Family Centered Care in Children's and Adolescents' Mental Health: Barriers and Possibilities

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Content of Presentation

- Why
- What
- How
- Barriers
- Possibilities

Reasons for Family Centered Care in Children's and Adolescents' Mental Health

- Prevalence of children and adolescent mental health problems
  - Approximately 1 in 5 children and adolescents experiences the signs and symptoms of a DSM-IV disorder during the course of a year
  - 5% of all children experience "extreme functional impairment (Department of Health and Human Services, USA, 1999)
- About a total prevalence of 16.3% in Hong Kong
- 51.7% belongs to behavioral disorders, neurotic conditions and adjustment reactions (Wong, 1990)

Reasons

- Family as the key socialization agent of children and adolescents
- Importance of context in conceptualizing child and adolescent mental health problems
- Reciprocal interaction between the afflicted child/adolescent and his or her family, in particularly the parents

Reasons

- Spill-over effects of mental health problems

  to the family

  - psychological distress of parents faced with eating disorders (ED) are even higher than for parents with a psychotic patient in the family (Treasure et al., 2001) in the UK and Germany (Graap et al., 2008)
  - Applicable in Hong Kong (Ma, in press)

Ma's study in Shenzhen (in press)

Symptom Check-List-90R(SCL-90R), McMaster Model of Family Functioning (FAD) and Dyadic Adjustment Scale (DAS) scores of Parents

	Fathers Mean (S.D.)	Mothers Mean (S.D.)	T-test T
Symptom Check-List-90R(SCL-90R) scores	(n = 15)	(n = 18)	
Somatization	.47 (.44)	.94 (.69)	-2.33*
Obsessive-Compulsive	.53 (.59)	.95 (.57)	-2.03
Interpersonal Sensitivity	.43 (.49)	.63 (.50)	-1.16
Depression	.47 (.51)	1.07 (.81)	-2.46*
Anxiety	.38 (.56)	1.05 (.81)	-2.76**
Hostility	.84 (.97)	.96 (.57)	-.44
Phobic Anxiety	.22 (.30)	.42 (.48)	-1.36
Paranoid Ideation	.51 (.54)	.72 (.65)	-.97
Psychoticism	.39 (.53)	.49 (.54)	-.57
Lower scores denote less symptomatic			

Symptom Check-List-90R(SCL-90R), McMaster Model of Family Functioning (FAD) and Dyadic Adjustment Scale (DAS) scores of Parents (Cont'd)

	Fathers Mean (S.D.)	Mothers Mean (S.D.)	T-test T
McMaster Model of Family Functioning (FAD) Scores	(n = 15)	(n = 18)	
Problem Solving	2.00 (.29)	2.02 (.41)	-.18
Communication	2.21 (.23)	2.21 (.39)	.03
Roles	2.35 (.21)	2.48 (.30)	-1.41
Affective Responsiveness	2.20 (.38)	2.11 (.42)	.62
Affective Involvement	2.23 (.38)	2.22 (.53)	.14
Behaviour Control	2.41 (.29)	2.42 (.27)	-.03
General Functioning	2.07 (.33)	2.03 (.38)	.31
Lower scores denote healthy Family functioning			

Symptom Check-List-90R(SCL-90R), McMaster Model of Family Functioning (FAD) and Dyadic Adjustment Scale (DAS) scores of Parents (Cont'd)

	Fathers Mean (S.D.)	Mothers Mean (S.D.)	T-test T
Dyadic Adjustment Scale (DAS)	(n = 15)	(n = 18)	
Dyadic Consensus	50.40 (8.58)	53.58 (9.00)	-.93
Affection Expression	8.57 (2.41)	9.08 (2.49)	-.53
Dyadic Satisfaction	37.00 (5.59)	36.00 (8.63)	.33
Dyadic Cohesion	16.15 (3.31)	15.31 (5.56)	.51

Results of Ma's study

- Level of the Shenzhen mothers' psychological distress within the clinical range, similar to results obtained in Hong Kong (Ma & Lai, 2009) and in the UK (Treasure et al., 2001)
- Shenzhen father's anxiety and depression levels have been lower than that of the mothers
- Shenzhen fathers more distressed than the Hong Kong fathers (Ma & Lai, 2009)

Results of Ma's study

- Shenzhen fathers score moderately high on hostility (mean = .84), more angry and hostile toward the young person with ED than the Hong Kong fathers (mean =. 57) (Ma & Lai, 2009)

What

- Family centered care (FCC) acknowledges the family as the expert on itself and the patient, and includes families as full partners in all aspects of service delivery and decisions around care (Allen & Petr, 1996)

Principles of Family Centered Care

- Acknowledge family as an expert
- Family as a full partner
- Partnership between the child, family and professionals based on trust, mutual respect, honesty and open communication
- Patient and family empowerment as intervention purpose

Principles of Family Centered Care

- Ongoing identification of family needs, strengths and resources
- Begins with first contact
- Individualized and flexible treatment plans
- Every interaction as an opportunity to use family strengths and abilities or to learn new skills and abilities
- Use and build on each family's informal support system (Spragins, 2007)

Barriers

- Stigma
  - Parent blaming
  - Child welfare and juvenile justice being blamed
- Lack of training and awareness among mental health professionals in working with families
  - Foster care parents and social workers have little training in mental health issues and family work

Barriers

- Provider driven model and medical model
- Organizational culture
  - Impersonal and bureaucratic
- Confidentiality restrictions
  - Issues of information sharing across multiple agencies

Barriers

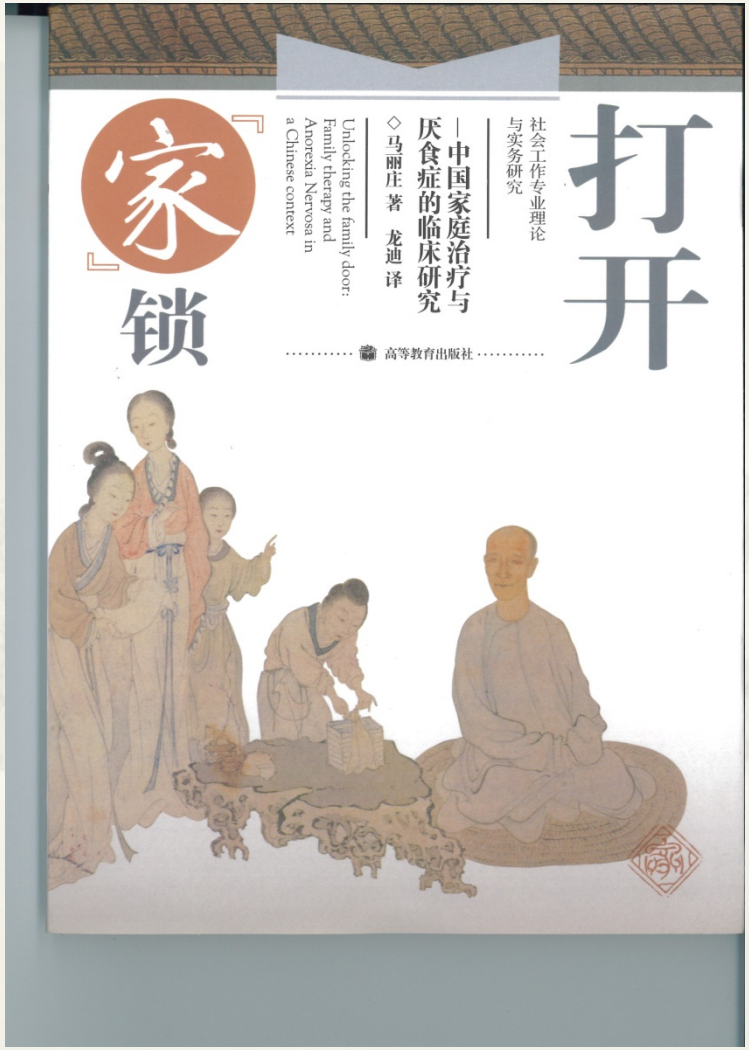
- Family perspective
  - Overemphasis on medical conditions
  - Lack of professional support during crisis situations
  - Frequent therapist turnover
  - Confidentiality issues
  - Lack of respect or interest in family perspectives
  - Being treated with distrust by psychiatric unit personnel (Rose et al., 2004)

Barriers

- Health care providers' perspective
  - Lack of system level support
  - Disruption of care between inpatient and outpatient settings
  - Focus on crisis care
  - Lack of appropriate physical space
  - No mandate to provide family care
  - Family resistance
  - Family pathology (e.g., substance abuse)

Possibilities

- New initiatives in Hong Kong
  - Applicability of family therapy for children and adolescents suffering from anorexia nervosa (Ma, 2008; Ma & Lai, 2009)



Possibilities

- Family therapy with adolescent substance abuse (Sim, 2007)
- Use of multiple family group for families with ADAD child

Encouraging but far from sufficient……

Possibilities

- Shift in organizational practices
- Shift in attitudes and behaviors of health care providers
- Service planning recognize family context, strengths, desires and experience and commitment
- Address stigma and increase awareness

Possibilities

- Cultivate climate of partnership and collaboration between families and health care providers
  - Involving families meaningfully in multiple aspects of intervention

  (Austin, 2004; Winters & Pumariega, 2007)
- Research
  - Evidence-based family centered care

Conclusion

The child can't be helped unless the family is helped

(Pierpont, Pozzuto & Powell, 2001)

THANK YOU VERY MUCH