

Preventive interventions for children of parents with depression: international perspectives

Systematic national programs are effectively helping children break the cycle of depression and other mental health problems in families

Depression is a public health problem of major proportions. In Australia, the prevalence rate for depression is over 15% in adults, and similar rates of illness have been reported around the world.^{1,2} Based on an analysis of a nationally representative data set in the United States,³ and assuming the same rates in Australia, there are about 1 million Australian children living with a parent who has experienced depression in the past year.

According to recent reviews,³⁻⁵ offspring of depressed parents have rates of depression that are between two and four times higher than their counterparts from homes without parental illness. These offspring also have an increased risk for a range of mental health disorders⁶ and associated difficulties, including deficits in academic performance, social relationships, and self-esteem. Because the risks for children of depressed parents have been recognised worldwide, several countries have implemented systematic national programs to assist these families. A recent meta-analysis of prevention trials has shown that prevention of offspring mental health problems is possible.⁷

Risk and resilience

Both specific (eg, having had a prior depression, having a depressed parent, genetic vulnerabilities) and non-specific (eg, poverty, exposure to violence) risk factors contribute to higher lifetime rates of depression in children of depressed parents. Goodman and Gotlib⁸ have proposed an integrative model to address the cross-generational transmission of risk, and this was the overall organising framework for the US Institute of Medicine³ report on depression in parenting. A recent review⁵ highlights key observations of the current research in this area:

- The impact of risk factors is bidirectional. That is, not only do parental behaviours influence child outcome, but children's behaviours influence the parent.
- Both genetic and environmental factors are involved in the transmission of risk, and recent advances in understanding the heritability of depression and gene/environment influences (eg, whole-genome comparisons, molecular genetics) offer great promise for the future.⁹⁻¹¹
- Parent-child interactions and parenting style have received significant attention as key factors in the transmission of depression risk from parent to child.¹² Psychiatric treatment for parents as well as support for parenting can reduce the risk for children.^{13,14}
- Although children of depressed parents are at increased risk for depression and other difficulties, many families cope well with these problems.^{15,16} In families with parental depression, Beardslee and Podorefsky¹⁷ found that

children who do well have individual, family and community resources that enable them to accomplish age-appropriate developmental tasks, engage in relationships, and understand their surroundings despite the parent's illness. Therefore, important opportunities for resilience promotion in children include supporting families to identify and build upon these resilient processes.

Preventive interventions

Selected preventive interventions targeted at parents with depression and measuring outcomes in children have a strong evidence base.⁴ A recent meta-analysis by Siegenthaler and colleagues of randomised controlled prevention trials⁷ showed that in studies reviewed, risk to offspring for the same mental disorder from which the parent suffered was reduced by 40%. This applied to internalising but not to externalising symptoms. There are a number of national selective prevention strategies designed specifically for children of parents with depression (see Box 1 online at www.mja.com.au/mjaopen). These have in common a focus on strengthening parenting and addressing youth needs. We discuss two national programs in detail below.

Finland

The Effective Child and Family Programme (ECFP)^{18,19} was launched in Finland in 2001 and is supported by the Ministry of Social Affairs and Health. The aim of the program is to make a system change in health and social services so that professionals can attend to the needs of adult patients and their children. The work began in families with psychiatric problems but expanded quickly to substance use issues and physical health problems in parents, and more recently, to issues of poverty and criminality in families. The ECFP is also involved in building community-based multiprofessional services for all families with multiple needs. Under Finnish health and child welfare law, services for adult patients must also attend to the needs of their children. This applies to mental and physical health and substance use services, social services including income-benefit services, and the criminal justice system. As many parents with mental or other illnesses have not sought treatment, the program is also active with children in kindergartens and schools.

Based on several smaller audits, it seems fair to say that it is mainstream practice now in most Finnish psychiatric services to discuss children and parenting with the patient. Some of the success factors for the ECFP include (i) the program is situated in an organisation that has national responsibility; (ii) work started at multiple levels

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simultaneously (national and community levels, decision-makers and grassroot practitioners, families, mass media); (iii) the initial training was extensive and provided expert practitioners and trainers across the country; (iv) a family of methods was developed to be used in different services and by those with different professional orientations; (v) the methods include a low-threshold option (Let's Talk About Children), which does not depart in format from traditional patient–clinician sessions; and (vi) research on the two core methods was carried out producing an evidence base for the work.²⁰ A remaining challenge is to ensure that the work remains of high quality when the program has expanded to become nationwide with thousands of practitioners and families participating.

Australia

Recently, the Children of Parents with a Mental Illness (COPMI) national initiative has developed resources to improve support for families where a parent has depression. The Family Focus intervention — based on the Family Talk Intervention developed in the US by Beardslee and colleagues²¹ (see Box 2 online at www.mja.com.au/mjaopen) — includes a DVD for families and an online workforce education resource that provides training for mental health professionals.

Primary care settings have been identified as potential facilitators of the Family Focus DVD and intervention, due to the availability of existing services and pathways for the treatment of depression. Similarly, the current focus on the provision of time-limited, evidence-based interventions in general practice, and the collaborative networks established as part of primary mental health and national health reforms, highlight the significant role of primary care in promoting the mental health of children of parents with depression.^{22,23}

Before the implementation of the Family Focus DVD and intervention in primary care, there are a number of changes needed that would enable mental health professionals to facilitate these interventions. These include increased support for primary prevention, an expansion of individual-orientated interventions to become family focused, and the establishment of pathways by which families can access the intervention (unpublished data, COPMI). Strategies to promote access to the DVD and intervention in primary care settings are being investigated as part of a pilot test in 2012. This work extends previously developed resources that aim to promote sustainability of COPMI initiatives.²⁴

Families and depression in primary care

Most parents who are seeking help for depression will present to primary care physicians. Key factors for physicians are (i) recognising depression; (ii) helping parents obtain treatment; (iii) understanding children's concerns and developmental needs; (iv) offering psychoeducation; (v) providing parental guidance; and (vi) follow-up.

It is important for a primary care practitioner to ask parents if they have experienced depressive symptoms, particularly if they are in high-risk groups such as having had prior depression, recent losses or multiple risk factors

(poverty and social isolation). In a number of countries, screening has been recommended for new parents, and parents in whom depression is suspected. Where screening tools are readily available and are paired with access to treatment, they can assist the practitioner. Evidence-based treatment for depression should be instituted. Assisting patients who are parents to obtain treatment when needed is essential.

Eliciting parent concerns is also important. Many parents are worried about possible long-term effects of depression on their children. Research demonstrates that depression in parents affects children differently, depending on the child's developmental stage.³ Early in life, attachment between parent and child may be disrupted, and symptoms such as difficulties in establishing routines for the child, frequent doctor visits, and difficulties with feeding and sleeping may signal parental depression. In the preschool and school years, difficulties accomplishing developmental milestones may signal the presence of depression, and anxiety symptoms before puberty and depressive symptoms after puberty are very common in children of depressed parents. During adolescence, the rates of diagnosis of depression and anxiety in children of depressed parents increase markedly, and these should be identified and attended to as well.

Depression is not well understood either in society in general or by parents. Helping families to identify their own strengths and to focus on them, providing clear psychoeducation on what parents can do to support the children and helping them to access and use out-of-home resources has proved valuable in a wide array of settings. Depending on the local circumstances, parents might be able to turn to extended family, friends, non-government organisations and family services. They can learn to preserve essential parenting functions despite their illness (eg, supporting their child's friendships and activities). In fact, children themselves place more emphasis on the importance of peer relationships as a form of support than do parents or mental health professionals.^{25,26} It is also important to emphasise that while there is increased risk, many children do well, and no child is irrevocably damaged.

Primary care mental health professionals are in an excellent position to provide long-term follow-up and ask periodically about the children of depressed parents. The Beardslee²¹ and Compas^{27,28} projects provided long-term follow-up, and the benefits of these interventions were revealed over time. We believe that follow-up with families with depressed parents is essential and can greatly strengthen the initial interventions. A list of resources for practitioners is provided in the box.

Conclusion

Systematic approaches, such as those used in Finland and Australia, offer the best opportunity for large-scale impact, and there are important strategies that practitioners can employ directly with families.

Although many of us began this work in an expert role, we came to recognise that in working with families with parental depression, there are two types of experts: the parents and children who are experts on their own

Parental depression resources

Recommended readings

Beardslee WR. When a parent is depressed: how to protect your children from the effects of depression in the family. Boston, New York, London: Little, Brown and Company, 2002

Goodman SH, Gotlib IH. Children of depressed parents: mechanisms of risk and implications for treatment. Washington, DC: American Psychological Association, 2002

National Research Council. Depression in parents, parenting, and children: opportunities to improve identification, treatment, and prevention. Washington, DC: The National Academies Press, 2009

Solantaus T. Let's talk about children [a manual for a two-session discussion with parents who suffer from mental health problems]. Available at <http://www.thl.fi> (expected release in English in late 2012)

Beardslee WR, Gladstone TR, Wright EJ, Cooper AB. A family-based approach to the prevention of depressive symptoms in children at risk: evidence of parental and child change. *Pediatrics* 2003; 112: e119-131

Training resources

Family Focus (Australia). Online training in the Family Focus intervention based on the US Family Talk intervention. <http://www.copmi.net.au> (expected release in late 2012)

Families Preventing and Overcoming Depression (USA). Family Talk intervention [online course]. <http://www.fampod.org> (accessed Mar 2012)

Resources for families

Family Focus: talking together about parental depression and anxiety [DVD]. <http://www.copmi.net.au> (expected release in late 2012)

Nicholson J, Clayfield JC, Phillips SM. Parenting well when you're depressed: a complete resource for maintaining a healthy family. Oakland, CA: New Harbinger Publications, 2001

A list of resources for health professionals and families where a parent has depression is available at <http://www.copmi.net.au> ◆

families, and the practitioner with expertise in the treatment of depression and the management of preventive interventions. In this sense, we came to develop partnerships with families and learned a great deal from them.

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1 National preventive strategies for children of parents with depression

Strategy	Description
Australia	
Children of Parents with a Mental Illness (http://www.copmi.net.au)	Targets children 0–18 years of age, promoting better mental health outcomes in children of parents with a mental illness Disseminates good practice and provides workforce training resources Provides information for family members with a mental illness Aims to embed support for families into health, social service, education, and community sectors through strategic collaboration* Highlighted as an action in priority 2 of the Fourth National Mental Health Plan†
Finland	
Effective Child and Family Programme (http://info.stakes.fi/toimivaperhe/EN/index.htm)	Provides health and social services with evidence-based methods to promote family life, children’s wellbeing and development, and to prevent child problems Established in response to the Finnish mandate that health and social services attend to both patients and their children Aims to build a functional multisectoral service system in community based services Includes family-intervention sessions ^{21,24,25} and family support groups, combining peer support and family processes
Netherlands	
Preventive program for children of mentally ill and substance-misusing parents (http://www.trimbos.org)	Developed by the Trimbos Institute, Netherlands Institute of Mental Health and Addiction Includes a parent–baby intervention‡ Includes family-intervention sessions ^{21,24,25}
Norway	
Adults for Children (Voksne for Barn) (http://www.vfb.no)	Long-standing organisation focused on the wellbeing of children and adolescents, especially related to mental health Offers promotion programs, parent guidance and training of professionals Offers training for the Family Talk Intervention
Sweden	
Children as Relatives (Barn som Anhöriga) (http://www.barnsomanhoriga.se)	Provides information to professionals about children of parents with a mental illness Includes family intervention sessions ^{21,24,25} Supported by the Swedish National Board of Health and Welfare
United States	
No coordinated national effort, but many good programs	
International collaborations	
Nordic Forum — Focus on Children	Represents continuous collaboration and annual conferences among the Nordic countries Paved the way for proactive legislation rather than reactive legislation Contributed to legislation in Sweden and Norway mandating that health services attend to both parents and children
Child and adolescent mental health in enlarged European Union: development of effective policies and practices (http://www.camhee.eu)	Focuses on the intergenerational transfer of mental illness and substance use Includes a work package for families with parental mental illness
International conferences	Inaugural World Children of Parents with a Mental Illness Conference, Adelaide, Australia, 2009 Voksne for Barn, Developing Strength and Resilience in Children, Oslo, Norway, 2010 Third International World Congress on Children of Parents with Mental Illness, Vancouver, Canada, 2012

* Australian Infant Child Adolescent and Family Mental Health Association. Principles and actions for services and people working with children of parents with a mental illness. Adelaide: AICAFMHA Ltd, 2004. http://www.copmi.net.au/files/PrinciplesandActions_final.pdf (accessed Mar 2012). † Australian Government Department of Health and Ageing. Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009–2014. Canberra: Commonwealth of Australia, 2009. <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-f-plan09> (accessed Mar 2012). ‡ van Doesum KT, Riksen-Walraven JM, Hosman CMH, Hoefnagels C. A randomized controlled trial of a home-visiting intervention aimed at preventing relationship problems in depressed mothers and their infants. *Child Dev* 2008; 79: 547-561. ◆

2 Preventive interventions for children of parents with depression

Intervention	Development and implementation	Target group	Description	Outcomes
Family Talk	Developed in the United States by Beardslee et al, ²¹ and implemented in the US, Finland, Holland, Sweden, Norway and Costa Rica	Families where a parent has depression	Two public health interventions — Family Talk (6–11 sessions) and a two-session public health lecture — focusing on providing education to parents. Links educational material to the unique experiences of families and helps families develop a plan for dealing with depression and building resilience in family members	A long-term randomised trial showed strong, sustained effects for both strategies, with a greater benefit for Family Talk. Outcomes included diminished adolescent internalising symptoms, increased positive family interactions, and increased rates of recognition and treatment for children who did eventually experience depression
Family group cognitive behavioural intervention	Developed and implemented in the US by Compas et al ^{27,28}	Family groups where a parent has experienced depression	10-session family group model in which families are enrolled in groups of four and are seen in parent or family groups. Participants are taught to understand and cope with depression	At the 24-month follow-up, relative to the control conditions, significant parent and child benefits occurred, including significantly fewer depressive episodes in children
Family cognitive behavioural preventive intervention	Developed and implemented in the US by Garber et al*	Adolescent groups that have a parent with depression	8-session group cognitive behavioural preventive intervention for adolescents with a depressed parent and with symptoms of depression and/or a past depression history	Relative to adolescents in the control group, adolescents who participated in the program evidenced fewer depressive episodes over an 8-month follow-up, and benefits were moderated by the presence of current parental depression. Longer follow-up of this sample is currently underway
Let's Talk About Children	Developed and implemented in Finland by Solantaus†	Parents/families where a parent has depression. Also designed for other psychiatric problems	A manual-based, two-session intervention with parents	A randomised trial with 18-month follow-up comparing Family Talk and Let's Talk About Children. Both interventions were found to be safe and feasible. In both interventions, there were significant decreases in children's emotional symptoms and anxiety, and increases in prosocial behaviour. Family Talk was found to be more effective in reducing emotional symptoms

* Garber J, Clarke GN, Weersing VR, et al. Prevention of depression in at-risk adolescents: a randomized controlled trial. *JAMA* 2009; 301: 2215-2224. † Solantaus T, Toikka S, Alasuutari M, et al. Safety, feasibility and family experiences of preventive interventions for children and families with parental depression. *Int J Ment Health Prom* 2009; 11: 15-24. Solantaus T, Paavonen EJ, Toikka S, Punamäki RL. Preventive interventions in families with parental depression: children's psychosocial symptoms and prosocial behaviour. *Eur Child Adolesc Psychiatry* 2010; 19: 883-892. ◆