you know if there was respite available, if somebody could come in, if I'm starting to overload, if someone could come in and care for my children for a week and I could go somewhere and get treatment.

- [You] Need somebody that can help you, can understand you, not be judgmental, not judge you, somebody that knows about mental illness, don't go to C&FS.
- Oh goodness, having someone to talk to, who didn't look at you like were nuts.
- Parenting group...

When asked if they had ever experienced symptoms of their illness while taking care of their children, seven of the eight mothers who responded to this question answered 'yes'. Six mothers who had a diagnosis of either depression or bipolar agreed that the most common symptom of their mental illness was their inability to get up in the mornings, and sometimes to get up at all. Some of the comments made by the mothers included the following:

- When I was in the hyper stage that was fine. I had plenty of energy; we could go, eat, play, I could do anything, but when I would crash, I didn't... only because of them I would get out of bed.
- ...it was the hardest thing, every morning to get out of bed, and then to play with them, I would just sit there and watch, or we would do quiet activities, I couldn't go out.
- There were a few mornings that I would stay in bed and sleep and then I would wake up with a start and run into the living room. They would all be there, watching television. That was scary I had to put locks on the doors so the kids couldn't go out...I was ashamed of sleeping in, I could not tell anyone this. You don't tell people you slept in, they would think I was lazy. ...it would have been nice to be able to feel like you could talk to someone about this. Like explain the tiredness in the morning and maybe get some help for a couple of hours in the morning. I don't think anyone would like to admit that they don't get up with the kids because, they, like me, might think the kids would be taken away.

The one mother with schizophrenia also had symptoms of her illness which differed from the women with depression or bipolar. She stated that she

would have audio hallucinations, which for her meant, "There was a time when I could not have the television on because I thought it was talking to me, sending me direction to do certain things. I knew it was not real, but this is hard to fight because it seems so real". When asked how she managed to parent feeling like this, her eyes glistened over with tears and she said, "It is hard, it is so hard".

This researcher next asked if they had ever experienced side effects from the medication they were taking while taking care of their child/ren and whether they could tell me about this experience. All ten mothers answered this question with five stating they had experienced side effects. Three women stated they had not experienced side effects and two didn't know. One woman who had experienced side effects described her experience:

I just felt like a zombie, it was disgusting, I would go to work, I would watch the girls, I would play with them but I just wasn't there. I felt like I, you know when you're running through water, it was like slow mo.

Another three mothers described similar side effects:

- It pushes everything down, its helps, but my energy is gone.
- Well the mindlessness, you know, I tried all of the different ...antidepressants, ...with some of them I mean I was just, I couldn't remember from here to there. I would leave the room and I would have forgotten, and that would give me a headache because I would try to remember what I wanted.
- ...I couldn't do anything, I was so relaxed. I couldn't do anything, it was fabulous, just kidding, I couldn't function. I mean, I was up, but it took everything I had in me to make breakfast.

Some women had a hard time functioning and two respondents described themselves as going 'wacko' and getting even more hyper on the medication they were taking to help them calm down. For example, one mother described

being referred to a psychiatrist by her family doctor because he thought the psychiatrist could diagnose her better. She described being prescribed medication that her boyfriend thought made her "...wacko, wacko, wacko". In three of the aforementioned cases the women stopped taking their medications without telling their doctors.

The interviewees were asked if the various professionals involved with their psychiatric care were in contact with one another. Four mothers replied they were, four said they were not, and two did not know. When asked if the various professionals involved with them encouraged them to participate in the decisions about their care, three mothers felt they were included in decision-making and three said they were not included. One woman spoke about her experience going to the psychiatrist:

The psychiatrist just said to me that he was going to give me some pills to help relax. I thought good, that's good because at this time I really thought I was nuts. I don't know if he even sent a report to my doctor. My doctor never mentioned anything about it to me and I never said anything to my doctor.

This researcher asked the mothers if there were any gaps and barriers that they had seen or experienced in accessing services, which they felt, would be helpful to them and their children. Four women spoke of feeling isolated and needing someone to talk to. Two of the mothers responded as indicated below:

- ...someone to talk to, someone to come in and help me with kids. That would have been very helpful. Someone I could trust enough to tell the truth about how I was feeling. I used to put on such an act in front of others, including the doctor. The only reason the depression was finally diagnosed was when I came clean about not being able to sleep for years and breaking down with exhaustion.
- Basically for me to be able to go to a group, I know that there are

some groups out there because (staff at) Sara Riel told me that there is for people to go, not necessary for moms, but places for people to go. ...but it would be nice if they had just moms ...right, because it is one thing to just talk about it, but it would be more helpful for me to have just moms. Then you don't have to talk to Joe Blow down the street talking about – whatever.

Three women also felt that there needed to be more counseling services available and not just for themselves, but for the whole family. The women noted the counseling would have to be free in order for them to access it. One woman felt that she wanted to restate that:

When one person in the family has a mental illness, all of us are affected and I don't think this is acknowledged at all.

This researcher asked the mothers what they thought social workers needed to know when working with mothers with metal illness. Eight of the ten mothers agreed that recognizing the symptoms of mental illness in their clients would be their number one priority. What follows are illustrative quotes:

- Well they definitely need to know what the symptoms of mental illness are, ah, her physical situation, and habitation (read housing). It would be good if they knew the person, so they could get a better idea of what it is they need, like in my case I need to work part of the time, ...I can't handle a full load right now, but I need to work part time to keep me healthy. ...if they could point me, an unemployed mother with a mental illness, to people who could help me that would help.
- Well number one, ...the first thing is to be able to recognize the symptoms of depression. Like people are not going to call and say 'well I am phoning because I am clinically depressed and I need some help'. I think social workers need to listen carefully to what people are saying and take the time necessary to listen. A lot of times social workers are so busy that I think they rush through their interviews. I also think that they need to understand that moms with depression are not lazy when they can't get up in the morning.
- I think maybe they should have some schooling in all that if they're going to be working with people with mental illness. ...in order for

the baby to be safe, they need to notice signs and stuff like that of the mother's relapsing, not to have the baby taken away but to help the mom before that happens.

- ...tell them about the depression; how it makes me feel, explain how I feel. They don't know depression; they are not in that spot. They need more research on depression, how people feel.

Other thoughts on what social workers need to know included the following:

- Whether or not you are taking your meds.
- They need to know that it's (mental illness) uncontrollable, it's not my choice, I think they need to know a lot more about mental illness and be more supportive. ...It's not like I asked for this disease.
- They need to find out about the person before they even start, and they should listen to the person, and not be judgmental.

The final question this researcher asked is whether they had anything, they would like to add to the interview that they thought important to note in research to do with mothers with a mental illness. Once again the topic turned to stigma and its affect upon mothers with mental illness. One mother articulated:

I feel we have a long way to go in terms of the stigma around mental illness for anybody and recognition that for mothers (stigma) is an extra add on. When you're not healthy, chances are your kids are not going to be healthy. ...I know some moms who don't do well by their kids. But if you're in a state of mind where you want to kill yourself, I think the kids need some attention and to me, the stigma, it has to go. ...so you can talk to workers when you have issues. You might be having symptoms, or side effects, whatever, be able to talk to them without fear.

Another mother wondered if some type of worker could be assigned to them after the birth of a child because:

Sometimes it would be good, if after the children were born, someone would come just to talk to me, to see how I was doing. Like someone I could confide in. I couldn't talk to mom cause I didn't want to admit

that I was wrong because she didn't like my ex in the first place and he wasn't helping me with the baby at all.

Along the same theme another mother suggested that she thought:

...it would be good to have somebody like a friendly visitor to come to the house when someone is a single mom, especially with small children. Single moms are so isolated and no one knows what's going on in the home. When the mom has depression, it would certainly help to have someone to talk to, not a nurse, just like I said, a friendly visitor, some to bounce ideas off and to talk to.

One more mother felt that it would be beneficial if mothers could have some validation of the importance of examining their own spiritual needs. She explained:

The one area that is not touched on anywhere is spiritual and in the case of mental illness, you find that it is very important, people get into tangents, they get into that part, you know, sometimes too far, you know, so if someone could actually sit down with you about what your spiritual beliefs are, if someone could set you up with a therapist that believes in the same way or can accept, like talking to a psychiatrist or a therapist that doesn't believe in God and I do and it's something I have to keep this to myself.

Another woman stated that if there were any new programs being developed for mentally ill mothers, the programs should include some funding for basic needs.

She explained:

...this is going to sound silly, you know, the basic needs, a little extra could be added in there for self care, like haircuts, and makeup if you're a woman, like all those things that are so expensive and they make a difference in how you feel, and you get such a little amount that all it covers is floor cleaner and toothpaste and all those kinds of items. ...cause if you're suffering from mental illness, you don't take good care of yourself oftentimes as good as you should.

One final comment from one mother sums up the need for workers to consult with mentally ill mothers. This mother emphasized that:

... It is important to listen to us, to hear our stories and we where we

are coming from.

In summary, the mothers were eager to tell their stories. The most predominant theme discussed was that all ten of the mothers with mental illness feared at one time or another that their children might be taken away from them because of their mental illness. In fact, some of them did lose their children and this raised another important theme. When working with the child welfare system, many of the mothers felt judged by their workers or the support staff placed in their homes. The mothers reported they did not think the child welfare workers understood mental illness and furthermore, did not understand what they needed for help because of this lack of knowledge. Some of the mothers stated that they felt less of a threat of having their children removed in their contact with the mental health system. However, they reported the mental health services were individualistic in nature and that many of the services and service providers often did not acknowledge them as mothers. They cited examples of not being asked if they had children when they were being admitted into hospital, no toys in the waiting room of the mental health agencies, and no childcare available should they have to bring their children to their appointments. The responses of these mothers were not unlike the responses of the mothers participated in a study commissioned by Manitoba Health in 1996 where twenty-five mothers with mental illness were interviewed. The mothers in that study also reported that their mental health workers rarely, if ever, addressed concerns they had about their children. The study suggested that one reason for the 'gap in service' was the issue of gender and the fact that historically the mental health system had

minimized the role of women as parents.

There was some hesitancy of the mothers with mental illness to join regular parenting groups and if they did, they did not speak about their mental illness. The fact that they could not speak about symptoms of their illnesses or the side effects of their medications was viewed as a barrier to fully participating in a regular parenting group. The mothers spoke of feeling isolated when they had small children and wanting someone to visit them in their homes, preferably a friendly visitor, rather than a nurse or social worker.

This researcher found that the mothers who reported themes of child welfare involvement appeared to be confused and angry at this involvement. There were also instances where it appeared that some of these mothers were vulnerable to involvement with an abusive partner. Often because of this involvement, the child protection agencies became involved.

Summary of Themes

All twenty-four of the social service agencies surveyed by telephone felt there was a need for some kind of 'specialized' program to work with mentally ill mothers and their children. Most of the agencies stated that they have mentally ill mothers mixed in with their population of mothers but these mothers do not discuss any difficulties related to their mental illness. In fact, they do not talk about their mental illness. Only one program in Winnipeg this researcher contacted had a "support program" for mentally ill parents but this was not a parenting program per se. In this program, the mentally ill parents picked topics to discuss and the next week these were the topics of discussion.

Interestingly, not even the mental health organizations contacted had parenting programs for their mentally ill mothers.

Child protection workers expressed a need for some “help” when working with mothers with mental illness. One problem identified was that some mentally ill mothers they worked with lived in constant chaos. Other mothers with mental illness had an inability to organize the facts given to them. Subsequently, they were often unable to comprehend the plan the child protection workers had discussed with them; therefore, they often failed to complete the requirements set out by the agency and the children were apprehended. Even after the children were returned to their mentally ill mothers, these mothers remained confused, not understanding why this had happened, and concerned about whether they could follow planning that did not make sense to them. For, example, one mother this writer interviewed who lives with schizophrenia stated that sometimes she has trouble in organizing her thoughts and needs assistance by way of prompts to enable her to plan. Therefore, what a professional assessed as non-compliant might have been the client’s inability to process what was expected of them. Unless one was very familiar with mental illness, one would not know the wide range of effects, both cognitive and physical, and the impact of these effects on a mentally ill mothers day-to-day functioning. In the example given, often it helps to have another person present to go over the facts again, and help design a planning tool and a way of monitoring the process in order to carry out the intervention.

Most of the child protection workers stated they felt people with mental

illness require different kinds of service than people who do not have mental illness, however, were quick to add that they did not have a clue as to what the 'different' service would involve. When asked if they felt Child and Family Services, on the whole, was sensitive to the issues faced by mothers with mental illness, most wondered how the agency could be seen as sensitive when there was no formal training and no acknowledgment that there might be some differences in treatment planning. Most agreed that the same 'hoops' were applied to all families, regardless of mental status.

Child protection workers indicated that they had not received any informal or formal training on developing specialized interventions with clients who might have mental health issues. They reported that many of their clients were mentally ill and they felt inadequate because they understood their needs were different. The child protection workers decided more training ought to be provided in the undergraduate social work course work, and courses on mental health should be mandatory, rather than elective. Although working in child welfare, most of the workers reported having many cases where mental illness was prevalent.

The child welfare workers agreed that mentally ill mothers were more at risk of abusing and neglecting their children than mothers who were not mentally ill, however, they felt the risk was not intentional. Their experiences were that in cases, which identified mothers as mentally ill, there had been more chaos, more crisis, and more emotional turmoil, than other cases. There was also consensus among the child protection workers that these children would experience more

emotional abuse and neglect, rather than physical abuse. One woman in the focus group shared how ineffective she felt parenting was when she was in crisis. She felt parenting, as a single mom, was difficult in times of crisis in her life, and if a mom living with mental illness were in constant crisis and turmoil, it would have to impact upon the children.

The child welfare workers were concerned about how 'closed' the mental health system was about sharing pertinent mental health information about their clients. As mentioned, they attributed at least one child death to this lack of information sharing.

All of the child protection workers felt having a mental illness should not automatically be assessed as a barrier to parenting. They believed all the mothers living with mental illness they had worked with to date love their children and could parent appropriately with the right interventions and supports in place. The child protection workers wondered if perhaps C&FS needed to hire more people with mental health experience. On the other hand, they felt the mental health system ought to train their workers in child welfare issues.

Child protection professionals work in a stressful environment and have large caseloads. The specialized mental health training necessary to work with mentally ill mothers would take significant time; that is if one could find a trainer. One of the workers in the focus group stated she already felt overwhelmed and adding on more training, which would take precious hours away from her work, overwhelmed her further.

When speaking with the focus group of mental health workers this writer

got another point of view about what some of the barriers were for mothers with mental illness to parent their children. One of the mental health workers felt that mothers with a mental illness certainly needed a different kind of service intervention than mothers without a mental illness. She noted that the literature identified being a single parent as one of the stressors that could lead to depression. She cautioned it was necessary to understand the difference between situational and 'organic' (referred to as clinical depression) depression. The major service differences would lie in the case management approach, which would incorporate the child welfare and mental health system with the clinical depression. In order to implement a more comprehensive case management approach, she stated that caseworkers needed a more extensive training in both mental health and child welfare.

Most of the mental health workers stated they believed the mental health system was sensitive to the issues faced by mothers with mental illness; however, was not in a position at this time to act on this sensitivity. The existing programs remain individualistic and were originally developed for "single" people. This is not surprising since historically mentally ill mothers were considered as poor candidates for parenting and some psychiatrists advise their clients to refrain from having children (Gamache, Tessler & Nicholson, 1995).

Mental health programs have been developed within the philosophy of consumer choice. Consumers do not have to take medications, nor are they required to meet with a mental health worker, unless of course, one was deemed as a 'threat to oneself or to others'. Ultimately this could possible translate into a

mother who was psychotic¹, yet not at a risk to herself and others, parenting her children. One wonders how conducive a 'psychotic' mother would be to a child's development. This is but one of the dilemmas that the child welfare workers reported dealing with. One can see where the quandary arises for both the mental health and child welfare professionals.

One worker noted that the mental health agency where she was employed had developed some policies regarding children. For example, the policy guidelines outlined the protocol for transporting children as well as the requirement that a supervisor would be contacted before calling Child and Family Services. The Child and Family Services Act was also acquired and placed in the library. Finally, the agency negotiated with Child and Family Services to have a child protection worker liaison assigned to the agency to answer any questions the workers might have regarding child protection issues. On the other hand, she noted that there are no funds available for daycare, no car seats provided, and no playroom at the front for children to play should a mother have an appointment. On a more positive note, she noted that the mental health workers are not restricted to office visits and are able to visit mothers in their homes.

The mental health professionals were asked what they felt would be helpful for them to be able to work with mothers living with mental illness. They thought that they might benefit from reading more literature as well as attending training that would assist them in developing specialized programming for mothers with mental illness. One worker provided the following example. Many women living with mental illness are on medication that leaves them with low

¹ Psychotic does not necessarily mean that one is a risk to oneself or others.

energy. One common side effect of many of the medications is that one becomes a bit confused. Therefore, she felt that service provision should be well coordinated with fewer service providers to eliminate the endless running from one to another, perhaps a "one stop service provision". In addition, because of the risk of the client not understanding the worker, communication between the worker and the participant needed to be as clear and concise as possible.

The mental health workers all agreed there is a need for more research as well as interventions designed for mothers who may have a dual diagnosis, such as mental illness and substance abuse. On the other hand, one woman cautioned she does not believe programs should be designed for specific mental illnesses due to subjectivity in diagnosis. The common denominator of mental illness would suffice in any special programs that may develop.

Mental health workers believed that children of a parent with mental illness were not more at risk for protection issues such as abuse or neglect than children whose parents were not mentally ill. They explained there have been delusional parents that have caused deaths but they felt confident that statistics would show the average death rates would not be any higher for parents living with mental illness. Mental illness is but one variable to examine when a death occurs. Substance abuse, poverty, and abuse are but a few examples of other variables that we need to examine – a fact reported by Gina Yarborough in the Boston Globe in September of 1996. Yarborough reported the results of a study conducted by the United States Department of Health and Social Services that explained "abuse and neglect quadrupled from 1986-1993 and the cause was not

mental illness but drug and alcohol abuse as well as unemployment”.

Finally, the mental health workers unanimously agreed that parents with mental illness required specialized services and case-by-case assessments of risk - exactly as we would have assessed any other family. Unfortunately, they noted, the moms who live with mental illness who are able to parent successfully are not in the statistics.

The Level 3 Support Workers appeared to be the most comfortable working with mentally ill mothers. Although they expressed they could always use more training in the area of mental health, they felt confident they had enough training and reported they felt supported by their supervisors who would assist them at “any hour”. The support workers also appeared to be the most sympathetic to the plight of the mentally ill mothers. They were more likely to ‘ride out an episode of depression’ rather than trying to ‘fix it’. ‘Riding out’ was described as not judging the depressed mother who was staying in bed, but going in to speak with her often during the day.

The support workers felt it would be beneficial to their clients if they were able to work more closely with the child protection workers. However, they reported they not invited to service coordination meetings and seldom, if ever, met the assigned child protection social workers even after being involved with clients for months. The support workers reported they had never met with any mental health professionals who were involved with their clients.

The support workers mandate, which guides their supportive role, does not place them in a therapeutic role where ‘therapeutic outcomes’ guide their

work. This fact facilitates the amicable working relationship between the mentally ill mothers and themselves. This is not saying the support workers are not guided by a concern for outcomes or that they do not do good work. The outcomes are simply 'support oriented' rather than 'therapeutically oriented' and this would make a difference in their relationships with the mothers.

The interviews with the mentally ill mothers revealed that 60% of them felt they were not ready to parent when they had their first child. All ten had been involved with the mental health system after the birth of the children, however, many stated that they now recognize they were ill before their children were born – they just were not yet diagnosed.

The most helpful services identified by the mentally ill mothers were the services in which they had ongoing, direct contact with their doctors, counseling services and mental health workers. Fifty percent of the mothers interviewed thought their psychiatrist was the least helpful person to talk to because they did not feel that their concerns, especially when it concerned side effects of their medication, were heard, let alone taken seriously.

An issue brought up by one mother was the need to be able to explore and express her spirituality. She explained that within the mental health system, "The one area that is not touched on anywhere is spiritual and in case of mental illness, you find that it is very important". She went on to explain that she believed in God and her psychiatrist did not. Consequently, she was unable to discuss her spirituality with her psychiatrist. I doubt this woman would agree that we currently have a holistic health care system.

The most dominant theme discussed by the mentally ill mothers was their fear that their children would be taken away from them because of their mental illness. This is consistent with Yarbrough's (1997) argument that mentally ill mothers "are still considered to be poor candidates for parenting and at risk of losing custody of their children...". This fear of losing a child prevented some of the mothers from being 'totally' honest about their mental status with their mental health workers. This fear and subsequent failure to seek psychiatric assistance could present grave risks to the children of these mothers. Nicholson (1996) in her study also found that this fear of losing a child might prevent a woman from disclosing her own problems or her parenting difficulties. As noted in Nicholson's study, most of the mentally ill mothers in Winnipeg preferred that services and programs related to parenting be offered at arm's length from Child and Family Services where the mandate is identifying child abuse and neglect, and this tends to overshadow the support mandate associated with parenting programs.

Another theme that emerged from the interviews was that of stigmatization. Most of the mothers recalled at one time or another being referred to as 'crazy' by their loved ones. They reported waiting up to ten hours to be seen by the on call psychiatrist in the emergency ward and spoke of knowing many others who could tell this researcher 'horror stories' of long waits. The mothers stated they thought the waiting time was related to being stigmatized because of their mental illness. They reported feeling that they were being treated as if they were not 'legitimately' sick, but just 'crazy'.

All of the mentally ill mothers this researcher interviewed expressed

gratitude that at last someone was going to tell their stories. When the interviews were completed this researcher had the opportunity to listen to all of the women expand on their life experiences. All the interviewees asked for a summary of the research and one woman even suggested that her name be printed in order to put a face to the research.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

There were common themes evident from all the data collected by this researcher. The mental health and child welfare workers were very forthright about the struggles they had encountered when working with mothers with mental illness. Both the mental health and child protection focus groups identified a lack of service coordination between their agencies. A quote from Blanche, Nicholson and Purcell (1994) aptly summarizes this situation: Mentally ill mothers “pose a classic interorganizational challenge to mental health and social service administrators” (p. 394). The mental health and child welfare workers reported there is a need for more formal training in the area of working with mothers living with mental illness. Most of the child protection workers expressed a need for more training in mental health issues and specific child welfare interventions in these circumstances and all of the mental health workers expressed a need for more training in child welfare issues. This lack of knowledge must have an effect upon the interventions and support given to mothers and this inadvertently would have a detrimental effect upon their children.

Both groups recognized that psychiatry’s individualistic approach, which has ultimately led to focusing interventions only on the mother, is problematic for both the mothers and their children. The groups also recognized child protection agencies focused their interventions on the ‘family’; however, ‘family’ appeared to be interpreted as the “best interest of the child” and the child welfare and mental health groups stated the child protection agency rarely provided any tangible assistance to mothers. However, both the child welfare and mental health

professionals agreed that this lack of tangible support was due to fiscal constraints rather than any lack of good will or neglect by the agency.

One area in which the child protection professionals and the mental health professionals differ involves the assessment of risk of abuse and neglect to children of mentally ill mothers. Child protection workers felt the children of mothers living with mental illness were more at risk of abusing and/or neglecting their children. The mental health workers felt that children of mentally ill mothers were no more at risk for abuse and neglect than the general population. This fundamental difference in attitudes between the child welfare and mental health professionals is an issue that might lead to some animosity between the two groups working together. For example, should a mental health worker assess a mother as safe to parent and a child welfare worker disagrees, the mandate of the child welfare system grants the child protection worker the ability to apprehend any children in spite of the mental health professionals' assessment. A situation such as this would definitely create tensions between the two systems.

A point from which the two systems might consider working together is their common agreement that 'risk' must be assessed case by case and not just assumed because the mother is mentally ill. Workers from both systems also expressed a desire for more training. Perhaps this training could be organized between the two agencies and they could do their training together. Participating in training together would facilitate the agency workers learning about each other's mandates.

The mental health workers spend a lot of their time in advocacy roles and educating collaterals about mental illness. The mentally ill mothers interviewed suggested more education about mental illness be presented to the public as they reported being stigmatized and marginalized. The stigmatization of the

mentally ill was another strong theme that emerged from this study. Every group interviewed mentioned stigma in their discussions.

One conclusion drawn from my discussion with all the respondents is that presently, as indicated in much of the literature, there is no unified approach in Manitoba when it comes to supporting either mothers living with mental illness or their children. The 'gap' in service coordination not only affects the successful parenting abilities of the mentally ill mother, but the formulation of successful intervention plans by the service providers from both the child welfare system and the mental health system.

Since the implementation of deinstitutionalization in Canada, neither the mental health system, nor the child welfare system, has developed any official policy on how to serve these mothers who now remain in the community with their children. After surveying Winnipeg's social service agencies it appears that Winnipeg's mental health system is no exception. The literature review shows that there has been some research on this topic, as well as some programs developed, to aid this forgotten group of deinstitutionalization. However, most of these initiatives remain in the United States where they began.

British Columbia had recently purchased an apartment block and dedicated six two-bedroom suites for mothers with severe and persistent mental illness. However, one wonders just how severe the mental illness has to be, as the admission criteria stated that the mother could not require inpatient care or need twenty-four hour supervision. In addition, this British Columbia program offers outreach services that are provided by a mental health agency Monday to Friday. Parenting support and symptom management were also provided off

site. There are no comprehensive services provided on site for either the mother with mental illness or her children. This researcher could not find any other residential services in Canada that provide parenting services to women with who are no longer institutionalized, is no longer relevant to this discussion, but the rationale for developing practice and policy for this neglected population is important for discussion. The social stigma associated with the mentally ill, and in particular, mentally ill mothers, needs to be eradicated. When this happens mental illness who are at risk of losing their children to the child welfare system. The reason for this omission, which is the lack of planning for women with mental illness, more women, will seek treatment without fear that they will be ostracized or, worse, their children will be taken away.

Both the mental health and child welfare system must move forward and review their policies and procedures about working with mentally ill mothers. Mental health services need to improve their outpatient services to include parenting programs and perhaps daycare facilities for continuity of care. Hospital psychiatric wards might want to examine the possibility of having a special visiting room for mothers and their children. Finally, the agencies need to meet and discuss their mandates and how they can work together more closely. Interagency cooperation would benefit the clients as well as the professionals serving them.

Another suggestion, which was presented by several mothers, would be the provision of short term, twenty-four to seventy-two hour respite care for their children in case of an emergency. One mother stated that she really needed to

enter a Crisis Stabilization Unit for the monitoring of a medication change but was unable to do so because she had no one to take care of her son. She remained home and felt guilty because she was unable to provide more than the necessities of life to her son because of the way she was feeling. One would wonder if feeling unable to access crisis services could potentially place children at risk.

This researcher was particularly impressed with the Emerson Family Project in Brooklyn New York. A supported housing program, like that of the Emerson Family Project in Brooklyn New York, inclusive of all the services, would be invaluable for mentally ill mothers and their minor children in Winnipeg. Mothers with severe and persistent mental illness and their children would have their needs met by such a project. The project would become cost effective quickly with children remaining with their mothers rather than the costly alternative (fiscally and emotionally) of being placed in the care of a child protection agency.

A project similar to the Emerson Family Project could become a reality if Manitoba Health and Manitoba Family Services worked collaboratively to provided funding for a scaled down pilot project similar to the Emerson Family Project. However, the planning process for such a project should incorporate the voice of consumers, and mentally ill mothers should be asked about the nature and scope of programs and services to be included. One way to locate the mothers would be to have a camping excursion set up for the mentally ill mothers and their children. The camp could include focus groups for the mothers in order

to ascertain their parenting needs. Camp counselors could be providing programming for the children while their mothers participated in the focus groups. This researcher believes that if this camping experience were subsidized, a large group of mentally ill mothers, who have never had the opportunity to attend camp, would come and participate in focus groups. The information from the focus groups, which would include the expressed parenting needs of mothers with mental illness, would need to be carefully examined and integrated into any future parenting program planning. If this is not done mentally ill mothers may not be interested in attending a program that they feel does not respond to their needs.

In addition, it is very important that this new initiative include a rigorous evaluation system. The success of any program will ultimately depend on the ability to demonstrate improved outcomes for mentally ill mothers and their children. Some outcomes might include reducing the number of out-of-home placements, improved parenting skills, and increased satisfaction for both parents and children. Both the funders and participants of the program would welcome these outcomes.

Although there are other venues which might facilitate mentally ill mothers participation in focus groups, this researcher believes that more mothers would attend a camp setting, especially if they could bring their children. A holiday away from home is a luxury many mentally ill mothers and their children have never experienced. The camp experience would be an opportunity to enrich their lives in a neutral setting that could be viewed as less threatening than other

venues. In addition, camp, for both mentally ill mothers and their children, would be a formal recognition by the 'system' of the role of parenting by mentally ill mothers and could be viewed by the mothers as the beginning of the 'system' validating their parenting roles. This camping experience would give the mothers an opportunity to learn about 'organizing for change' while their children were in other supervised activities.

Participation in the focus groups could be seen as the beginning of mobilization for social action – the first step toward educating policy makers about their specialized needs as mentally ill mothers. Women's strengths in collective action at broader organizational levels have been demonstrated since the 1960's. Women have "organized networks, opened resource centers including rape crisis centers and shelters, and provided each other with personal and group support. They shared information, and together lobbied for change" (Women and Mental Health Working Group, 1996). Women have been an ignored population in psychiatric rehabilitation and mental health services for too long. Undeniably, the focus of social service funding has mainly been on vocational needs, which are primarily a male domain. According to Mowbray, Oyserman, Lutz and Purnell, (1996) the "top domain considered in services is vocational. There has been some consideration of the generic topic of rehabilitation in housing choices. However, those domains where women are considered to occupy primary roles, e.g., the family, parenting, and interpersonal relationships have received little attention" (p.171). It is clear that policy,

research, and service provision should prioritize female clients to improve this situation.

It would be detrimental to mothers with mental illness if further research were the only outcome of this study. It has been over thirty years since the implementation of the Health and Mental Health Reform, which moved women, many of whom ultimately became mothers, from an institutional to a community, based service provision. Now is the time for action, now is the time to begin to address the gap in service provision for mothers with mental illness and right the wrongs of “Deinstitutionalization: The Unplanned Parenting Paradigm”.

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APPENDIX A

Telephone Survey Questionnaire

Telephone Survey Questionnaire:

Definition: Mentally ill mothers- a mother who has a diagnosis of mental illness.

#1 Do you provide services to moms that are mentally ill?

a] yes

b] no

#2 Do you provide any specialized residential services for mentally ill mothers and their children?

a] yes

b] no

#3 Do you have any specialized programs that formally assess parenting skills of mentally ill mothers?

a] yes

b] no

If yes, what is the nature of the service?

If no, do you see a need for a specialized service?

#4 Do you provide any specialized programs that directly focus on parenting skills for mentally ill mothers?

a] yes

b] no

If yes, what is the nature of the service?

If no, do you see a need for a specialize service?

#5 In your opinion, how could your agency, and/or the network of family agencies, best meet the service needs of mentally ill mothers and their children?

APPENDIX B

Interview Guide for Focus Groups

Focus Group Questions

Definition: Mentally ill mothers- a mother who has a diagnosis of mental illness.

The questions for discussion are:

1] What have been your experiences, successful and less successful, working with mentally ill mothers and their children?

2] What are your experiences, successful and less successful, working with outside social service providers in order to access what you have assessed as an appropriate resource for a mentally ill mother and her child/ren?

3] Do you feel that your agency has provided you with enough training to work with mentally ill women and their children?

4] Do you think that mentally ill mothers and their children require different services than that of mothers who are not mentally ill? Why or why not?

5] Do you think that the services currently available to mentally ill mothers provide for their own and their children's special needs? Why or why not?

6] Is there anything that you would like to discuss which you assess as relevant to this study?

APPENDIX C

Interview Guide for Mothers with Mental Illness

Interview Guide for Mothers with Mental Illness

1. I would like to start with some general information.

a] age?

b] partnership status?

c] number of children?

d] age of children?

e] mental health diagnosis?

f] age when diagnosed?

g] education?

h] What is your cultural background?

i] How many people living in your home?

j] Which of the following categories best describes your total income?

____ Less than \$9,999

____ \$10,000 to \$14,999

____ \$15,000 to \$19,999

____ \$20,000 to \$24,999

____ \$25,000 to \$29,999

____ \$30,000 to \$39,000

____ OVER \$40,000

k] presently parenting child/ren? Y or N [Meaning that the mom is involved in parenting the children. Does not have to have custody of the children

l] have Full Custody? Y or N Joint Custody? Y or N

2 (a) Do you think you were ready to parent a child at the time you got pregnant? Yes or No.

What were the things you felt you could do or could not do?

(b) Do you think you are ready to parent now?

3 (a) Were/are you involved with any mental health services? Y/N

(b) Which mental health agency/agencies and or program/s are you/have you been involved with?

4. Specifically in relation to your pregnancy and birth of your child, if any of these mental health agencies were/are involved with you, what services were/are provided to you?

5. What is the most helpful service you have received from the mental health system?

6. What is the least helpful service you have received from the mental health system?

7. What additional services do you think the mental health system could provide which would help you as a parent? What is missing for you?

8 (a) Were/Are you involved with Child and Family Services? Y/N

(b) Which Child Welfare agency and/or program/s were/are you involved with?

9. Specifically in relation to your pregnancy and birth of your child, which if any, of these child welfare agencies were/are involved with you?

10. What services were/are provided to you?

11. What is the most helpful service you have received from the child welfare system?

12. What is the least helpful service you have received from the child welfare system?

13. What additional services do you think the child welfare system could provide which would help you as a parent? What is missing for you?

14. Why do you think Child and Family is/has been involved with you?

15 (a) Tell me about what arrangements you make for your children in

order to attend treatment appointments, for example, psychiatrist, doctor, group therapy, individual therapy, etc.

(b) If you had to be hospitalized for your illness who would look after your children?

16. Do you ever worry that your child/ren will be taken away from you? Why? Why not?

17. What/Who has helped support you the most with parenting responsibilities?

18 (a) Overall, what do you think you as a mom and other moms, who live with a mental illness, need in the way of support in order to successfully parent?

(b) Parenting skills? [i.e. groups, teaching homemakers, etc.].

(c) Ongoing support? [i.e. ongoing drop in, friends, parents, etc.].

(d) Symptom management training [i.e. skill-training groups, individual skill training].

(e) Babysitters? [i.e. daycare, babysitter for medical/psychiatrist appointments, respite for evenings].

(f) Back-up babysitters for hospitalizations?

(g) Information on how to explain your condition to the children?

(h) Other?

19. Have you ever experienced symptoms of your illness while taking care of the children? Y or N? Can you tell me about this experience?

20. Have you ever experienced side-effects from the medication you are taking while taking care of the children? Y or N? Can you tell me about this experience?

21. Are the various professionals who may be involved with you in contact with each other? Y or N? If yes, do they make decisions together with you about your treatment?

22. What are the gaps and barriers that you see/ have experienced in accessing services which you feel would be helpful to you and your children?

23. What do you think social workers need to know/need to do when working with mothers who live with mental illness?
24. Is there anything you would like to add to this interview that you think is important to note in research to do with moms who live with a mental illness?