RECOMMENDATIONS FOR SUPPORTING CHILDREN LIVING WITH PARENTS WITH MENTAL ILLNESS: IMPLEMENTATION, EVALUATION, AND SUSTAINABILITY

The document was created as part of the project "Initiative for Supporting Children's Mental Health," funded under the EEA Norway Grants 2014–2021 Financial Mechanism Programme Health.
The recommendations include a summary of the partners' experiences and presentations at the ChildTalks+ seminar during the XV. Conference on Eating Disorders in Prague.
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WHY IS IT IMPORTANT TO SUPPORT CHILDREN LIVING WITH PARENTS HAVING A MENTAL ILLNESS?

Current research indicates that 15-23% of children live in families where parents are diagnosed with mental disorders, (Leijdesdorff et al., 2017; Reupert & Maybery, 2016),— representing a **large group of children**. These children face similar challenges regardless of their parent's specific diagnosis.

Studies show that they often face social isolation and limited opportunities for interaction with others, often due to the stigma surrounding their parent's condition. This stigma can evoke feelings of guilt and shame (Mordoch & Hall, 2002). Additionally, these children often experience adverse outcomes, including impairments in social, behavioural, emotional, and cognitive development, along with challenges such as early school failure and reduced social competence (van Doesum et al., 2019; Hosman et al., 2009).

There is a strong connection between mental health illness among parents and increased lifetime psychiatric risk for their children. The risk of developing mental health disorders among these children ranges from 41% to 77%. Rates as high as 50% for the occurrence of depression by the end of adolescence have been found in offspring of depressed parents.[1]

Why such a high risk?[2]
The cause is multifactorial, a combination of genetic transfer, biochemical transfer, and cumulation of risk factors. Risk factors related to a parent include diagnosis (symptoms of the specific mental illness), chronicity, and severity. Risk factors related to a child include temperament, biological and genetic features, as well as social competence and resilience. Family risk factors are associated with parent-child interaction/communication, social stressors (such as marital discord), the absence of another parent, the mental health of another parent, and social and economic status. Risk factors related to support networks

[1] *Reedtz C., ChildTalks+ seminar at XV. Conference on Eating disorders, Prague, 2025*.

[2] *Van Doesum K., ChildTalks+ seminar at XV. Conference on Eating disorders, Prague, 2025*.

(broader family, friends, school, professionals) include social isolation, stigmatization, availability, and a limited support network (Hosman et al., 2009).
When supporting children of parents with a mental illness (COPMI), some **risk factors** cannot be changed, but these families can be supported by focusing on factors that can be mitigated and strengthen these in a positive way: such as social competence and resilience, parent-child communication, and broader social support.

One-third of the children of mentally ill parents grow up without mental health problems. **Protective factors** in the family are high competence (understanding mental illness), positive parent-child interaction, support of a healthy second parent, close relationships with friends/ other adults, and positive school experience/activities outside the home.

WHAT IS CHILDTALKS+?

ChildTalks+ is a specific method/intervention to help Children of Parents with Mental Illness (COPMI) feel better psychologically in the long term. It is an intervention designed for parents with mental illness and can be used as a standard procedure to talk to parents and children. The aim is to focus on the children's perspectives and needs due to the parents' situation, strengthen the coping skills of the children by providing them with information about their parent's mental illness, as well as emotional and social support by.
Specific aims are to:

- Raise parents' awareness of their children's experiences and the impact of mental illness.
- Improve parenting skills by advising parents on how to discuss mental illness with their children.
- Identify social-emotional problems in children early.
- Offer the family guidance on additional support and resources.
- Help families to cope better with stress and challenges. [3] [4]

The ChildTalks+ intervention

ChildTalks+ involves working with the entire family. It consists of 4 structured sessions with a therapist, where 2 sessions are attended only by the parents and 2 sessions involve the whole family, including the children. Both parents participate in the meetings (or one parent if the child is in the care of one parent and the other cannot attend).

- The first meeting is aimed at educating about the illness and collectively mapping protective and risk factors within the family.
- The second meeting focuses on specific techniques that enable parents to openly discuss their illness with their children and reflect on their needs. Techniques include role-playing, conversation practice, and preparing parents for respectful discussions with their child about the illness, according to the parents' wishes.

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[3] *van Doesum K., ChildTalks+ seminar at XV. Conference on Eating disorders, Prague, 2025.*

[4] *van Doesum, K., Lauritzen, C., Reedtz, C. (2020). Manual Child Talks+. UiT.*

- The third meeting includes the parents and the child/children. In a safe environment facilitated by the therapist, children are given the opportunity to express their understanding of the family situation from their perspective, articulate feelings they are experiencing, and collaboratively find solutions for improving the situation.
- The fourth meeting again involves both parents and the children, during which the family the therapist evaluates the outcomes of ChildTalks+ interventions and receives recommendations for further professional care.

The methodology provides therapists with **structured manuals** for assessing risky symptomatology in children and the family situation, along with detailed descriptions of activities. Therapists also have access to additional explanatory materials for parents and children.
After training and supervision, nurses, psychiatrists, clinical and counselling psychologists, addiction specialists, or social workers can become **ChildTalks+ therapists**. The requirement is that the professional work either with the whole family or with an adult client diagnosed with a mental illness who is a parent of a child under 18 years old. Psychotherapeutic training is an advantage, but not a requirement for using the methodology in practice.
Training in the Czech Republic is provided by the organization E-clinic, z.ú., a partner of the project. The training consists of a one-day workshop followed by supervision, during which the work with families is discussed. For more information, visit: www.childtalks.cz
In Norway, training is provided by the project partner Voksne for Barn, visit: www.vfb.no

IMPLEMENTATION OF CHILDTALKS+

A) RECOMMENDATIONS FOR DECISION-MAKERS: IMPLEMENTATION OF CHILDTALKS+ IN A NATIONAL CONTEXT

SWOT analysis of the broader implementation of preventive intervention ChildTalks+ in a national context: "Not to create new patients should be rule number 1."[5]

Strengths	**Weaknesses**
ChildTalks+ is a **minimal intervention** that can be provided to a relatively large population in a relatively short time. It can be delivered in various types of facilities and **for clients with different mental illnesses**. The broader implementation would help **relieve overburdened psychiatric** services by identifying problems in children in early stage. There is a shortage of child	**Resource Intensive:** Implementing the program requires trained professionals, which may be a limitation in regions with scarce mental health resources. **Engagement Challenges:** Encouraging families to participate, especially those who may feel stigmatized by mental health issues, can be difficult at this time until it is offered as a standard service.

[5] *Källsmyr K., ChildTalks+ seminar at XV. Conference on Eating disorders, Prague, 2025*.

psychiatrists and clinical psychologists in the Czech Republic. **Evidence-Based Approach:** ChildTalks+ is grounded in research and has been tested in multiple countries, including the Netherlands, Norway, and Portugal, demonstrating its adaptability and effectiveness across different cultural contexts. **Structured Psychoeducational Sessions:** The program consists of four structured sessions that provide clear guidance for therapists, ensuring consistency and quality in delivery. **Focus on Family Communication:** By enhancing communication within families, ChildTalks+ aims to strengthen parenting competencies and family protective factors, which are crucial for the well-being of children. The inclusion of the patient's family is **significant motivation factor** in patients' treatment.	
Opportunities **Expansion Potential:** Given its structured format, ChildTalks+ can be disseminated to various regions, including underserved areas, to reach more families in need. **Professional Development:** Training therapists in this intervention will enhance their skills and broaden the scope of services they offer. **Support for COPMI as standard service:** Follow the Netherland's good practice - Finance preventive interventions as part of a patient's treatment from health insurance. **Law regulations:** Follow the Norway law regulations - **I**n Norway, the child has a legal right to information about parental illness. Healthcare professionals are obliged to	**Threats** **Funding Constraints:** Securing sustainable funding for widespread implementation is challenging. **Infrastructure Constraints**: lack of qualified available professionals.

inform children, and ChildTalks+ is a tool that makes it easy for them. **Focus on mental health literacy in schools** to improve well-being, which will help COPMI on a broader scale and also, in the long term, decrease stigmatization of mental illnesses and their treatment.	

Background information from Norway: Health personnel in Norway are required to ensure that a patient that have minor children or minor siblings are offered support according to the Norwegian Health Personnel Act, §10A. The Act applies to all health personnel, regardless of position or level and type of services. Health personnel are required to ask whether their patients have children under 18 years and have a conversation about their parenting capacity, their children's wellbeing, and how the children should be informed about their parent's illness. If needed, children should receive appropriate, age-adjusted information from the health personnel about their parent's health situation. Health personnel are obliged to refer children to appropriate municipal or specialist health services if necessary. [6]

In the Netherlands COPMI preventive support is financed from healthcare insurance as a part of the treatment of the parent. It started 30 years ago, and it is offered as a standard service in healthcare services.[7]

B) IMPLEMENTATION FROM THE PERSPECTIVE OF AN ORGANIZATION

This section focuses on recommendations for implementing ChildTalks+ in various healthcare and social service facilities, drawing from our experience implementing the intervention in Norway, the Czech Republic and the Netherlands. We have faced similar challenges in the Czech Republic and Norway. This section outlines the key factors that contribute to successful implementation within organizations and identifies the barriers and challenges these organizations might encounter. It is primarily intended for the management of organizations that are considering implementation.

[6] *Gutteberg C., ChildTalks+ seminar at XV. Conference on Eating disorders, Prague, 2025*.
[7] *Van Doesum K., ChildTalks+ seminar at XV. Conference on Eating disorders, Prague, 2025*

SWOT analysis of implementing the preventive intervention ChildTalks+ in an organization that provides healthcare or social services.

Strengths	**Weaknesses**
The organization can **offer better care** to their current patients - adult patients who are parents. Parents have reported positive experiences with the intervention. The organization will support prevention for children. ChildTalks+ can be utilized in healthcare, social services, and psychological counselling settings. In the Czech Republic, in healthcare facilities, providing the intervention can be financed through health insurance as a family intervention, if it is conducted by personnel qualified for providing family interventions.	Obstacles: time, resources, culture, competence. The organization's readiness to support COPMI as part of the parent's treatment might be too low. Providing a new service requires costs and qualified personnel: • Costs and time for training personnel: after one day of training, the therapists need practical experience – usually about two months of practicing – they are considered fully trained after the supervision part, where they consult their practical experience. • General costs for starting to provide and maintaining a new service. Mental illness and substance abuse treatment are associated with a high level of stigma. Especially for services that provide substance abuse treatment, it can be difficult to motivate patients to involve the family. Clients are hiding their substance abuse. This experience also comes from social care services, where clients were reluctant to talk about their mental illness and feared stigmatization. [8]

[8] *Kučerová M., ChildTalks+ seminar at XV. Conference on Eating disorders, Prague, 2025.*

Opportunities	Threats
The whole organization, therapeutic personnel, and management could be involved by using a new type of digital learning resource (TeraVRi), which will support the implementation and sustainability of the organization.	The lack of aftercare services in some regions. The lack of qualified personnel available in the organization. The lack of sustainable financing for providing the service.

Factors that increase the likelihood of therapist involvement:[9] [10]

- Medium-sized mental health centres that already provide services to families.
- Intention to improve their services to provide the best possible care to clients.
- COPMI are prioritized.
- Sufficient staff in the workplace.
- Personnel and leaders at all levels are involved.
- Sufficient time for training and time to do the intervention.
- Multiple therapists are trained.
- Therapeutic experience.
- Therapists are psychologists and social workers (there is a shortage of psychiatrists in the Czech Republic).
- Available supervision and consultations from the ChildTalks+ team.

Good practice from the Netherlands: This intervention is a basic offer for all parents with mental illness and can be used as a standard procedure to talk to parents and children. Parents are positive: they are seen as a parent that has skills and not as a patient with disabilities.[11]

[9] *Štěpánková T. ChildTalks+ seminar at XV. Conference on Eating disorders, Prague, 2025.*
[10] *Kristensen K.B. ChildTalks+ seminar at XV. Conference on Eating disorders, Prague, 2025.*
[11] *Van Doesum K., ChildTalks+ seminar at XV. Conference on Eating disorders, Prague, 2025.*

C) RECOMMENDATIONS FOR THERAPISTS WORKING WITH CLIENTS USING THE CHILDTALKS+ FROM THE PERSPECTIVE OF PSYCHOLOGISTS AND SOCIAL WORKERS.

Challenges in recruitment families for the intervention:

- Primary barrier: It is a family intervention, and the parent in treatment has concerns about involving children and her/his partner.

Recommendations:

- Add one additional non-binding session with parents to explain ChildTalks+, after which no further participation is required.[12]
- The likelihood of family involvement increases: a long-term therapeutic relationship between the therapist and the client.[13]
- Share positive feedback from other parents in similar situations.
- Focus on the children's perspectives and needs due to the stress in the family.
- Support parents in your care to talk with children, the communication will bring mutual understanding.
- Involving the children and family of the patient will bring a new perspective and a great benefit to your practice in treatment in healthcare as well as in counselling in social services.[14] It will help your client to get better.
- If parents are reluctant to participate, explore why.

KNOWLEGDE IS POWER! [15]

Information about the parents' mental health problems:

- Is a significant factor that can reduce the likelihood of problems in children (Beardslee & Podorefsky, 1988).
- Helps to change and improve circumstances (Reupert & Maybery, 2009).
- Improves knowledge and understanding of what is happening (Grove, Reupert & Maybery, 2015).
- Explaining helps children understand that they are not responsible for the parent's problems (Discussions with children, Cooklin & Barnes, 2021).
- Knowing what is going on concerning the parents' situation, their treatment and how it effects their life will help children to worry less about their parent and their own situation.
- It becomes less stigmatizing if the family is open about their challenges and the children may be less likely to seek help in the future if needed.

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[12] *Štěpánková T., ChildTalks+ seminar at XV. Conference on Eating disorders, Prague, 2025*
[13] *Farářová A., ChildTalks+ seminar at XV. Conference on Eating disorders, Prague, 2025*
[14] *Kučerová M., ChildTalks+ seminar at XV. Conference on Eating disorders, Prague, 2025*
[15] [13] *Van Doesum K., ChildTalks+ seminar at XV. Conference on Eating disorders, Prague, 2025.*

Keep in mind:

- Giving information does not harm the parent or the child.
- Attune to questions the children have.
- Offer understanding.
- Talk about mental illness and stimulate talking together.
- All parents want the best for their children.
- Having a mental illness does not mean they are no good parent.
- Support them in parenthood.
- Give children a chance to be a child.

Child Talks+ is the first step to support the children.

Ask children what they need:

What children want from health professionals:

- 'Give us information'
- 'Tell us what is happening'
- 'Talk and listen to us, remember it is not difficult, we are not ‘aliens'.
- 'Ask us what we think and how we feel'
- 'Explain that it is not our fault (guilt), keep informing us'
- 'And please do not ignore us we are part of the family’[16]

Broader scope of use of ChildTalks+ and other interventions aiming on supporting children, young people, and family members[17] includes further support in families where children have a:

- parent or sibling with a mental illness,
- parent or sibling with substance dependence,
- parent or sibling with a serious somatic illness or injury,
- in general families experiencing distress, such as low-income, family conflict or unemployment.

Additionally, elderly people who have impaired relationships with their adult children also expressed interest in ChildTalks+. The lack of communication about these problems impacts the next generation (grandchildren) as well. [18]

[17] *Haukeland Y. and Gutteberg C., ChildTalks+ seminar at XV. Conference on Eating disorders, Prague, 2025*

[18] *Kučerová M., ChildTalks+ seminar at XV. Conference on Eating disorders, Prague, 2025*

EVALUATION

D) MAIN FINDINGS FROM THE EVALUATION. THE IMPACT OF THE CHILDTALKS+ INTERVENTION WHICH CAN BE USED WHEN INTRODUCING CHILDTALKS+.

Data from the Czech study will be further analysed in cooperation with The Arctic University of Norway, and we plan to publish the findings. Therefore, we cannot make them available online yet. Here is a summary of the experience with ChildTalks+, which can be useful when introducing ChildTalks+.

Evaluation sources:

- Quantitative data: Questionnaires for parents and their children (children aged 12/15 years).
- Feedback from parents.
- Case studies and experiences from therapists.

The Czech study took place from May 2021 to December 2024. We offered participation in the project to more than 100 organizations providing psychosocial services in the Czech Republic. 20 of these organizations expressed interest in training their staff. From these organizations, we trained 44 ChildTalks+ therapists. 23 of them actively participated in the project, working with at least one family. The families in the project were recruited by the therapists. Family recruitment occurred in five waves (the first two waves were during the Covid-19 pandemic). We jointly offered participation in the project to 176 families for whom ChildTalks+ was indicated. 65 families became involved in the project.[19]

Feedback from parents who participated in the intervention is very positive; the majority view the ChildTalks+ program as helpful. It has assisted them in better understanding how their mental illness affects their children, provided useful recommendations for subsequent services, and they would recommend the program to other families where a parent is suffering from a mental illness. They also appreciated the materials provided—explanatory brochures for parents and children.

From the statements and case studies of the therapists, it is clear that they see ChildTalks+ as a valuable intervention that helped identify children's problems at an early stage and directed them to appropriate further professional care. It motivated parents with mental illness to seek treatment, supported communication about mental health within the family, encouraged shared activities, and helped parents and children understand each other's needs. This has contributed to preventing parentification in families (i.e., where children take on caregiver roles, provide emotional support to parents, take care of the household, or younger siblings, etc.), ensuring that children are not placed under inappropriate demands and supporting the natural boundaries between children and adults. [20]

[19] *Gricová J., ChildTalks+ seminar at XV. Conference on Eating disorders, Prague, 2025*
[20] *Farářová A., ChildTalks+ seminar at XV. Conference on Eating disorders, Prague, 2025*

After the program, there was an increase in parental competencies, and parents felt better and more confident in their parenting role. The case studies from therapists indicate that without ChildTalks+, many children would not have received professional help, and their issues would have gone unnoticed or worsened. ChildTalks+ is thus an important preventive program and a gateway to further professional care.

E) RECOMMENDATIONS FOR RESEARCH AND EDUCATIONAL INSTITUTIONS, RECOMMENDED DIRECTIONS FOR FURTHER RESEARCH.[21]

Research in COPMI:

- Identify cases before they have problems.
- Identification of risk factors.
- Identification of minor children of parents with mental illness/COPMI in clinical practice.
- Barriers to support COPMI in the workforce.
- Implementation of interventions to support COPMI.
- Effects of interventions to support COPMI.

Research at the Arctic University of Norway - based on Implementation projects in Norway, Portugal, Czech Republic, we contribute to:

- Revising the manual for ChildTalks intervention.
- Publish study protocols and share with international research colleagues.
- Evaluate the identification of COPMI in clinical/social work practice.
- Evaluate ChildTalks intervention, ongoing RCT in Norway and Prague.
- Evaluate barriers in clinical/social work practice.
- Evaluate characteristics of mentally ill patients related to parenting,
- Evaluate characteristics of COPMI,
- Evaluate new teaching materials based on simulated-based and virtual reality learning resources.

Challenges in mental health services

- Professionals must identify and take action for children who live with mentally ill parents.
- Services must build infrastructure for preventive interventions, and systematically use of successful programs.
- There is a need for systematic capacity building in training the workforce in interventions to support COPMI.
- Researchers must evaluate the effects of interventions, and the cost-effectiveness of different prevention strategies.

[21] *Reedtz C., ChildTalks+ seminar at XV. Conference on Eating disorders, Prague, 2025*

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