REVIEWS

The importance of intervening in adult mental health services when patients are parents

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Abstract

This article addresses the issue of parental mental illness. The theoretical background and rationale for developing new routines to change clinical practice is described, suggesting a policy change in which a child focus is implemented in adult mental health services. Furthermore, proposed strategies that have the potential of being effective within existing health care systems are discussed.

Key words

Health services, Health policy, Prevention, Implementation, Parental mental illness

1 Introduction

Many studies have documented that mental illness is very common and has grown in magnitude, such that it currently constitutes the most common reason for absence from work in the western part of the world [1, 2]. Mental illness is defined as a psychological pattern, potentially reflected in behavior, that is generally associated with distress or disability and is not considered part of normal development [3]. The most common mental health problems are anxiety, depression and substance abuse issues [2].

In a 2009 report on mental illness in Norway, The Norwegian Institute of Public Health [2] estimated that up to 50% of the population will suffer from mental health problems at some point during their lifetime. A study from Oslo found a lifetime prevalence of 52.4%, however, only 10%-15% of this figure referred to those with serious mental illness [4]. According to Kringlen and colleagues, the incidence of mental disorder is higher in women than in men, with the exception of problems with alcohol and drug abuse.

Studies conducted in Norway also point to a relatively high prevalence of mental health problems in children. It is generally agreed that 15% to 20% of children between the ages of four and ten suffer from mental health problems to the extent that it interferes with their daily functioning [5]. In the Bergen Child Study, 7% of the child population was found to have mental health problems within the diagnostic criteria [6]. According to Wadell and colleagues, mental health problems are the most important health issues among children today [7].

Internationally, the picture is similar. A total of 25% of the world's population has been estimated to suffer from some kind of mental health problem [8]. In Australia 45% of the population is expected to experience problems with their mental health during their lifetime [9]. According to a study by Wittchen and Jakobi [10], 82.7 million adults in Europe, which accounts for an estimated 27% of the entire European population, meet the criteria for at least one psychiatric diagnosis.

Based on this, it is fair to assert that mental illness is common among children, adolescents and adults.

2 Prevalence of parents with mental illnesses

Patients seeking help for mental disorders are not less likely to be parents than other adults [11]. In a cross-sectional study conducted by the independent, non-commercial research organization SINTEF [12], 13% of patients at in-patient clinics and one third of patients at out-patient clinics are parents who have custody of their children. This study was conducted among patients who received treatment by the mental health services in Norway in 2008.

The Norwegian Institute of Public Health has estimated the number of children living with mentally ill parents based on prevalence studies performed on the entire adult population that show the number of adults who qualify for the diagnosis of mental disorder or alcohol abuse disorder [13]. They estimated that approximately 410,000 children in Norway (37.3% of the total child population) had either one or two parents with a mental illness in the past year. This included mild depression and anxiety as well as more serious mental health problems such as psychosis. When minor mental health problems are excluded, the prevalence of children living with mentally ill parents is 260,000 (23.1%) [13].

In Great Britain, a survey of psychiatric conditions reported that about 10% of women and 6% of men with a mental illness were parents [14]. In Australia, it was estimated that one in five families consist of one or two parents with a mental illness [15, 16]. In the United States, 65% of women and 52% of men identified as having a psychiatric disorder, were also parents [17].

2.1 Parental mental illness as a risk factor

Being a parent can be challenging and difficult in itself. It is easy to understand how having an illness may constitute an extra challenge to the parenting role. The idea that the children of psychiatric patients should be given attention and consideration is a fairly new one. Before the 1990's there was hardly any awareness of the consequences parental mental illness had on children among services available (*e.g.* child protection services, social services or health care services, and hardly any research existed on the topic [18]). During the 1990's and the beginning of the 2000's a substantial development in the level of attention and knowledge production started to come about, for instance, in terms of attachment theory and family systemic views on child development [19, 20]. In the past 10-20 years, there has been an immense shift in focus when it comes to adult mental health services' regard for the impact of parental mental health on the offspring of patients. There is now a growing evidence base in several areas, including prevalence rates, interventions and implementation studies [19].

Parental mental illness is considered a powerful risk factor with the potential for serious impact on children. Mental illness may affect parenting behaviors in a variety of negative ways. For example, parents with depression have more difficulties in interacting with their children, are more intrusive, less involved and less responsive [21, 22]. Maternal depression has been found to have a negative impact on children's social, behavioral, emotional and cognitive development [23]. Furthermore, studies have shown that mentally ill parents are more likely to be hostile in their relationship to the child; *e.g.*, they tend to be angry, critical and irritable [21, 22]. A harsh parenting practice may be the result of parental mental illness and increases the risk of problem behavior in children [23]. Although a child's risk of developing mental health problems is generally thought to be multi-factorial [24], parental mental illness is a significant risk factor for children. Furthermore, parental mental illness is linked to the child's sense of attachment security [22]. Highly sensitive responsiveness on the part of the mother has been found to promote secure attachment and healthy development of the child. There is strong evidence that maternal depression has a negative effect on the quality of the mother-child interaction [22, 25]. More than one third of these

children develop serious and long-lasting problems [21]. Early in life, these children run a higher risk of abuse and neglect, depression, eating disorders, conduct problems and academic failure. Later in life, they are at a higher risk of depression, anxiety disorders, substance abuse, eating disorders and personality disorders [23, 26, 27]. Nonetheless, parental mental illness alone does not necessarily mean that children themselves will automatically develop problems. Many parents with mental illnesses are adequate caregivers, but there are many other related factors that may add to the risk; the family context (*e.g.*, divorce), violence, presence or absence of the other parent, lack of social support, severity and chronicity and genetic characteristics of the parent's illness all play a part [21]. Additionally, several protective factors, such as coping skills, activities outside the home and close relations with other adults, may reduce risk factors for these children [28].

Parental mental illness affects parenting behavior [22, 24], and parenting behavior is related to the development of socio-emotional problems in children [30]. According to Van Doesum [22], parental mental illness is one of the major known risk factors for the onset of psychopathology in the population. However, parental behavior is also seen as a malleable risk factor. Parenting quality is considered to be the most potent, but also the most modifiable, risk factor for developing mental health problems, such as emotional and behavioral problems, in children [22].

Children of mentally ill parents are often referred to as "the invisible children" because there have been no systematic routines to detect whether or not patients receiving mental health services also have children [31]. According to the SINTEF study, "the invisible children" are often found in statistics on children with self-injury disorder as well as adolescents who develop addictions [32]. According to the same study, between 30% and 50% of children who grow up with a mentally ill parent develop depression, by the age of 19, if no measures are taken to help them [32].

In summary, the past two decades have produced multiple studies indicating that children with mentally ill parents are at risk of developing mental health problems themselves [33].

2.2 Mental health prevention and preventive interventions

Labeling parental mental illness as a malleable risk factor means that there are measures that may be taken to counteract the risk. There is a substantial amount of research documenting that teaching parents positive parenting strategies to promote children's self-confidence, pro-social behaviors, problem-solving skills and academic success reduces the risk for those children [24, 34]. In order to develop preventive interventions for children of mentally ill parents, the focus should be on the malleability of psychological and social risk and to improve protective factors such as parenting behavior, social support and coping skills.

In a report from 2004, the World Health Organization concluded that, in order to reduce the health, social and economic burdens of mental disorders, it is essential for countries and regions to pay greater attention to prevention and promotion of mental health at the level of policy formulation, legislation, decision-making and resource allocation within the overall health care system [35]. As a result of the increased focus on prevention of mental disorders, there is growing evidence showing that preventive efforts can influence risk and protective factors and reduce the incidence and prevalence of some mental disorders [35]. Internationally, there is already a variety of intervention programs available and there is now an expanding evidence base to demonstrate the effectiveness of a number of these interventions [36-38].

2.3 Existing interventions for families affected by mental illness

It is widely accepted that parenting behavior influences the development of socio-emotional and behavioral problems in children [30]. There is strong and growing evidence that preventive interventions can result in risk reduction and the strengthening of protective factors related to first onset of mental health problems [39]. In a recent meta-analysis, interventions to prevent mental disorders in the offspring of parents with mental illness appeared to be effective [40]. Several studies have emphasized that parenting programs are among the most powerful and cost-effective interventions available to prevent child maltreatment and socio-emotional and behavioral problems in children [41, 42]. However, according to a review done by Reupert and colleagues [43], more evaluation is needed to specifically examine the

comparative efficacy of different approaches and determine which interventions work, how they work and for whom. Although some interventions have been evaluated in randomized controlled trials, further evaluation is required [43]. The U.S. intervention, Family Talk [44] and the Finnish intervention, Let's Talk [45] are examples of interventions that have been proven effective in reducing children's emotional symptoms and level of anxiety.

Many existing interventions for families affected by mental illness, such as Beardslee's preventive family intervention [44] and the Dutch intervention Child Talks [46], contain components of psycho-education. Psycho-education refers to education that provides information and knowledge to enhance the understanding and possible consequences of the disease [47]. According to Honig and colleagues, psychiatric psycho-education has been shown to play an important role in the treatment of mentally ill patients. Psycho-educational interventions are also generally thought to contribute to the de-stigmatization of psychopathology, and studies have shown that such interventions play an important role in reducing symptoms and relapse rates in mental illnesses such as bipolar disorders and schizophrenia [48].

Psycho-education is a common component across programs for parents with mental illnesses and their children [43]. In the particular context of parental mental illness, psycho-education is seen as a tool to reduce feelings of guilt and shame from materializing in the children and their parents. Mevik and Trymbo [49] stated that "the lack of information and knowledge provided to the family by the mental health care services reinforce the attitude of remaining silent about the disease, and thereby taboos are being maintained within the family". The lack of openness is also thought to restrain children from venting emotions such as anger, despair and insecurities about their own life situation and that of their parents [49].

Little is known about the effects of psycho-education from a preventive perspective. In several qualitative studies on families affected by parental mental illness, numerous families reported great benefits from age-appropriate information for children. Families additionally stated that receiving support from the health care system helped them to be more open about mental health issues [49]. Further research and assessment of which interventions work, how and for whom, is nonetheless required to test this assumption [43].

3 Implications for clinical practice

In addition to what is known about the benefits of preventing transmission of problems from one generation to the next, it has also been suggested that incorporating a child perspective in adult mental health care may lead to further improved health outcomes for patients who are parents. According to Kowalenko and colleagues [50], it is generally assumed that successful treatment of parental mental illness can be associated with reduced psychopathology in offspring. However, treatment that does not take into account the parent-child perspective has been proven less efficient [50, 51]. According to these studies, depressed mothers were less responsive to their infants, experienced more parenting stress, and viewed their infants more negatively than did non-depressed mothers. The treatment only affected the level of parenting stress, which improved significantly but was still higher than the stress level for non-depressed mothers in the control group. Treatment for maternal depression should also target the mother-infant relationship as well as the mothers' depressive symptoms [51].

Intervening early and targeting adverse influences on children and parents may improve outcomes for children [50]. According to Beardslee and colleagues [52], early interventions that support parents with a mental illness and their children can mitigate vulnerabilities and increase resilience, thereby contributing to the positive development of the next generation. Additionally, early family interventions may improve parental mental health as well as family functioning.

According to Cowling and McGorry [19], it is essential to establish effective multidisciplinary relationships between GP's and mental health practitioners. This is due to the fact that most people who seek professional support for mental illness, not only in Norway but in many countries across the world, approach their general practitioner first. The GP's are, therefore, in a prime position to identify and support families suffering from mental illness [53].

3.1 Evidence based practice

When we discuss preventive strategies and early intervention approaches, it is important to investigate what kind of evidence we have that prevention is effective. Durlak and colleagues conducted a meta-analysis in 1997, demonstrating that programs to prevent mental disorders can be effective for children [54]. In 2002, Jané-Llopis found that effects of prevention programs are stable over time, and are effective for populations with different levels of risk [55].

Many of the strategies within preventive interventions involve aspects of parent training. The idea is that parent-training programs can help families and children to regulate the child's thoughts, feelings and behavior [56]. Within the field of parenting there are several programs that have an extensive evidence base [57]. An example of an intervention addressing the needs of the children is the COS intervention (Circle of security). The intervention has been proven effective in decreasing insecure attachment in children at risk [58]. Parenting programs may be used to promote good mental health in children also in the field of parental mental illness [24].

There are also some programs that are more specifically designed to target families affected by parental mental illness. In 2012 a meta-analysis was published. The authors assessed the evidence in terms of effectiveness of the preventive interventions in decreasing the risk of mental disorders in the offspring of mentally ill parents.

The conclusion in this meta-analysis is that the evidence indicated that such interventions may be effective [40].

3.2 Challenging knowledge transfer

Proctor and colleagues found that one of the most critical issues in mental health services research is the gap between what is known about effective treatment and what is provided to consumers in the form of routine care [59]. We know much about interventions that are effective, but make little use of them to help achieve important health outcomes for children, adults and families [60]. It is, therefore, important to increase research in an effort to better understand service delivery processes and contextual factors to help improve the efficiency and effectiveness of program implementation [60].

The most efficient way of establishing new work methods and routines in an organization is by introducing and implementing interventions that are well described [60]. However, the implementation of interventions is a complex endeavor. In addition to changing the service providers' behavior, there is also the matter of restructuring organizational contexts [60]. To enable organizational changes and workforce developments, strategies should encompass the active building of service providers' capacity to implement innovations with high fidelity and good effect [61].

In order to ensure the integrity of interventions and encourage the maintenance of the change in practice, it is crucial that we study how to implement and disseminate interventions in an adequate and practical manner. According to relevant research literature on implementation, there is a gap between the knowledge on effective interventions and what is actually done in the field of practice [60, 62].

It is important to determine the relevant components and conditions for a successful implementation process. Only when effective practices and programs are fully implemented can we expect positive outcomes [63]. Experiences and outcomes of the implementation process for new interventions have yet to be studied in a systematic way in Norway, and we still know too little about contextual factors that promote or hinder the sustainability of the implementation [64].

The essence of implementation is behavioral change. In relation to health services, this implies that the practitioners "are" the intervention. Subsequently, this means that the actions of those who convert it into practice are either the key to success or a major reason for failure. Nevertheless, implementation efforts cannot solely focus on workforce development. Implementation projects must incorporate every known aspect; from system transformation to changing service provider behavior and restructuring organizational contexts [59, 60, 63].

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3.3 Workforce barriers to implementation

The literature on implementation concurs with the idea that the key to successful implementation is behavioral change [60, 63, 64]. Having established this idea, and the idea that the workforce is the key to successful implementation of a new practice, it is important to study potential workforce barriers in detail. Based on existing research, we believe that there are several barriers to implementing inclusion of the child perspective in adult mental health care and that the key to achieving change lies with the professionals in the workforce [65]. In a study conducted in 2009, Maybery and Rupert [66] concluded that there is a large gap between what psychiatric services should provide and what they do in practice when it comes to implementing the child perspective in adult mental health care. Korhonen and colleagues [67, 68] stated that there are many factors limiting support for families within mental health services; *e.g.* health professionals' qualifications. In order to understand why there is a discrepancy between the services delivered in mental health care and the existing knowledge of the importance of a family-focused practice, it is important to study workforce attitudes more extensively. It is crucial that the workforce recognizes or accepts the premise that a change is needed. If not, an innovative project has little hope of surviving [69, 70]. In order to detect important predictors for workforce barriers to identifying and supporting parents and children in adult mental health services, existing attitudes must be examined.

3.4 Readiness to change

Unless the organization implementing new interventions accepts the premise that a change in practice is needed, any innovative project has little hope of succeeding [60]. Readiness to change is reflected in the beliefs, attitudes and intentions of organizational members in addition to the organization's capacity to make those changes [70]. According to Rogers [70], a clear rationale for the intended change must be communicated. Rogers also emphasized the need to develop "champions" within organizations who can consistently advocate the implementation process, thereby contributing to workforce and organizational readiness to change.

Any attempt to achieve organizational change is, thus, a waste of time unless the organization is ready. Many scales have been developed to measure readiness of practitioners. Measuring readiness to change is, nevertheless, not as easy as it sounds. There are no widely accepted or standardized methods for measuring readiness to change. The most common method is the use of self-report questionnaires filled out by the workforce [71, 72].

In general, little research exists on the relationship between measures of readiness and subsequent success of an implementation. It is, therefore, important to include measures of readiness in longitudinal implementation studies, and to investigate the association between organizational readiness and implementation success.

4 Conclusion

It is possible to prevent the transmission of mental illness from one generation to the next, by establishing a clinical practice that considers this knowledge. Long-term implementation strategies may contribute to changes in clinical practice in terms of support of mentally ill parents and their children. In terms of implementation work, in general, it is important to accept the basic premise that innovations takes time. There are several steps to take in order to encourage the process of implementing new practice. Firstly, it might be fruitful to initiate meetings with management and to involve the managers in the process of fostering readiness to change. Allocation of staff resources, time and arenas are factors in which management needs to actively be involved in order to encourage the implementation process. Secondly, educating the staff, providing training and courses is important. The staff responsible for internal courses may need additional training. In the training of trainers, it might be a good idea to include training on how to supervise colleagues in carrying out the interventions. Another idea may be to create arenas (or take advantage of existing arenas) to discuss actual cases where patients are parents. Finally, it might be a good idea to turn to the education of mental health workers (*e.g.* nurses, psychologists, doctors) in trying to stimulate the inclusion of the child and family perspectives in curriculums.

As of today, psycho-education is a core element in several preventive interventions for families affected by parental mental illness. There is an assumption that this has a preventive effect, however, studies documenting this assumption has yet to be done. Future studies should compare the effects of various approaches and interventions in order to identify effective components in the prevention of trans-generational transmission of mental illness. If the new practice is not found to be effective in terms of preventing socio-emotional and behavioral problems in children, interventions should be differently rigged.

Preventing the transmission of mental illness from one generation to the next is a very important investment in the future. According to Nobel prize-winning economist, James Heckman, investment in early intervention is a sound investment in the productivity and safety of our society [73]. Treatment is much more costly and challenging than prevention, and less likely to have an effect. This makes it safe to say that a focus on the children of mentally ill parents constitutes a very worthwhile focus on the future.

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