

Family Ties:

Engaging, Empowering, and Partnering with Families in the Treatment of Mental Illness

Silver Hill Hospital

Grand Rounds

January 14, 2026

Michelle D. Sherman, PhD LP ABPP

Disclaimer

Michelle Sherman has indicated a relevant financial relationship with an ACCME-defined commercial interest: Author – Johns Hopkins University Press and Seeds of Hope Books. This presentation will be evidence-based and unbiased. All relevant financial relationships listed have been mitigated.



Happy to be with you today,
joining from chilly Minnesota



Sincere gratitude to Dr. Jeff Katzman and
Dr. Mark Russ for the invitation

Upsplash, Showkat Chowdhury

As a result of participating in this activity, you should be able to:

1. Describe the rationale for supporting families in the treatment of mental illness
2. Describe four common challenges clinicians can face in working with families
3. Apply two specific skills for engaging and partnering with families in your work

My Background



- Licensed clinical psychologist for 30+ years
- 17 years in the Veterans Affairs (VA) System
- 25 years as a Professor at the University of Oklahoma and Minnesota Medical Schools
- Board certified in Couple and Family Psychology
- Fellow of the American Psychological Association
- Editor of the APA journal, *Couple and Family Psychology: Research & Practice*
- Volunteer on NAMI Boards of Directors
- Disaster Mental Health Volunteer, American Red Cross
- Personal lived experience as a family member

Private Practice – Virtual Only

- Can provide therapy to people in 43 US states
- Specialties
 - Couples therapy
 - Supporting adults who love someone with a mental illness



CLINICAL AND
DEVELOPMENTAL
SERVICES LLC

A New Engagement Strategy in a VA-Based Family Psychoeducation Program

Michelle D. Sherman, Ph.D.
Ellen Fischer, Ph.D., M.P.A.
Ursula B. Bowling, Psy.D.
Lisa Dixon, M.D., M.P.H.
Lauren Ridener, B.A.
Denise Harrison, B.S.

Objective: This brief report describes the engagement strategy used in the Reaching out to Educate and Assist Caring, Healthy Families (REACH) program, a nine-month family psychoeducation program for veterans with serious mental illness or posttraumatic stress disorder (PTSD). **Methods:** A motivational interviewing-based strategy was created and implemented in a Veterans Affairs hospital to engage providers and veterans and their families into the intervention. **Results:** Of

with PTSD, 34% of veterans with an affective disorder, and 25% of veterans with a schizophrenia spectrum disorder went on to participate in at least one session of the REACH program with a family member; these rates compare favorably with those for programs requiring a much shorter commitment. **Conclusions:** This engagement strategy shows promise as an effective tool in recruiting veterans and their families into family psychoeducation. (*Psychiatric Services* 60:254–257, 2009)

Professional Psychology: Research and Practice
2008, Vol. 39, No. 4, 443–450

In the public domain
0735-7028/08/\$12.00 DOI: 10.1037/0735-7028.39.4.443

Key Factors Involved in Engaging Significant Others in the Treatment of Vietnam Veterans With PTSD

Michelle D. Sherman
Oklahoma City Veterans Affairs Medical Center; South Central
Mental Illness Research, Education and Clinical Center; and
University of Oklahoma Health Sciences Center

JoAnn Kirchner
Central Arkansas Veterans Healthcare System; South Central
Mental Illness Research, Education and Clinical Center; and
University of Arkansas for Medical Sciences

Dean Blevins
Central Arkansas Veterans Healthcare System and University of
Arkansas for Medical Sciences

Lauren Ridener
Oklahoma City Veterans Affairs Medical Center

Troy Jackson
South Central Mental Illness Research, Education and Clinical Center

In an effort to be responsive to the often complicated, multilayered family issues of people living with posttraumatic stress disorder, many well-intentioned therapists create a variety of family-based services—only to be discouraged when participation is very low. In the current project, 10 Vietnam veterans with posttraumatic stress disorder who were active in a stress recovery program and their live-in female partners completed separate semistructured interviews. Interviews explored each couple's perceptions about family participation in mental health treatment, including potential benefits and barriers. Findings revealed 9 key themes that elucidate many of the important issues in family engagement. The authors make 7 recommendations about how clinicians can overcome some of the possible obstacles to involving families in care.

Keywords: posttraumatic stress disorder, engagement, Vietnam veterans, family psychoeducation, family therapy

Been thinking about these ideas for a while...

SAFE Program: Mental Health Facts for Families



18-session family education program for people who care about someone living with mental illness or PTSD

SAFE Program: Support and Family Education

An 18-session family education curriculum for adults who care about someone living with a mental illness or PTSD. Named a best practice by VA Central Office.

[Learn more](#)

Veteran Parenting Toolkit: Together Building Strong Families

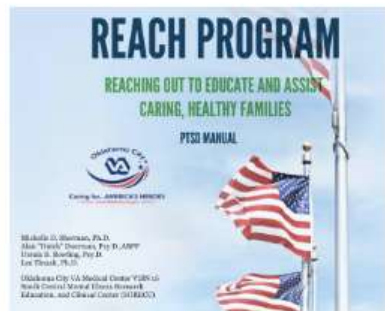


Five age-based parenting toolkits for Operation Enduring Freedom and Operation Iraqi Freedom veterans and their partners

Veteran Parenting Toolkits

Five age-based parenting toolkits for Iraq/ Afghanistan veterans and families, including infants, toddlers, preschoolers, elementary, and teenagers. Paper copies of toolkits were distributed nationally to all VAs in 2013.

[Visit](#)



REACH Program: Reaching out to Educate and Assist Caring, Healthy Families Program

The Oklahoma City VA Medical Center's adaptation of the multi-family group treatment for PTSD. Website includes the curriculum and student workbook.

[Learn more](#)

Family education curricula/resources

Funded by the VA South Central MIRECC

(Mental Illness Research, Education and Clinical Center)



A Veteran's Guide
to Talking With Kids About PTSD

Veteran's Guide to Talking with Kids about PTSD

An interactive pamphlet to empower adults living with PTSD in exploring if, when, how, and what to share with their children about their trauma and well-being. This guide emerged from a [research project](#) in which we learned from veteran parents about their experiences and needs.

I've concluded...

Working with families can be...(no...)
is often... (no...)
IS challenging!!

But it can be incredibly gratifying and meaningful as well

We are systemic jugglers—needing to listen, monitor, and respond to (sometimes conflicting) feelings and needs of the client, family members, organization/insurance, and other people in the healthcare team.

We are walking into a complex system in which the homeostasis has been shaken

Juan Pablo Rodriguez (Unsplash)



Outline

- WHY: Rationale for family involvement
 - WHO: Who is “family?”
 - WHEN: Timing
 - WHAT: Existing models
 - HOW: The art
 - BUT.... Challenges
 - RESOURCES
-
- P.S. to encourage further reflection on a long-neglected angle

WHY: Rationale for Family Involvement

- Relationships can be protective (& known adverse impacts of social isolation)

Families:

- Know the person's personality, preferences, strengths, history (meds, treatment, hospitalizations)
- Can help carry out treatment plans
- Are the “early warning system”
- Often experience a lot of suffering – and we can work to help improve their wellbeing
 - High rates of depression, anxiety, worry, exhaustion, powerless, burnout, etc.
 - Impaired role functioning in other domains (work, relationships, etc.)

Holt-Lunstad et al., 2025; Glecia & Li, 2023; Kalhovde et al., 2023; Shiraishi & Reilly, 2019

“The most difficult part for me was seeing how it (schizoaffective disorder) changed my son’s life. One moment he was a typical kid going off to college and the next he is in a psych ward with a disability. Seeing him in torment and not being able to fix it is horrible.”

—A DAD

“As an engineer by training, I want to fix things . . . I know I can’t just fix her depression . . . letting go of trying to change her is the hardest part of the job.”

—A HUSBAND

Family Involvement and Psychosis

Reduces relapse & hospitalization

- Via understanding psychosis, supporting treatment adherence, offering instrumental support, and connecting with the treatment team

AND

- Decreasing negative Expressed Emotion (EE)
Criticism, emotional over-involvement, hostility

Rodolico et al., 2022

Example: Research with coordinated specialty care (CSC) programs

- Clients usually WANT family involvement
- Over 70% of people in CSC programs live with family
- Lack of family support has been associated with increased client disengagement rates
 - An important issue as about 1/3 of clients disengage from services before the end

Jones et al., 2021; Polillo et al, 2022; Lucksted et al., 2015; Mascayano et al., 2020

WHY Family Involvement: Early Psychosis Programs

Systemic Review and Meta-Analysis of 40 studies

Significant treatment effects for family interventions within 5 years after onset (compared to treatment as usual) for:

Carers

- Psychological distress

- Burden

- Critical comments & emotional overinvolvement (parts of EE)

Patients

- Reduced rates of hospitalization

Gleeson et al., 2025

HOWEVER...

- Most providers in general psychiatric care report having minimal to no contact with families
- Most families say they have little to no access to the treatment team
- Many providers struggle with engaging and keeping families positively oriented in care

WHO is “Family?”

- **Explore this with your patient**
 - Tie to your patient’s goals
 - Consider pros and concerns with them
- **Don’t assume** someone actively engaged is the person your patient finds supportive
- **Assess contraindications**
 - Family violence
 - Severe distress / acute crisis in psychiatric functioning of family member (?)
 - Family substance use disorder or dementia (?)
 - Family cut-off





WHEN

New to agency and new to illness - crisis	New to agency but has had illness over 6 months
Has been in treatment with you but in crisis	Has been in treatment with you and stable



<p>New to agency and new to illness – crisis</p> <p>EASIEST to engage</p>	<p>New to agency but has had illness over 6 months</p> <p>“This is how we do things here”</p>
<p>Has been in treatment with you but in crisis</p> <p>“It’s time to change your treatment plan to avoid future crises”</p>	<p>Has been in treatment with you and stable</p> <p>“You’re ready to take the next step in your recovery! Want to help you meet your goals!”</p>

WHAT: Models

- **Shared decision making** with patient and family, considering their goals
- Availability and expertise of staff can vary considerably
 - Risks of family interventions by those without expertise in SMI
- **Common themes** across models
 - Communication
 - Managing symptoms and supporting treatment adherence
 - Planning for crises and encouraging early intervention
 - Problem-solving and boundaries
 - Education about the illness, treatment, and coping
 - Lowering overall levels of stress

Family Involvement During Admission

- Phone calls
- Individual family meetings
- NAMI meetings
- Family educational series
- Family resource centers (physical space / website)
- Resources provided at admission and discharge
- Discharge planning
- Family peer advocates

Research on family contact:

Having any contact between family & inpatient staff was associated with increased likelihood of patients attending a follow-up outpatient appointment (Haselden et al., 2019)

Example: Family Member Information Guide Oklahoma City VA Medical Center

- Your veteran's care team
- Visiting information
- How to communicate with veteran while admitted
- Family meetings
- Taking care of yourself
- How to support your kids during the hospitalization
- Family treatment options at our hospital
- Tips on when your veteran comes home

Family Member Information

PSYCHIATRY INPATIENT UNIT
8TH FLOOR



Veterans Affairs Medical Center
921 NE 13th Street
Oklahoma City, OK 73104-0501

Revised June 2012

We are honored to have the opportunity to care for your Veteran on our psychiatric inpatient unit. We created this booklet to:

- Explain our unit's procedures and how you can communicate with your Veteran while he/she is here.
- Encourage you to take good care of yourself.
- Educate you about family treatment options available here at the Oklahoma City VA hospital.

Continuum of Services

- **Disorder-specific couple/family therapy** (all with research base)
 - Behavioral Family Therapy (BFT) for psychosis – Glynn & Mueser
 - Family-Focused Therapy for Bipolar Disorder (FFT) – Miklowitz
 - Cognitive-Behavioral Conjoint Therapy for Posttraumatic Stress Disorder (CBCT for PTSD) Monson & Fredman
 - Couples Therapy for Depression - Beach
 - Multiple Family Group Therapy (MFG) – McFarlane
 - Behavioral Couples Therapy for Alcoholism and Drug Abuse (BCT) O'Farrell & Fals-Stewart
- **Family-assisted intervention** (emerging research base – can be used to promote engagement)
 - Family-supported Prolonged Exposure for PTSD - Meis

Family Education Courses (family member only)

Family Education Courses	
Mental Health Condition	Name of Course
All mental illnesses	Family to Family Program (National Alliance on Mental Illness, NAMI)
All mental illness including PTSD (military)	NAMI Homefront
All mental illnesses	Mental Health First Aid (MHFA) (National Council for Mental Wellbeing)
Borderline Personality Disorder (BPD)	Family Connections (National Education Alliance for Borderline Personality Disorder)

- RCT of the NAMI Family to Family Program (Dixon et al., 2011) found enhanced coping and decreased distress among attendees
- Family Connections research has found decreased burden, grief, and depression (Hoffman et al 2007)

Family Support Groups (family member only)

Family Peer Support Groups	
Mental Health Condition	Name
All mental illnesses	Family Support Group (National Alliance on Mental Illness, NAMI)
Depression and bipolar disorder	Depression and Bipolar Support Alliance (DBSA)
Alcohol misuse / drug use	Al-Anon / Nar-Anon
Alcohol misuse / drug use	Alateen
Any addiction	Self-Management and Recovery Training – SMART Recovery: Family and Friends
Alcohol misuse / drug use	Community Reinforcement Approach to Family Training (CRAFT) - Helping Families Help

Newer Supports for Families Managing Psychosis

- Psychosis REACH (Dr. Kate Hardy and colleagues)
 - Online skills training, live workshop, option to connect with a family ambassador
 - FIRST skills

Fall back on your relationship
Inquire Curiously
Review the information and put it together
Skill development
Try out the skill and get feedback

Hardy et al. (2020)



Supports for Families

(current research studies)

- **UPLIFT** (Understanding Prodromes & Lowering Risk in Family Therapy): Michelle Friedman-Yakoobian Ph.D. (PI)
- 6-months of Family Focused Therapy (FFT)
 - Psychoeducation
 - Communication skills training
 - Problem-solving skills





HOW

Paradigm Shift

Traditional Family Therapy

- Family “caused” it and “has a need to maintain” the illness
- Mental disorders are just “symptoms of the real problem”

Psychoeducational Approaches

- Validates the family as essential collaborators for consumer success
- Works to correct traditional view of “blaming” the family

[Home](#) > [Community Mental Health Journal](#) > [Article](#)

Applying the Readiness to Change Model to Implementation of Family Intervention for Serious Mental Illness

Published: April 2005

Volume 41, pages 115–127, (2005) [Cite this article](#)



[Community Mental Health Journal](#)

[Aims and scope](#) →

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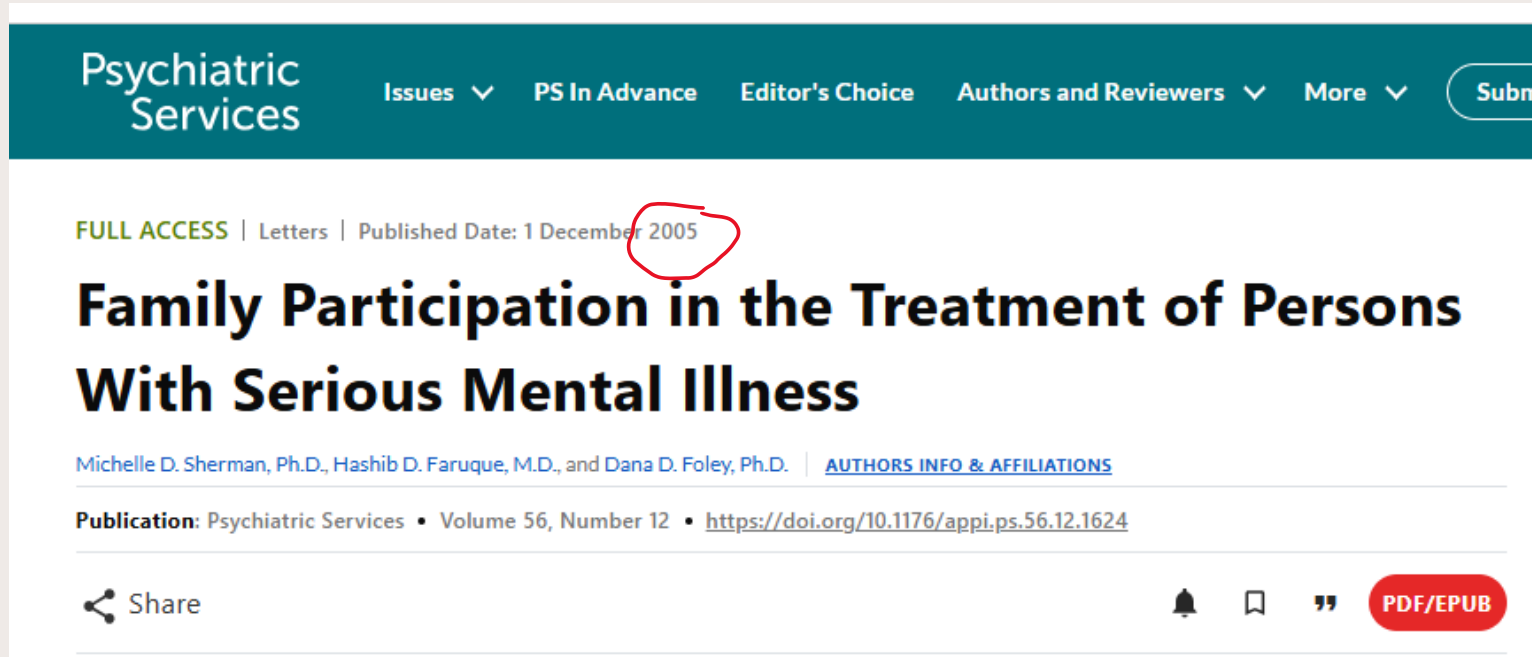
[Michelle D. Sherman](#) & [Richard A. Carothers](#)

[Access this article](#)

Need Buy-In at All Levels

- **Public health/policy**
 - Funding for work with families
- **Administrators**
 - Staffing
 - Training of all staff
 - Building design (waiting rooms, visiting rooms on inpatient units, etc.)
- **Clinicians**
 - Training, supervision, time
- **Family**
 - May need to overcome past negative experiences
 - Importance of being responsive
- **Patient**
 - Confidentiality
 - Addressing paranoia, mistrust, etc.

BUT.... Been trying some approaches for a while...



Psychiatric Services




Issues ▾ PS In Advance Editor's Choice Authors and Reviewers ▾ More ▾ Submit

FULL ACCESS | Letters | Published Date: 1 December 2005

Family Participation in the Treatment of Persons With Serious Mental Illness

Michelle D. Sherman, Ph.D., Hashib D. Faruque, M.D., and Dana D. Foley, Ph.D. | [AUTHORS INFO & AFFILIATIONS](#)

Publication: Psychiatric Services • Volume 56, Number 12 • <https://doi.org/10.1176/appi.ps.56.12.1624>

Share    PDF/EPUB

70% had regular contact with a family member within 90 miles
 46% allowed us to contact them
 3 conditions: pamphlet; added letter; added phone call
 Minimal response!

We learn from our failures! This is not easy!



Question:

**What are the most common challenges
you experience in ENGAGING families?**



COMMON FAMILY-LEVEL BARRIERS to ENGAGEMENT

- Stigma and shame
- Lack of knowledge (symptoms, treatment availability/access, how treatment could help)
- Cultural differences
- Family dynamics (power struggles, pre-existing relationship challenges, communication problems)
- Time constraints
- Transportation, financial barriers, childcare
- Family's own mental health challenges
- History of families not feeling engaged/appreciated/valued (“expert-itis”, Karpa et al., 2025)
- Concerns about privacy / confidentiality
- Anosognosia



Question:

**What are the most common challenges
you (or clinicians broadly) experience in
WORKING and PARTNERING WITH
families?**



COMMON CHALLENGES IN WORKING WITH FAMILIES

- Lack of coordination of services
- Stigma within the system (our own/other providers' negative attitudes or stereotypes)
- Lack of training: on how to engage & work w/ families
- Limited funding or resources
- Large caseloads
- Organizational demands/paperwork
- Families making recommendations that are not consistent w/ team's treatment plan
- Helping families to provide support while fostering autonomy (& without enabling)
- Substance abuse

Despite the challenges, your relationship with the client and family are very important

- Qualitative research regarding early psychosis intervention services
 - Top-rated facilitator of client ENGAGEMENT in care (for both clients & families): Positive therapeutic relationship with the clinician
- Per families: Common BARRIER to client continuation in CSC: disliking or not trusting the clinician

Polillo et al., 2022

Michelle's Three Reflections on the HOW

(from my clinical experience, research, and review of available models)



Specific Credit to Colonel Dutch Doerman PsyD ABPP, US Air Force (Ret)

1. Remember “It’s all about the okra”



Amber Malquist (Unsplash)

HOW

- ✓ Treat like a guest in your living room
- ✓ Assess “who is family” (& encourage a ROI)
- ✓ Listen to their story, culture, beliefs, experiences: They are the expert in their experience/family & important part of the team
- ✓ See and talk about their loved one (client) as more than an illness & having strengths & a life of purpose
- ✓ Offer grace & patience & kindness
- ✓ Ride the waves without panic



HOW

- ✓ Validate the family's challenges & mental health/illness themselves
 - Caring can be HARD
 - Acknowledge the burden/toll

It's tiring to be strong all the time. Can someone just take care of me?

"The way you do it is important...the way you talk to us & ask us questions. It's not like you're going through a process..." (Mohammed, service user)

- ✓ Instill HOPE

Federation of Families, 2025, British Psychological Society, 2021

2. Pause and Offer Family Grace

- ✓ Think about “why” they’re behavior this way - Check your attributions (“resistance, sabotaging, manipulative, low functioning, checked out”?)
- ✓ Remember they are doing their best - and have a life outside of caring. Thank them for how they are showing up
- ✓ Honor their strengths (they are here today) & how they’ve overcome really hard things
- ✓ Focus on making 1-millimeter changes and offer options
- ✓ How can I as a clinician stay hopeful




3. Focus: How can I help the family today?

How are you different from the system?

- Listen to what matters to THEM
- Figure out the gap between where the family is today and where they want to be:

- ✓ What are your biggest worries/concerns today?
- ✓ How can I help?
 - a. Provide and/or connect with education & resources
 - b. Be aware of supports in the community



**Reaching out to
Educate &
Assist
Caring
Healthy Families**

Date: _____ Name: _____

In our appointment today, we are going to talk about a new program at our hospital for Veterans and their families/friends, the **REACH Project** (Reaching out to Educate and Assist Caring, Healthy Families). In order for us to think about how this program might help you, please check the goals below that apply to you right now. What would you like to be different in your life? We believe we can help you move toward your goals.

I would like to:
(please **CHECK** all that apply)

<input type="checkbox"/> Communicate better with my family and friends	<input type="checkbox"/> Have my family/friends better understand what I'm going through
<input type="checkbox"/> Have my family more involved in my mental health care without sacrificing my privacy	<input type="checkbox"/> Help my family/friends learn to back off and stop pressuring me
<input type="checkbox"/> Have less tension and fewer arguments with people	<input type="checkbox"/> Find a job that I can enjoy
<input type="checkbox"/> Learn how to better manage my temper	<input type="checkbox"/> Learn what I can do to stay out of the hospital
<input type="checkbox"/> Do more fun things	<input type="checkbox"/> Feel closer to important people in my life
<input type="checkbox"/> Manage money more effectively	<input type="checkbox"/> Learn how to better manage my medications and their side-effects
<input type="checkbox"/> Learn how to relax	<input type="checkbox"/> Find some hobbies
<input type="checkbox"/> Have less stress at home	<input type="checkbox"/> Learn how to solve problems more effectively
<input type="checkbox"/> Feel less lonely	
<input type="checkbox"/> Be able to trust people more	

3. Focus: How can I help the family today?

Teach specific skills

- Give self grace & practice self-compassion

It's OK:

- ✓ To make mistakes
- ✓ To not be perfect
- ✓ To put my own needs first
- ✓ To have regrets
- ✓ To disappoint my partner
- ✓ To feel angry with him
- ✓ To say no
- ✓ To take time for myself

—A WIFE

Just as you cannot yell at a flower to grow faster,
you cannot hurry people along in their mental
health journey.

People grow at their own pace.

You can only control yourself
and your choices.



Find the balance between being a supportive advocate and taking care of yourself.

Sometimes it's a daily recommitment to

- releasing your efforts to control,
- focusing on being in the present,
- & showing up in love for your loved one and yourself.



3. Focus: How can I help the family today?

Teach specific skills

- Goal setting skills
- Early warning signs / Psychiatric Advanced Directive
- Problem-solving skills
- Strategies to empower their loved one
- Limit-setting skills (& conflict disengagement skills)

3. Focus: How can I help the family today?

Teach specific skills

- Recognize recovery can be not linear (coping with ambiguity and uncertainty)
- Regularly encourage self-care for families

“The most challenging part is unpredictability. Just when things seem to be going well, there can be very real, unexpected setbacks. The path to healing and wholeness is seldom smooth and steady. That can be exhausting.”

—A DAUGHTER

Sample Skill:

Teaching Families How to Respond when their Loved One Declines Care

- Listen
- Use their words rather than focusing on labels or diagnoses
- Explore the WHY: How could treatment help your loved one move toward their goals?
- Recognize the positive steps your loved one makes, and offer practical help
- Encourage your loved one to advocate for themselves

Dr. Pat Deegan encourages people to create **power statements** to convey their wishes. For example, your loved one could tell their provider: “I want you to help me find a medication that will help me _____ so that I can _____.”



Deegan et al., 2017

Summary

- 1. Remember: It's all about the Okra**
- 2. Pause: Offer family grace**
- 3. Focus: How can I help the family today?**

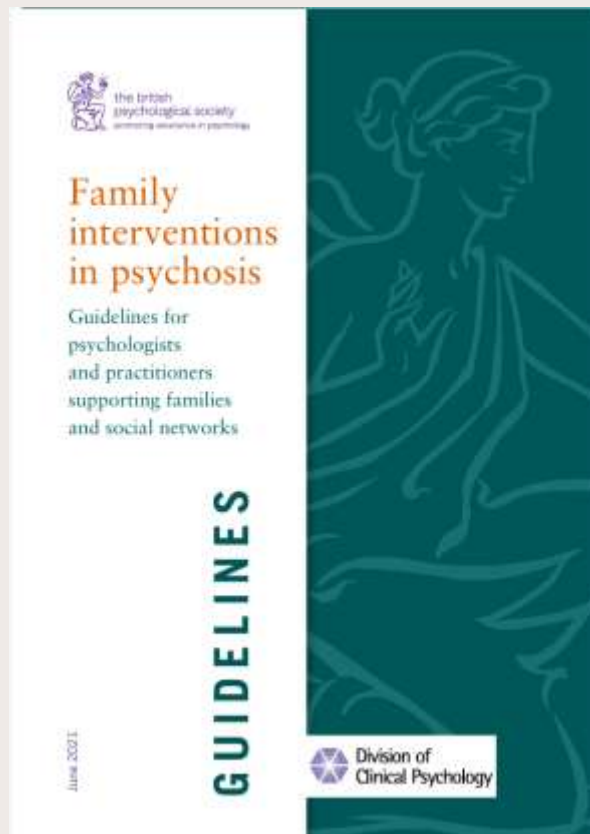


Resources



Free Online Resources (see handout)

For Clinicians



Free Online Resources

For Families:
Psychosis REACH





Free Online Resources

For Families: Caregiver Action Network



Free Online Resources

For Families

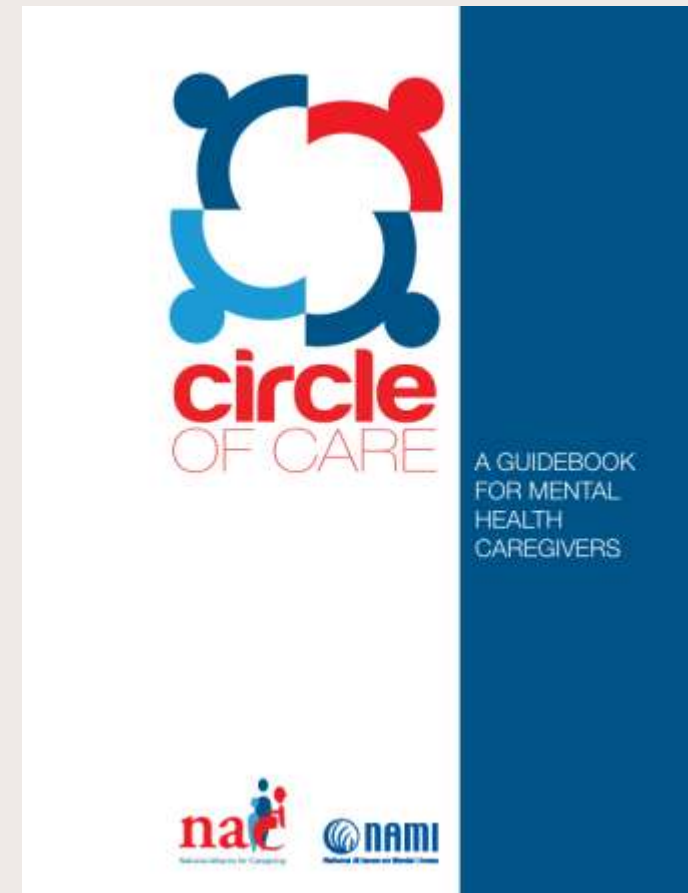
Schizophrenia & Psychosis Action Alliance:
Caregiver Toolkit



Free Online Resources

For Families:

NAMI Circle of Care Guidebook



Schizophrenia: Three Moms in the Trenches

- As of January 2026, have 140 videos
- 3 moms whose sons have schizophrenia, often with a wide variety of guests
 - Randye Kaye, Mindy Greiling, Miriam Feldman
- Recent Silver Hill guests: Katharine Dougherty PhD, Lisa Mann, PhD , and Dr. Rocco Marotta on changing the course of psychotic illness
- Free and on YouTube and wherever you enjoy podcasts



If client has anosognosia

- Xavier Amador, PhD
- LEAP communication skills
 - Listen
 - Empathize
 - Agree
 - Partner



Free Online Resources (Parenting resources)

For Clinicians AND Families:

Parenting Well Approach

National Research Center for Parents with
Disabilities, Brandeis University



Free Online Resources (Parenting resources)

For Clinicians AND Families:

Temple University's Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities:

Parenting with Mental Health Challenges

Advanced Self-Advocacy Plans (ASAPs)





Now for the P.S.



For Further Reflection: What about the KIDS?



Prevalence of ACEs by Category for CDC-Kaiser ACE Study Participants by Sex, Waves 1 and 2.

ACE Category	Women	Men	Total
	Percent (N = 9,367)	Percent (N = 7,970)	Percent (N = 17,337)
ABUSE			
Emotional Abuse	13.1%	7.6%	10.6%
Physical Abuse	27%	29.9%	28.3%
Sexual Abuse	24.7%	16%	20.7%
HOUSEHOLD CHALLENGES			
Mother Treated Violently	13.7%	11.5%	12.7%
Household Substance Abuse	29.5%	23.8%	26.9%
Household Mental Illness	23.3%	14.8%	19.4%
Parental Separation or Divorce	24.5%	21.8%	23.3%
Incarcerated Household Member	5.2%	4.1%	4.7%
NEGLECT			
Emotional Neglect ³	16.7%	12.4%	14.8%
Physical Neglect ³	9.2%	10.7%	9.9%

CDC, 2016; Swedo et al., 2024

Risk of Transmission

Lifetime risk for youth of developing ANY mental disorder

- Parental bipolar disorder: 55%
- Parental depressive disorder: 51%
- Parental psychosis: 17%

Meta-analysis of over 3 million offspring: Uher et al (2023)

Disparities in CPS Involvement

Child Protective Service Disparities and Serious Mental Illnesses: Results From a National Survey

Individuals with mental illnesses were just as likely to be parents as those without



Parents with mental illnesses were 8x more likely to have contact with Child Protective Services (CPS)



Poverty & Discrimination may play a role in CPS involvement. Greater support through psychiatric services is needed.



Visual Abstract from: Kaplan, K., Brusilovskiy, E., O'Shea, A. M., & Salzer, M. S. (2019). Child protective service disparities and serious mental illnesses: results from a national survey. *Psychiatric Services*, 70(3), 202-208.



Sabreena shares her story

"During my childhood, my mum had depression. My dad died when I was young in a car accident, which caused my mum to deteriorate. After sitting down with my mum and advising her to get the help she needs, she would become very dismissive and paranoid. Her fear was that me and my sister would be taken away from her if she asked for help. This stopped my mum reaching out for help for many years."

Despite clear impact on parents, children, and families...

*“Children with a parent with mental illness often **fall through the cracks** and are **seen as nobody's responsibility**. Nothing is explained to them, and they often receive no help at all to deal with the effects of the parent's illness. These children need to be seen and heard.”*

- Dr. Alan Cooklin (2004)



Resources and Models from Other Countries



Great group in Florida – not focused on mental illness



Advocacy Opportunities:

Example: UK Mental Health Code of Practice

- Code (October 2025) requires
 - “Take steps to **identify** children of patients being detained (involuntarily admitted)
 - **Provide information** about support available for the children
 - **Make the appropriate referrals** if a Young Carer’s Needs Assessment is needed”
 - **Add question** in Advance Choice Documents about offspring

“Like all children, children of parents with mental health labels need to be seen, heard and valued.

We need to change the false narrative of genetic destiny and invisibility to one of hope and continued healing.”



– Cheri Bragg, MSW (2018)

Opportunities in Your Setting for Identifying and Supporting Offspring?

My Hopes for 2026 and Beyond...

SHIFT FROM...	TO....
"Just refer to the family therapist" or "That's not my job"	EVERYONE is attuned to and engaged with families
Managing repeated crises	Early intervention and prevention, including family peer supporters
Not consistently asking about or supporting offspring	Routine assessment and resource provision to kids
Worry about cuts to family programming	Dedicated funding to engaging families
Families often feeling silenced and clinicians juggling desire to support them with HIPAA regulations	Finding ways to have communication that respects patient autonomy while also families having a voice
Tendency to pathologize or dismiss families	Welcome and connect (remember the okra!), listen, partner, and empower
Focus on healing largely in our clinics/hospitals	Increased focus on building community and connection (for patients and families)



And in the words of a mom whose son has schizophrenia...



“More than anything, I long for, seek, and only sometimes find clinicians who have the ability to work with clients' families.

These are clinicians who welcome our input, not because they feel they have to go through the motions, but because they know deep in their bones that having families on the team helps their patients.

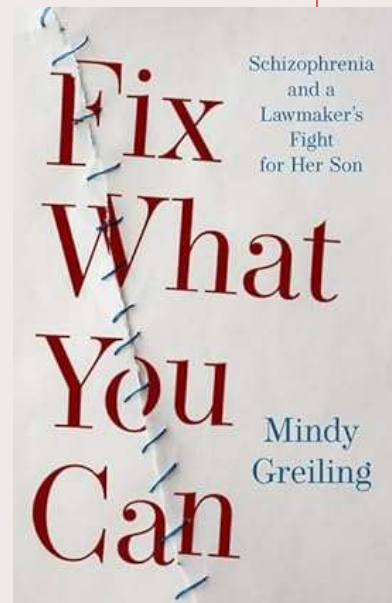
For wise and confident clinicians, this knowledge is enough. They find common sense ways to work with or around HIPPA.

For the majority who can't, we need education.

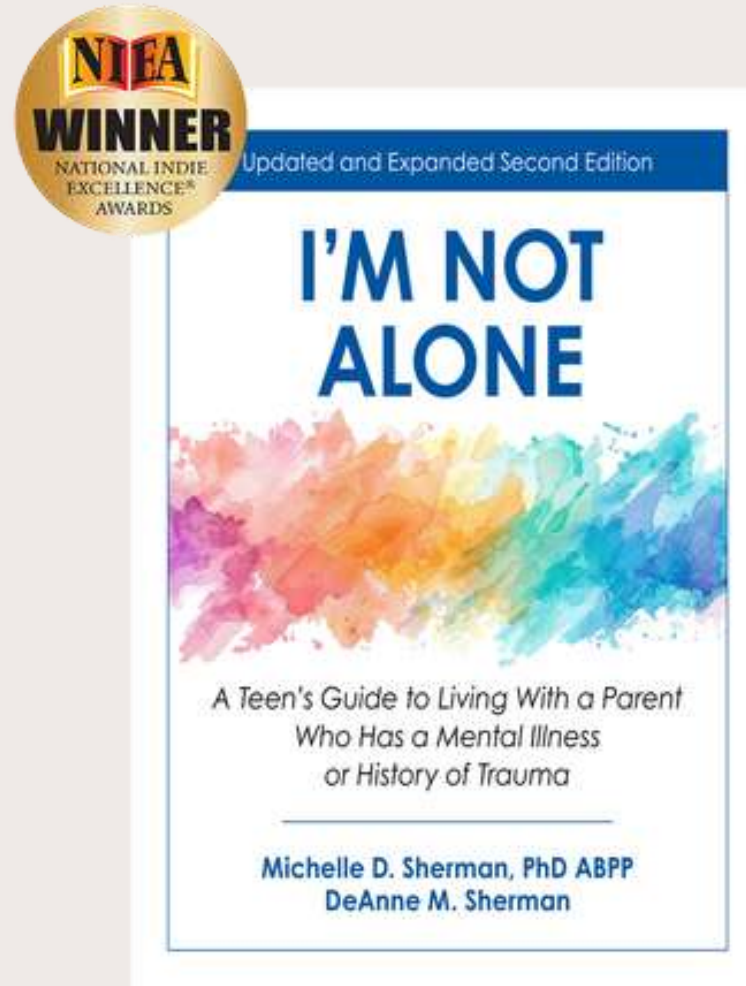
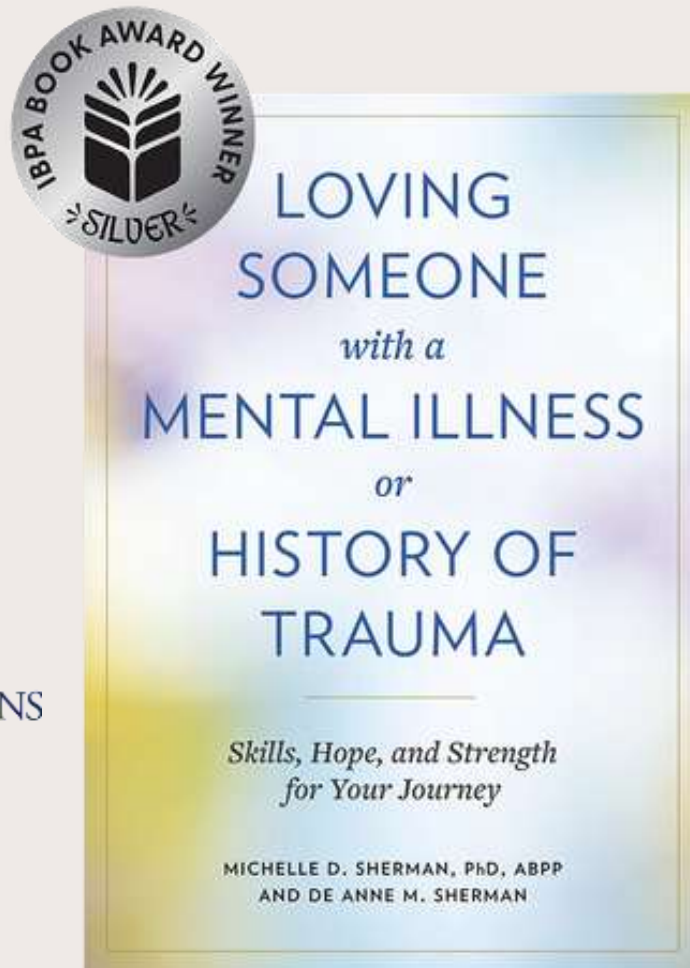
For those who don't want to and hence hide behind HIPPA, we must clarify the law.

Families go into crisis along with their loved one, and one cannot be helped without the other.”

Mindy Greiling, 1-1-2026, Shared with her permission



For additional information and many free resources:
www.SeedsofHopeBooks.com



Thank you

Michelle D Sherman PhD LP ABPP
MichelleShermanPhD@gmail.com



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