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Features

Erica Pitman

From: "Christine Glogovic" <Christine.Glogovic@facswaterloo.org>
To: '"Erica Pitman"' <ericap@ix.net.au>
Sent: Thursday, 28 October 2010 4:50 AM
Subject: RE: SMILES

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Providing S.M.I.L.E.S to Children of the Waterloo Region Whose Caregiver has a Mental Health Diagnosis

By Pam Baldwin, MSW, RSW, and Christine Glogovic, MSW, RSW

PURPOSE

The purpose of this article is to review the process undertaken by the authors to find a program for children whose caregiver(s) has a diagnosed mental health issue and resides within the Waterloo Region, to provide a summary of the program Simplifying Mental Health Life Enhancement Skills (S.M.I.L.E.S.), to summarize the outcomes of t program, to review the lessons learned, and to encourage other agencies to consider providing direct services for children who have a caregiver or sibling with a mental hea diagnosis.

MENTAL HEALTH IN THE FAMILY

Given that 20% of the population will be diagnosed with a mental health issue at some point in their lives (Canadian Mental Health Association, 2002), it is not surprising that child welfare agencies often support families where there is a caregiver struggling with mental health issue. "The lifetime prevalence of mental health disorders in adults has been estimated to be somewhere between 50% and 60% and about half of all adults v mental illness care for a child" (Maybery, Reupert, Goodyear, Ritchie, & Brann, 2009). Case planning and emphasis is often placed on supporting the adult with the unintend consequence that the children of these caregivers are not serviced or supported.

CHILD WELFARE TRANSFORMATION AGENDA

In response to Transformation during the fall of 2008, the Mental Health Committee wa formed at Family and Children's Services (FACS) of the Waterloo Region. The authors

one of whom is Co-Chair and the other a member of this committee, began researching "best practices" for working with families where a caregiver has a mental health issue.

BEST PRACTICES LITERATURE REVIEW

While the outcome of the literature review clearly emphasized the importance of working with the entire family, available services focused on adults and not the child (Byrne et al., 2001; Hinden, Biebel, Nicholson, Henry, & Stier, 2002; Mordach & Hall, 2002; Ostman & Hansson, 2002). This review also found that "children with a parent who utilizes mental health services are between two and five times more likely than the norm to be scoring in the clinical range on the Strengths and Difficulties Questionnaire" with respect to their own mental health (Maybery et al., 2009).

GAP IN SERVICES FOR CHILDREN WITH A CAREGIVER WHO HAS A MENTAL HEALTH DIAGNOSIS

Based on the current best practices research, and the subsequent identified increased risk of mental health difficulties for these children, a search within the Waterloo Region was completed to identify what services were available for these children. While there were many excellent groups for anger, anxiety, and self-esteem for children at local counselling agencies, there were no services specifically available for children who have a caregiver with a mental health issue.

THE SEARCH FOR S.M.I.L.E.S.

The absence of a relevant program led the authors to review several existing international programs for children whose caregiver has a mental health diagnosis. According to Children of Parents with Mental Illness (COPMI) (2010) "in the eleven years between 1998 and 2009 over 170 children have participated in the S.M.I.L.E.S. program in NSW Australia along with one location in Montreal and now Kitchener" (p. 8). Comprehensive qualitative and quantitative data regarding S.M.I.L.E.S. has been published in the Orthopsychiatric Journal.

After consultation with the S.M.I.L.E.S. program creator, Erica Pitman, the authors submitted a proposal and successfully obtained funding through the FACS of the Waterloo Region Foundation. The proposal was to run a S.M.I.L.E.S. pilot program consisting of two groups in the summer of 2009. Two clinically trained social workers, along with two protection support workers, were the facilitators of the programs. All being members of the Mental Health Committee.

STEPS ALONG THE WAY

In order to obtain referrals and achieve optimal group composition, a great deal of work was required up front, which included the facilitators seeking out workers and reviewing caseloads to identify appropriate referrals. This allowed us to advertise the new service to child protection workers and to ensure that the referrals were appropriate for the groups. This resulted in a significant and unforeseen number of referrals-53 in total. These restricted groups were provided to children who resided either at home or in a kinship placement.

The child protection workers were then invited by the facilitators to attend the "Recruitment & Interview" stage. The program creator, Erica Pitman, clearly emphasized the importance of this initial stage in her program material. Specifically, "before accepting a child for group, a meeting with parent/guardian and child is to happen with one or both facilitators. The goal of the meeting is to develop rapport with family, gain background information, alleviate concerns, review parent expectations, explain the purpose of the program" (Pitman, 2007, p. 9).

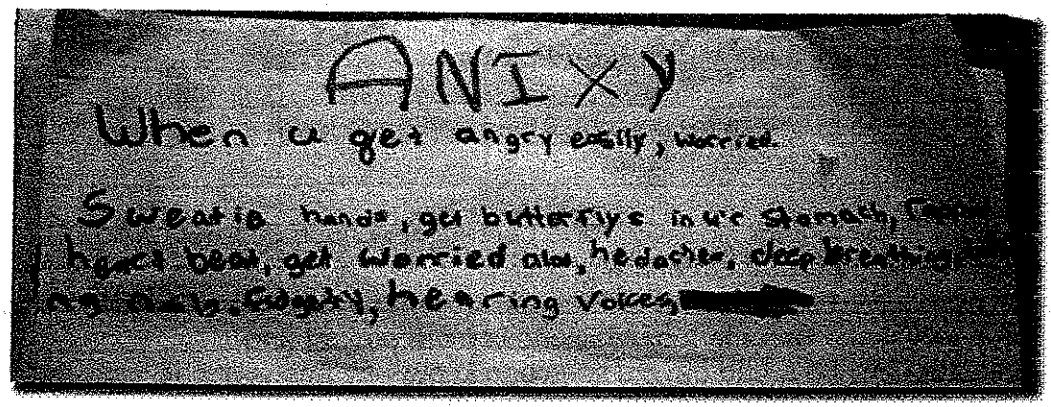
At the end of each group meeting, home visits were offered to the caregivers, which allowed opportunity for additional feedback both formally and informally through evaluations. This was an important step that resulted in a high rate of evaluation return.

S.M.I.L.E.S. PROGRAM

The goals of the S.M.I.L.E.S. program is to achieve:

"Increased ability to cope effectively, increased resiliency, a new freedom for self expression, development of creativity, reduction in feelings of isolation, increase in self-esteem. This is achieved through: education about mental illness, communication exercises, interactive exercises, artwork and music, relaxation exercises, problem solving, peer support" (Pitman & Matthey, 2007, p. 6).

The exercises promote discussion, understanding, reflection, and an opportunity to be in a group where the children felt they "fit in". An example of one of the exercises that demonstrated the level of impact the group had on the participants occurred on the last day of a group meeting. The children were organized into small groups and assigned a specific mental health issue (i.e. anxiety), which they then presented back to the large group. The children were encouraged to present the assigned mental health issue by using a creative means of their choice. Children's art is a window into their world, and the illustration of anxiety is an example of this. This illustration is profound in its accuracy in text and sketch.



Throughout the groups the children disclosed very personal and thought provoking information. At the conclusion of S.M.I.L.E.S., the children were asked what they learned from the groups. They reported the following:

"My mom had depression and now I know how to deal with it."

"[I learned] about mental health and it is not just my mom, other's moms have it too."

"[I learned] more about my mom and how to understand her better."

"I am not worried about getting mental health because I took S.M.I.L.E.S. and will know what to do to help myself."

OUTCOMES

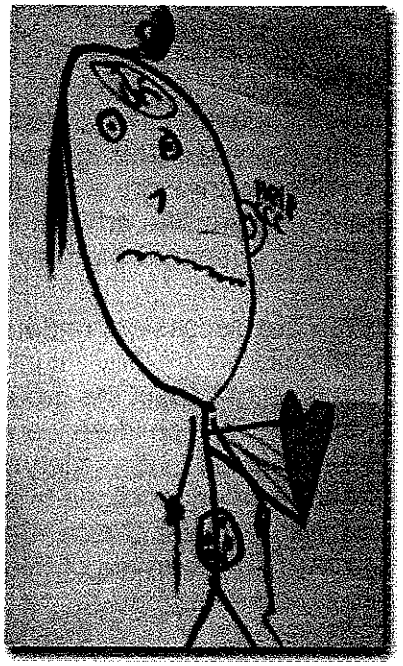
Pre and Post-Test Results

The S.M.I.L.E.S. program provides pre and post-test material to be completed with group participants and their caregiver(s). This data was collected by the group facilitators and correlated by the Manager of Quality Assurance at FACS of the Waterloo Region, Jill

Stoddart, and is summarized below.

Importance of S.M.I.L.E.S. (Caregiver results)

Caregivers reported that these groups were very important to both their children and themselves:



78% reported that (according to their children), it was 'important' or 'extremely important' for their children to attend group;

89% of caregivers reported that it was 'extremely important' to them that their children attend the group and the other 11% reported that it was 'important' to them;

75% of caregivers reported that their relationship with their children improved following the child/youth's participation in the S.M.I.L.E.S. program; and

89% of caregivers reported that they would recommend the group to other caregivers.

Comments from the Caregivers of S.M.I.L.E.S. Participants

"The most beneficial aspect of the program for [my child] was getting to learn more about my condition and he enjoyed going there each time."

"I think the program is really important for kids who have parents who have depression so they can understand what is wrong with them and why."

"[My child] is happier in general and with me too. I think he is more patient and understanding and when I am having a bad day he seems to know why and is not as anxious about it and tells me it will pass."

"I believe the program has helped [my child] deal with some difficult changes in her life since the program (placed in group home) and it has helped to build her confidence."

"[My child] understands more and is more helpful to me; he used to ask me why I did stupid things, now he tells me he knows it is the mental illness."

"The program helped me be able to talk about my mental health with [my child] more. I am able to describe feelings and symptoms and [she] understands them and does not get all 'freaked' out like she used to."

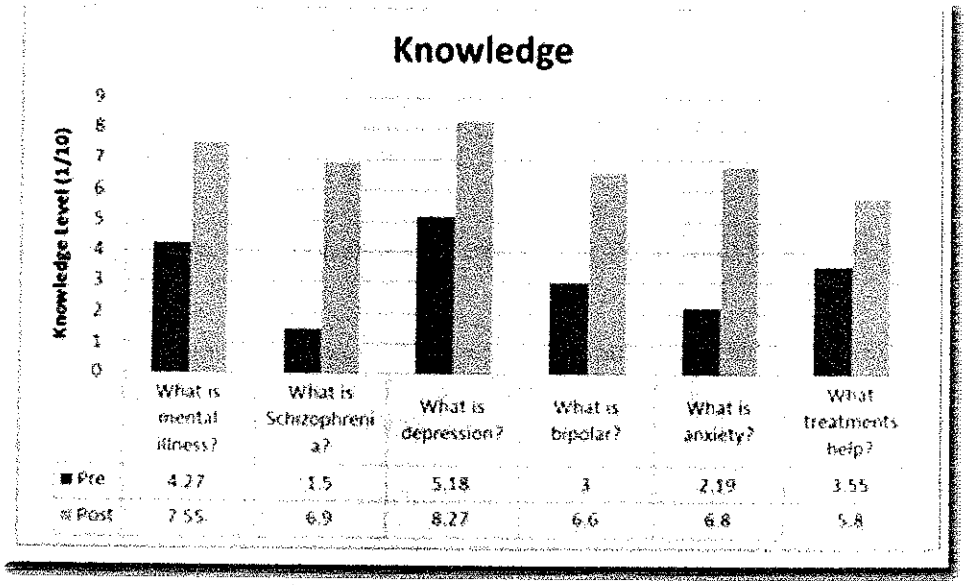
"We get along better - we do more activities together."

S.M.I.L.E.S. PARTICIPANTS

The children also participated in pre and post-tests. Their tests focused on the following topics: Knowledge of Mental Health Issues; Change in Knowledge about Mental Health; and Life Skills Development.

Knowledge Questions

The children were asked to rate their knowledge about mental health on the first and last days of the S.M.I.L.E.S. program. This was done using a scaled measure of 1-10, with 1 being "nothing at all" to 10 being "knowing everything there is to know". Collectively for both groups the average pre-test score on these questions was 3.38 out of 10 and the average post-test score on the same questions was 6.99 out of 10.

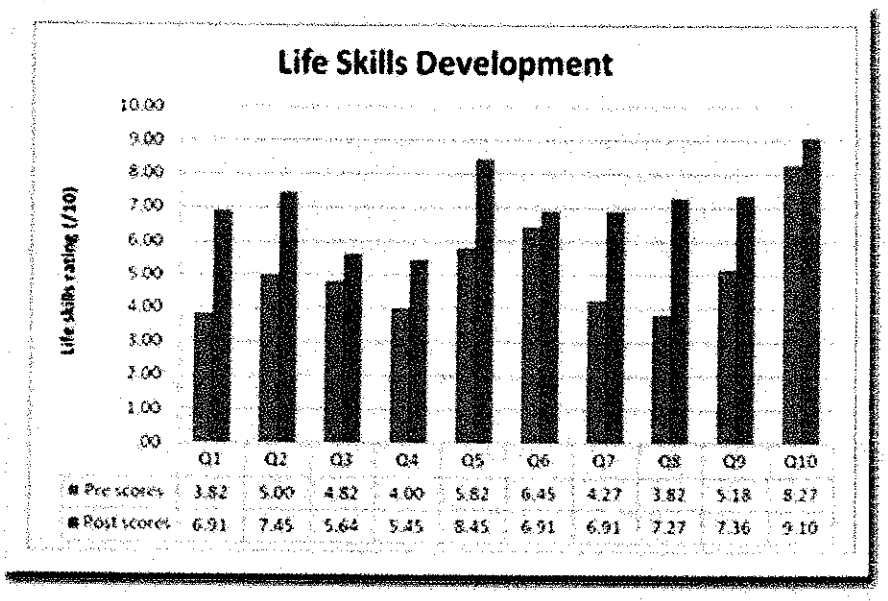


Change in Level of Knowledge

S.M.I.L.E.S. participants were then asked if they knew "more", "less" or if there was "no change" in their knowledge from the first to the last day of the program. Participants reported having "more" knowledge 88% of the time.

Life Skills Development

The Life Skills Development section noted improvement in all areas for the children and youth in the post-test. They were asked if the skills became "easier", "harder" or if there was "no change". Participants reported that these skills were "easier" for them 65% of the time.



Legend for Life Skills Questions

Q1– My ability to talk to other people
Q2– My ability to listen to other people
Q3– My ability to express my 'ok' feelings
Q4– My ability to express my 'yucky' feelings
Q5– My ability to recognize my strengths
Q6– My ability to be creative
Q7– My ability to solve problems
Q8– My ability to relax
Q9– My ability to feel good about my self
Q10– My ability to have fun

LESSONS LEARNED

Implementing a program such as S.M.I.L.E.S. in a child welfare setting came with some challenges.

First, two of the facilitators held full child protection caseloads. Consequently for the first group, only one of the facilitators was able to complete the recruitment and interview stage with the children and caregivers due to competing workload demands.

Another challenge was that an intake was completed by an individual not involved in facilitating the program. This resulted in a child attending the program who was not group appropriate.

Food also proved to be a very important element of the program. This proved to be a struggle for this pilot due to the quality and variety of food available. It is important to note that poverty can be an issue for participants in this program. Facilitators need to ensure that there is a sufficient amount of nutritious food choices available.

Lastly, it is very important that caregivers of potential participants have a diagnosed mental health issue. Child protection workers often work with caregivers who appear to be struggling with symptoms associated with assumed versus diagnosed mental health issue. Perceived mental health difficulties and diagnosed mental health issues are very different. As part of the screening process, this area requires extra sensitivity. This program requires transparency and open communication by all involved parties.

Despite the above challenges, the S.M.I.L.E.S. program was said to be very successful by the clients we service-children.

CONCLUSION

The program outcomes were clearly met as demonstrated through the post-tests. The authors strongly recommend that if other agencies use the S.M.I.L.E.S. program they follow the program guidelines. Additionally, agencies should use the lessons learned section as a foundation and area of growth to work from in delivering this program in their community.

The S.M.I.L.E.S. program not only met but surpassed intended expectations and outcomes. Bearing witness to children understanding for the first time that they were not alone and that the mental health issue was not their fault, was an unforgettable experience. The children each left the S.M.I.L.E.S. program with a t-shirt with a smile printed on it (outlined in the first photo). The t-shirt was given to them to use as a reminder when times were hard to remember S.M.I.L.E.S. and the skills they learned.

We thank not only the children of the S.M.I.L.E.S. Pilot for their candor, honesty, and courage but also their caregivers for their continued pursuit to bring smiles to the faces of their children.

ABOUT THE AUTHORS:

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