Intervention programs for children whose parents have a mental illness: a review

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Abstract

Objective: To identify and describe intervention programs to improve outcomes for children whose parents have a mental illness.

Data sources: Grey and black literature was sourced from (i) three previous reviews/scoping studies, (ii) PsycINFO and MEDLINE searches of English, German and Dutch papers, and (iii) in consultation with researchers, clinicians, consumers and carers in the field.

Study selection: Only programs specifically targeting children whose parent/s have a mental illness. No restrictions were placed on study quality.

Data extraction: Program description, target group and evidence base.

Data synthesis: Programs from Australia, Europe and North America were found and collated into (i) family interventions, (ii) peer-support programs, (iii) online interventions and (iv) bibliotherapy. Some programs had been evaluated, with promising results. Others had minimal or no evaluation.

Conclusions: The core component across programs is the provision of psychosocial education to children about mental illness. More rigorous research is required to establish the conditions through which children's outcomes are enhanced.

An Australian epidemiological study found that 21%–23% of children have at least one parent who has a mental illness,[1] with varying levels of risk exposure, depending on several child, parent, family and community variables.[2] In recent years, there have been a number of programs that aim to promote the positive determinants of children's wellbeing and reduce the risk factors associated with living with parental mental illness. As these children are at higher risk of developing mental illnesses, suicide ideation and attempts, and functional impairment than their peers,[2] it is essential that appropriate early intervention programs are developed. Scoping projects conducted in 1999[3] and 2008[4] found that peer-support programs were the main form of intervention offered in Australia. However, Fraser and colleagues[5] found that the evaluation methodology employed by most programs, including such peer-support programs, was weak and thus their effectiveness was uncertain.

Our review aimed to identify the range of interventions that clinicians might employ, or refer to, when working with such children. Building on previous reviews,[3-5] this article presents available interventions for children, highlighting evidence data when available. Given the different needs of very young children and older children, we focused on programs that target children aged 5–18 years (although some programs also include younger or older children).

Methods

Grey (unpublished) and black (published, peer-reviewed) literature was sourced from three fields. First, we examined a review of evaluated programs by Fraser and colleagues,[5] as well as Australia-wide scoping projects conducted in 1999[3] and 2008.[4] Second, searches were conducted using PsycINFO and MEDLINE in June 2011, using key terms (list available from the authors on request) with no date limits, for papers published in English, Dutch or German. Finally, on the basis of these approaches, we identified various programs and circulated this list among our professional networks (carer and consumer groups, researchers and clinicians) to identify other programs and program types that we might have missed.

We included only those programs with a specific focus on children whose parents have a mental illness (excluding parental substance abuse). This meant that parenting programs for parents with a mental illness were excluded. Conversely, family programs were included if children were included in the intervention. Interventions targeting children with existing mental health problems were excluded. As the focus of our review was on identifying available programs, no restrictions were placed on study quality.

Information extracted included program description, length, target group and available evidence base.

Programs from Australia, Europe and North America were found and collated into (i) family interventions, (ii) peer-support programs, (iii) online interventions, and (iv) bibliotherapy.

Results

Family-intervention programs

We identified seven family-intervention programs (Box 1).[6-13] Of these, six programs target families where a parent has depression and/or anxiety.[7,8,10-13] The most prominent, Family Talk, targets families where a parent is diagnosed with a major depressive disorder or bipolar disorder, with children aged between 8 and 15 years who have never been treated for an affective disorder.[10,11] Family Talk employs a cognitive psychoeducational approach of between six and 10 sessions, some of which are directed to parents, some to the children and some to the whole family. Another program, Family Options,[9] employs a care-coordination model tailored for individual families where a parent has a serious mental illness; however, at this point, child outcomes are not available.

Overall, family programs focus on minimising family dysfunction and maximising children's support networks and competencies. Family programs can range from two to 20 sessions, and more research is required to determine

1 Family-intervention programs for children whose parents have a mental illness*

Program: year, country	Target population	Intervention frequency	Intervention description	Evaluation method and results
CAPS: 2009, USA[6]	Parents with anxiety and their children aged 7–12 years	Six to eight weekly sessions and three monthly booster sessions; first two sessions with parents alone, others with the family	Children: anxiety management, cognitive restructuring, problem solving skills. Parents: anxiety management, contingency management, communication and problem-solving skills	Design: RCT comparing CAPS (n = 20) with waitlist control group (n = 20). Measures: ADIS Child Version, SCARED. Results: 30% of waitlist children developed an anxiety disorder at 1-year follow-up compared with no children in CAPS group
EFEKT-E: 2011, Germany[7]	Parents with depression and their children aged 4–7 years	Six sessions for parents/ children	Parents: education regarding parenting and impact of depression on children's development and parenting. Children: education regarding social problem-solving skills	Design: RCT of 375 families comparing usual care and intervention. Measures: group facilitators rated children's on-task and off-task behaviour during each session. Mothers reported on children's social behaviour and skills. Results: children reported significantly less emotional disruption and hyperactivity
Family group cognitive behavioral preventive intervention: 2011, USA[8]	Parents with major depressive disorder and their children aged 9–15 years	Eight weekly and four monthly group sessions for family groups (four families per group)	Clinician-facilitated cognitive behavioural skills training to parents and children. Parents provided with parenting skill training and children with adaptive coping. Group meetings also with other families	Design: RCT comparing family intervention (n = 56) and families receiving written information only (n = 55), at 18 and 24 months. Measures: CES-D; CBCL; K-SADS-PL. Results: children in experimental group had significantly lower anxiety/depression levels and internalising symptoms at 18 months, and significantly lower externalising symptoms at 18 and 24 months
Family Options: 2009, USA[9]	Parents with serious mental illness and their children aged 1.5–16 years	Meetings at least weekly with the family and family members over 12–18 months, depending on the need of the families (phone link also available)	Clinician facilitated a care plan tailored to needs of family members	Design: qualitative (interviews) and quantitative (within-group), pre, 6, 12 and 18 months (n = 22). Results: no children's outcomes available yet
Family Talk: 2003, 2007, USA[10,11]	Parents with affective disorder and their children aged 8–15 years	Lecture delivered over two meetings with group of parents; and six to 11 clinician-led weekly sessions with parents/children/family plus follow-up at 6–9 months	Psychoeducational material about mood disorders, risk and resilience	Design: RCT comparing lecture (n = 40) and clinician-led intervention (n = 69) pre, immediately post, 1, 2.5 and 4.5 years. Measures: K-SADS-PL, YSR questionnaire and semi-structured child interview. Results: at 4.5 years after clinician-led intervention: significantly more gains in children's understanding of parental disorder; children's functioning increased for both groups and internalising symptoms decreased
Keeping Families Strong: 2011, USA[12]	Depressed mothers and their children aged 9–16 years	10 sessions including parent and child multifamily groups (no more than four families in one group) and individual family group meetings	Clinician-facilitated cognitive behavioural sessions	Design: within-group pre and post (n = 16). Measures: child coping strategies checklist; coping efficacy scale; BASC; LER. Results: decreased internalising symptoms, improved coping and decreased stressful family events
Let's Talk: 2010, Finland[13]	Parents with affective disorder and their children aged 8–16 years	1–2 weekly sessions	Clinician-facilitated psychoeducational sessions with parent/s	Design: RCT comparing Family Talk (n = 40) and Let's Talk (n = 44), at 4, 10 and 18 months. Measures: SDQ; SCARED. Results: both interventions effective in decreasing children's emotional symptoms and anxiety, and in improving children's prosocial behaviour. Family Talk more effective on emotional symptoms immediately after intervention

ADIS = Anxiety Disorders Interview Schedule. BASC = Behavior Assessment System for Children. CAPS = Coping and Promoting Strength Program. CBCL = Child Behavior Checklist. CES-D = Center for Epidemiologic Studies Depression Scale. K-SADS-PL = Schedule for Affective Disorders and Schizophrenia for School-age Children. LER = Coddington Life Events Record. RCT = randomised controlled trial. SCARED = Screen for Child Anxiety Related Emotional Disorders. SDQ = Strengths and Difficulties Questionnaire. YSR = Youth Self-Report.
*In family programs, methodology relates to child participants only. ◆

2 Peer-support programs for children whose parents have a mental illness

Program: year, country	Target population	Intervention frequency	Intervention description	Evaluation method and results
Action for Young Carers: 2008, UK[14]	11–16 year olds caring for their parents with a mental illness	Not time limited	Support and respite	Design: qualitative interviews (n = 10). Results: participants valued project workers and group work
Auryn groups: 2001, Germany[15]	7–16 year olds (split in separate age-related groups)	24–38 weekly sessions with children; home visit (1 week before start); four to six parent sessions; one booster session	Clinician-facilitated psychoeducation and support groups (children and parents)	None reported
CHAMPS: 2009, Australia[16]	8–12 year olds	Offered as either after-school weekly program or 3–4-day holiday program	Structured peer support, psychoeducational groups, family participation during program, activity based	Design: within-group, pre, 4 weeks post (n = 69). Measures: Kids Connections, Kids Problems and Kids Coping scales; RSSE. Results: improvements in self-esteem, problem-focused coping and connections within family
Group cognitive therapy prevention: 2001, USA[17]	13–18 year olds, with a parent with depression, who reported subdiagnostic levels of depressive symptoms but insufficient to meet full diagnosis of depression	15 1-hour sessions for groups of six to 10 young adolescents	Teaching of cognitive restructuring techniques to identify and challenge irrational, unrealistic or overly negative thoughts. Three separate parent sessions conducted to inform parents about the program (but not to discuss parent's depression)	Design: RCT comparing usual care (n = 49) and intervention (n = 45) pre, immediately post, 12 and 24 months. Measures: K-SADS-PL to obtain diagnoses, CES-D, HAM-D, GAF. Results: Intervention group significantly less likely to report major depressive incidence
Kids with Confidence: 2009, Australia[18]	12–18 year olds	Monthly meetings	Semistructured activities that provide respite, education, support and fun	Design: verbal feedback and program attendance. Results: regular attendance, reported improvements in self-esteem and confidence
Kids in Control: 2006, Canada[19]	8–13 year olds whose parent or sibling has a mental illness	8-week program	Learning about mental illness and practising coping and interpersonal skills; social support	Design: RCT (waitlist control), pre, post, 8 weeks (n = 33). Measures: CSEI, Kids Coping and Kids Knowledge scales. Results: higher levels of self-esteem and diminished use of maladaptive coping strategies
KOPING Program: 2008, 2009, Australia[20,21]	12–18 year olds	Initial three group sessions; follow-up support	Peer-support groups. Ongoing support, including newsletters, email contact, drop-in group	Design: RCT pre, post, 8 weeks (n = 44). Measures: knowledge and awareness of parental mental illness measures; SC, RSQ, CDI, SWLS, SDQ, YCOPI. Results: increased mental health literacy, prosocial behaviour and life satisfaction. Decreased depression and emotional symptoms. No significant differences between groups
PATS: 2008, 2005, Australia[22,23]	12–18 year olds	8-week group program, 2 hours/week; activities during year	Peer-support groups (four to eight adolescents, peer leader, health professional); reference committee; recreational activities	Design: Within-group, pre, post, 6 and 12 months (n = 64). Measures: MBCBS, PSSS, SPSI, SMFQ, plus self-developed scales. Results: significant reduction in depressive symptoms, risk of homelessness and experience of stigma. No differences reported over time in substance use, social support and problem solving
Play and talk groups: Netherlands[24]	8–12 year olds	Eight weekly sessions (child); one parent session; one booster session	Clinician-facilitated psychoeducation and support groups. Activities include group conversations, role plays, games, home-work assignments, leisure activities. One parent meeting	Design: RCT (waitlist control), pre, post, 3 months (n = 254). Measures: emotional and behavioural problems, negative cognitions, social support, competence, parent–child interaction. Results: not yet available
Positive Connections: 2003, USA[25]	8–13 year olds	Three phases of two consecutive 5-week groups; 6 months of mentoring	Clinician-facilitated psychoeducation and support groups; mentoring through Big Brothers/Big Sisters; graduation ceremony.	Design: Within-group, pre and post (n = 11). Measures: SEI, FAM, knowledge and coping skills measures. Results: significance not indicated; most measures showed improvement

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2 Peer-support programs for children whose parents have a mental illness (*continued from page 20*)

Program: year, country	Target population	Intervention frequency	Intervention description	Evaluation method and results
SMILES: 2004, Canada, Australia[26]	8–16 year olds whose parent or sibling had a mental illness	3-day consecutive program	Peer-support groups; activities include artwork, games, singing, interactive and relaxation exercises; parent program	Design: Within-group, pre and immediately post (n = 25). Measures: knowledge and life skills measures. Results: improvement in knowledge of mental illness and self-rated life skills
Youth and Education Support: 2009, USA[27]	10–16 year olds	Six 2-hour sessions	Mental health literacy, adaptive coping strategies	Design: Within-group, pre and post (n = 17). Measures: A-COPE, KPIRT. Results: knowledge significantly increased post-intervention; no change in coping behaviour

A-COPE = Adolescent Coping Orientation for Problem Experiences. CDI = Children's Depression Inventory. CES-D = Center for Epidemiologic Studies Depression Scale. CHAMPS = Children and Mentally Ill Parents. CSEI = Coopersmith Self-Esteem Inventory. FAM = Family Assessment Measure. GAF = Global Assessment of Functioning Scale. HAM-D = Hamilton Depression Rating Scale. KPIRT = Knowledge of Psychiatric Illness and Recovery Test. K-SADS-PL = Schedule for Affective Disorders and Schizophrenia for School-age Children. MBCBS = Montgomery Borgatta Caregiver Burden Scale. PATS = Paying Attention to Self. PSSS = Multidimensional Scale of Perceived Social Support. RCT = randomised controlled trial. RSQ = Responses to Stress Questionnaire (family stress version). RSSE = Rosenberg–Simmons Self-esteem Scale. SC = Social Connectedness Scale. SDQ = Strengths and Difficulties Questionnaire. SEI = Self-esteem Index. SMFQ = Short Mood and Feelings Questionnaire. SMILES = Simplifying Mental Illness plus Life Enhancement Skills. SPSI = Social Problem-solving Inventory. SWLS = Satisfaction with Life Scale. YCOPI = Young Caregiver of Parents Inventory. ◆

whether intensity equates to effectiveness. While current evaluation data are mostly rigorous (employing a randomised controlled trial design), programs need to be developed and evaluated for families where a parent has disorders other than, or in addition to, depression. As shown in Box 1, programs indicate positive results in terms of children's symptoms.

Peer-support programs

We identified 12 peer-support programs, offered as school holiday programs, after-school programs, or camps (see Box 2).[14-27] Peer-support programs target children aged 7–18 years, and aim to increase children's knowledge about mental illness, develop peer relationships and enhance children's adaptive coping skills. Programs commonly adopt a group, strengths-based, preventive approach. One program is facilitated by a peer leader who is also the child of a parent with a mental illness, thereby providing opportunities for the development of leadership skills.[22,23]

Potential risks associated with peer-support programs include exposing children to unsettling information about mental illness and limiting peer-support networks to those in the program.[22] In one program, prosocial behaviour (measured by parents' scores on the Strengths and Difficulties Questionnaire) decreased as children began to ask more questions about mental illness.[16] Five of the 12 programs have been, or are currently, offered in Australia. Although a number of peer-support programs have been evaluated, many have not used valid outcome measures and have not employed waitlist or control groups. Longitudinal data are often not available, so long-term outcomes remain unclear. Overall, it would be appear that the evidence base for peer-support programs is emerging.

Online interventions

We identified two online interventions targeting older children and young adults (12–25-year-olds) (Box 3).[28-30] Websites provide easy access at all times of the day and the option of remaining anonymous when studying information and/or sharing experiences. Potentially, young people might misunderstand a message in the absence of non-verbal cues, and websites do not necessarily provide the opportunity for immediate clarification. Additionally, staff must be trained in computing skills. Future evaluation needs to focus specifically on child outcomes. We did not find any online interventions that were designed for Australian young people.

Bibliotherapy

Bibliotherapy presents children with literature involving characters who are in similar positions to themselves. This enables children to normalise their situation, gain insight into the problem-solving techniques of those characters, and apply this learning to their own lives. Tussing and Valentine[31] advocate employing bibliotherapy with children whose parents have a mental illness, in conjunction with discussions about the material with a trained professional. In Australia, the Children of Parents with a Mental Illness national initiative identifies various books, DVDs and consumer stories (many of which are Australian) that might be employed in this approach (http://www.copmi.net.au/jsp/resources/resource_index.jsp). Bibliotherapy might consolidate other forms of psychoeducation, and could be useful for rural/remote populations and those on waiting lists. However, it requires a certain level of literacy and has the potential to be misinterpreted. There is no evidence for the efficacy of bibliotherapy in children affected by parental mental illness, although Marrs[32] found that it was useful for adults, in conjunction with other forms of treatment.

Summary

The common component across programs is the provision of psychosocial education about mental illness to families and children. This suggests that it is important to provide age-appropriate information about mental illness to children whose parents have a mental illness, although further research is required to test this assumption. More evaluation is required to specifically examine the comparative efficacy of different approaches, to determine what interventions work, for whom, and how. With the exception of peer-support programs, most interventions are located in either Europe or North America. These interventions typically focus on children living with

3 Online interventions for children and young adults whose parents have a mental illness

Program: year, country	Target population	Intervention frequency	Intervention description	Evaluation method and results
Kopstoring: 2010, Netherlands[28]	16–25-year-olds	Eight weekly sessions	Theme-based online chat group meetings	Design: multicentre randomised controlled trial with waitlist control. Measures: cost-effectiveness analysis, cost-utility analysis, Youth Self-report questionnaire. Results: not yet available
Survivalkid: 2011, Netherlands[29,30]	12–25-year-olds	Anonymous access at all times; weekly monitored chat sessions (90 min)	Secluded virtual platform with personalised feedback, psychosocial education, message board, blog facility, monitored chat groups, and opportunities for private chats and email correspondence with a professional	Design: Usage statistics and satisfaction questionnaire. Results: increased access to information and support; peer support appreciated

parental depression and/or anxiety. Although some programs have been evaluated in randomised controlled trials, further evaluation is required. Program evaluation needs to incorporate validated outcome measures and rigorous evaluation designs, compatible with the community settings in which many programs are delivered, and sensitive to the heterogeneous nature of the target group — children whose parents have depression and/or anxiety, as well as other disorders.

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