Plenary - Oslo Conference
"Prevention in Families with Parental Mental Illness: An Idea Whose Time Has Come"
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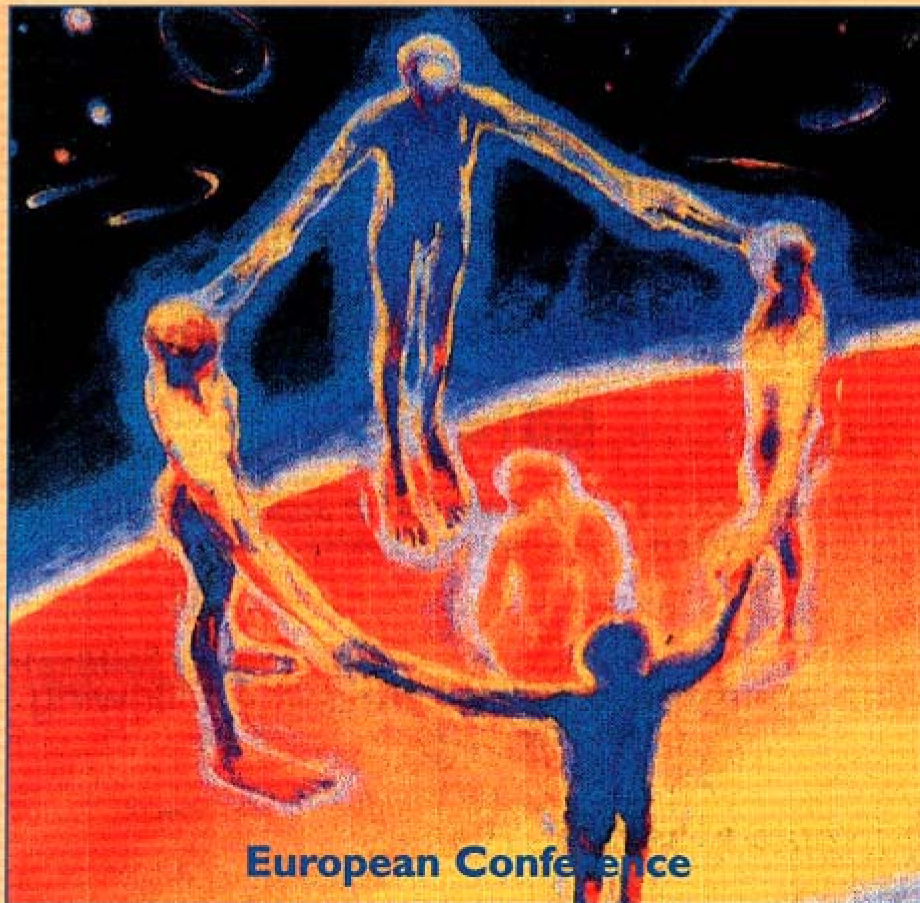
William R. Beardslee, MD
Department of Psychiatry
Children's Hospital Boston
Harvard Medical School



Parents with a mental illness –

effects on children and preventive interventions

Oslo

17th – 19th September 2001

Organisation Adults for Children

CIC – Caring for the Invisible Children: European Prevention Network for Children of Mentally ill Parents

Chronology I

1996

Solantaus T & Beardslee WR. When mother or father suffers from depression. Intervention to prevent children's psychiatric disorders. Intervention lasten psyykkisten hairioden ehkasemiseks. Duodeciu 1996, 112:1647-1656

2000

Initial meeting of Drs. van Doesum, Hosman, Solantaus and Beardslee. Carter Center/WHO Inaugural conference on mental health. Atlanta, Georgia, USA

2001

Norway conference in Oslo, Norway

Chronology II

2002

Second annual conference – WHO/Carter Center, London – Drs. Beardslee, Solantaus, van Doesum, Hosman and other international collaborators

2004

New Zealand conference

2005

First meeting involving Sweden, Norway, Finland, Denmark, and Iceland to establish a Nordic Forum to address children of the mentally ill; extensive collaboration and sharing of ideas

2006

May 2006 – Nordic Forum, Oslo

October 2006 – Fourth Biannual Conference on International Prevention Efforts – WHO/Carter Center

Declaration of the Rights of the Child

Proclaimed by General Assembly Resolution 1386(XIV) of 20 November 1959

Principle 4

The child shall be entitled to grow and develop in health; special care and protection shall be provided both to him and to his mother. The child shall have the right to adequate nutrition, housing, recreation and medical services.

Principle 5

The child who is physically, mentally or socially handicapped shall be given the special treatment, education and care required by his particular condition.

The Richmond Model

Depression's Effects Occur at Four Levels

- The Individual Level
- The Family Level
- Healthcare System Level
- Community Level

Depression in Parents – Key Factors

- Rapidly Developing Knowledge Base
- Excellent Studies of Treatment
- Sound Understanding of Mechanisms of Risk and Resilience
- Promising Prevention Studies
- Huge Gap Between Knowledge of Treatment and Wide-Scale Implementation

Risks for Depression

Specific:

- Extensive family history of depression, especially parents
- Prior history of depression
- Depressogenic cognitive style
- Bereavement

General *(Risks for many disorders)*

- Exposure to trauma
- Poverty
- Social isolation
- Job loss
- Unemployment
- Family breakup
- Loss of community
- Dislocation / immigration

Five Ways of Looking at Depression

Bartlett, et al. Maternal depression interferes with asthma medication adherence.

Miranda, et al. Depression treatment can be effective in low income minority women.

Casey, et al. Maternal depression linked to poor reported health status, hunger and loss of financial and food stamp support.

Head Start and Early Head Start. Forty-eight percent of mothers considered depressed.

Frasure-Smith, et al. (1995). Substantial literature on depression and medical illness. The co-occurrence of depression and heart disease or depression and cancer leads to a much poorer outcome.

Characteristics of Resilient Youth

- Activities - Intense Involvement in Age Appropriate Developmental Challenges - in School, Work, Community, Religion, and Culture
- Relationships - Deep Commitment to Interpersonal Relationships - Family, Peers, and Adults Outside the Family
- Self-Understanding - Self-Reflection and Understanding in Action

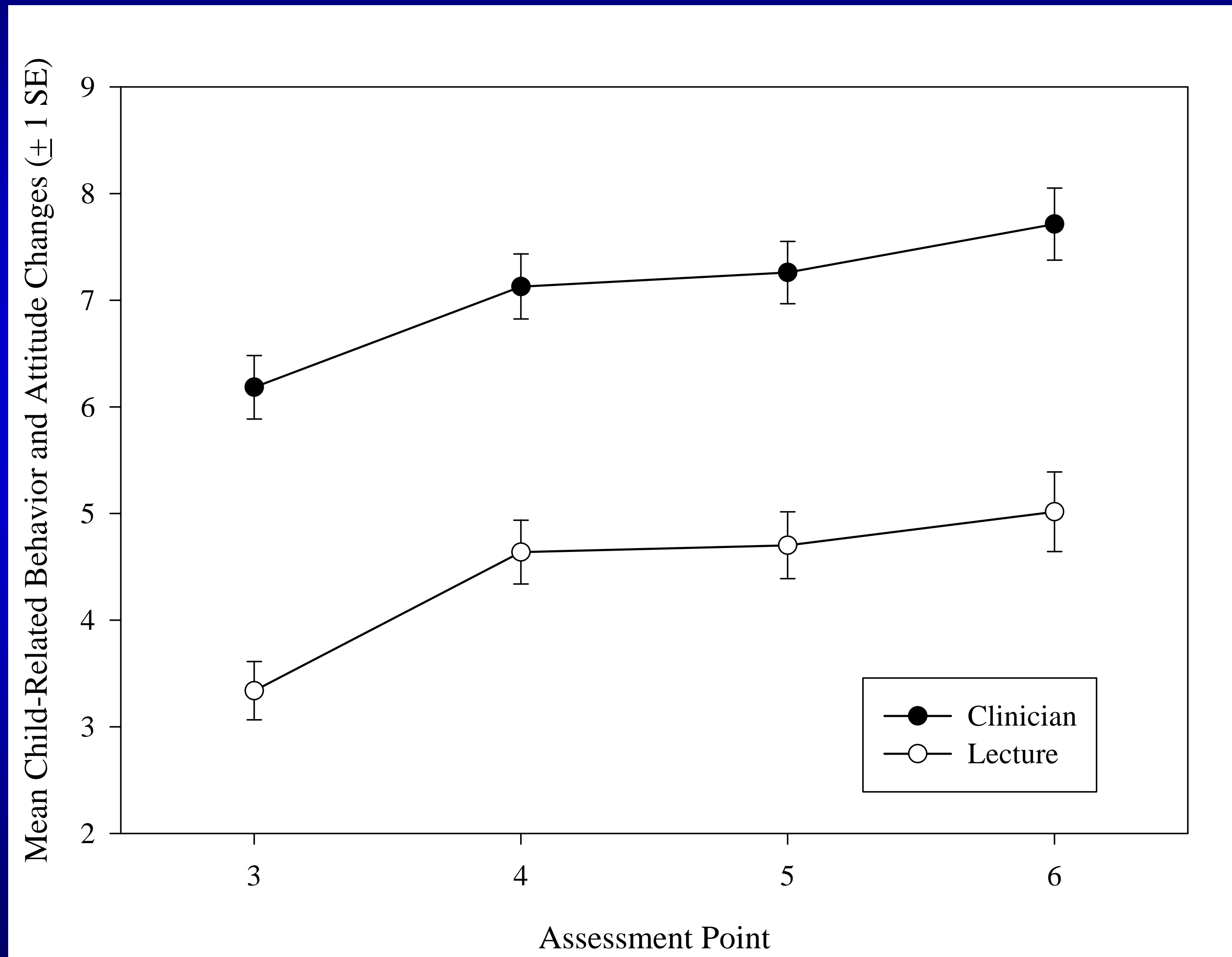
Six Different Implementations of Family Depression Approach

1. Randomized trial pilot – Dorchester for single parent families of color
2. Development of a program for Latino families
3. European Collaborations – Holland, Finland, Norway, Nordic Forum
4. Head Start – Program for parental adversity / depression
5. Blackfeet Nation – Head Start
6. Costa Rica

Core Elements of the Intervention

1. Assessment of all family members
2. Presentation of psychoeducational material (e.g., affective disorder, child risk, and child resilience)
3. Linkage of psychoeducational material to the family's life experience
4. Decreasing feelings of guilt and blame in the children
5. Helping the children develop relationships (inside and outside the family) to facilitate independent functioning in school and in activities outside the home

Figure 1. Average Adult Child-Related Behavior and Attitude Changes By Group Across Time



Narrative Project for Families Who Sustained Changes

1. The emergence of the healer within

2. The need to understand depression anew across development

- Children's growth

- Vicissitudes of parental illness

Systematic Countrywide Intervention

1. Finland
2. Holland
3. Australia
4. Norway

Finland – Systematic Implementation of Large-Scale Program for Children of the Mentally Ill

Dr. Tytti Solantaus:

- ❖ Use of a family of well specified interventions with common principle
- ❖ Support from scientific governmental and clinician leadership
- ❖ Commitment to place trained individual in all clinics
- ❖ Stage sequential process

Successful Strategies

1. Ongoing involvement of key organizations – Ministry of Health and Social Affairs / STAKES
2. Clinical and family needs – intervention met the unmet needs and created more requests for training and service
3. Intervention programs able to be widely used
4. Flexibility in the adaptation
5. Recognition that training takes place in a larger context with larger goals
6. Decision to train the trainers
7. Collaborative multinational effort

Holland – Systematic Implementation of Large-Scale Program for Children of the Mentally Ill

1. Regular budget / staff time set aside for prevention specialist in all community mental health centers
2. Systematic attention to the children of the mentally ill – Mother Baby Program and others
3. Other interventions through the prevention specialists

"Of all the forms of inequality,
injustice in health care
is the most shocking and inhumane."

Reverend Martin Luther King, Jr.

Recommendations I

1. Pair highly specific, measurable outcomes with broader vision.
2. Have specific goals for positive change for families, for caregivers, and for systems.
3. Make advocacy a fundamental part of research and practice.
4. Support for staff – time and space for reflection.
5. Shared ownership: Significant change occurs when families or caregivers can make the interventions their own.
6. Look for partnerships.

Enhancing Cultural Sensitivity to Research and Intervention Protocols

"Research is made culturally sensitive through a continuing and open-ended series of substantive and methodological insertions and adaptations designed to mesh the process of inquiry with the cultural characteristics of the group being studied. The insertions and adaptations span the entire research process ... Research, therefore, is made culturally sensitive through an incessant, basic, and active preoccupation with the culture of the group being studied through the process of research." (p.99)

(Rogler cited in Padilla & Lindhom, 1995)

Recommendations II

1. Children of the mentally ill are a high priority for prevention.
2. Expanded sharing of knowledge and collaboration is essential.
3. Ongoing empirical evaluation for both intervention development and dissemination is crucial.
4. Cultural sensitivity and cultural humility required.
5. Systematic countrywide and health district wide implementation strategies are best.
6. Focus on the needs of families at risk in developing countries is needed.

"The test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough for those who have too little."

Franklin Delano Roosevelt (1937)