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FIDELITY AND FEASIBILITY OF PREVENTIVE FAMILY-BASED INTERVENTIONS IN ADULT MENTAL HEALTH SERVICES: CLINICIANS' EXPERIENCES

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ABBREVIATIONS

FTI The Family Talk Intervention

IOM The Institute of Medicine

LT The Let's Talk about Children Discussion

THL National Institute for Health and Welfare (formerly Finnish National Research and Development Centre for Welfare and Health STAKES)

WHO World Health Organization

YLD Years lived with a disability

ABSTRACT

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Mental health disorders are among leading public health challenges in health care services. Beliefs, attitudes, and practices regarding clinicians' care for their patients in adult psychiatric services have been changing over the past century with new views particularly focused on helping the children of mentally ill parents by clinicians. The present study deals with successful implementation of child mental health measures in psychiatric services for adults.

The aim of the present study is to establish if the clinicians, having no or very little basic training in prevention or in clinical work with children, can be trained and are able to carry out child-centered and family-based preventive methods with fidelity, and if the methods are feasible to be practised in adult psychiatric services.

Results: the clinicians benefited from the log books in utilizing two preventive interventions. The interventions were feasible for implementation and were delivered with fidelity. The clinicians reported that the working relationship with parents correlated with the children's motivation and openness during Family Intervention, and the motivation and openness in the Child's Session were related to the parental openness in the intervention sessions. The clinicians' assessments of both interventions were very positive.

In conclusion, both intervention methods are feasible and can be implemented in the psychiatric services for adults with fidelity to the principles and the structure of the interventions. Family-based and child-centered public health interventions can be implemented in adult mental health services.

1 INTRODUCTION

1.1 Needs for prevention and promotion

Promoting mental health constitutes one of the biggest public health challenges in Europe since mental health problems affect at least one fourth of the population at a given time. Of the almost 900 million people living in the European Region, approximately 10 percent are estimated to suffer from anxiety and depression at any given time. The prevalence of mental health disorders is very high, and depression has been estimated to be the second leading cause of disability and disease-burden worldwide by 2020 (WHO 2001, 2005). In addition, 5 of the 10 leading causes of disability measured in years lived with a disability (YLD), were mental health and substance abuse problems i.e. unipolar depression, bipolar affective disorder, schizophrenia, alcohol use, and obsessive-compulsive disorder. All combined, these conditions accounted for 22 percent of YLD. (Murray & Lopez 1996)

The burden of mental disorders includes pain and suffering experienced by individuals and their families. Loss of productivity at home and at work and the stigma are still pervaded within society (WHO 2001). With this magnitude of impact on public health and quality of life, the potential of prevention to reduce the expenditure on mental health is considerable. Maintaining mental health and the availability of effective preventive interventions for mental health for the whole population could have a significant public health impact. Effective preventive services and interventions could be particularly significant for public health because there is still a treatment gap in Western Europe with well-organized health care systems: approximately 45 percent of individuals suffering from depression are without adequate treatment (WHO European Ministerial Conference on Mental Health 2005). Furthermore, the clinicians working in health care organizations should have effective working methods.

Although there have been studies on preventive working methods for mental diseases (e.g. Beardslee et al 2003; Mueser and Fox 2002; Riley et al. 2008), questions about the clinicians' importance for the treatment process have come to public awareness in adult psychiatric services (e.g. Korhonen et al. 2008; Toikka & Solantaus 2006; Riley et al. 2008). There is increasing evidence of recognizing the need to promote positive mental health and wellbeing and it is equally essential to prevent the onset of mental illness (Lehtinen et al. 2005; Smith et al. 2002). The existing data shows that promotion and prevention strategies reduce the impact of poor mental health on

individuals and society (Cuijpers et al. 2005; Riley et al. 2008).

1.2 Definition of fidelity and feasibility

Fidelity has been described as "faithfulness to a person, cause, or belief, demonstrated by continuing loyalty and support" (Oxford Dictionary of English 2003), "and strict conformity to truth or fact, and how much a piece of work remains unchanged from an earlier piece of work, or the facts that are known" (Longman Dictionary of Contemporary English 2005).

The term fidelity is a component of innovation theory. It is a way to understand the process of putting new ideas into practice (Rogers 2002). Intervention fidelity has been determined as a multifaceted concept. Aspects of adherence describe the intervention's core content components and its competent execution using accomplished clinical and teaching practices. Before assessing fidelity the critical elements of an effective program should be identified (McGrew et al. 1994). Fidelity in an intervention means that these essential theoretical and procedural elements have been adequately covered when the intervention has been performed. In addition, it requires that the clinician's skill in utilizing the core intervention techniques is sufficient and it responds to the unique needs of the participants. Intervention fidelity also requires that each intervention component is delivered in a comparable manner to all participants. Finally, the structure of the intervention should adequately represent the theory and goals beyond the intervention.

Various kinds of checklists can be used for assessing fidelity. (Dumas et al. 2001; Foregatch et al. 2005; Hogue et al. 2005) They are used to show that the content and the process of the intervention are the same across the participants throughout the study. In addition, if the intervention covers multiple components, the contents and processes require attention. Dimensions such as breadth and depth of the intervention content should also be assessed. Finally, the frequency of the sessions and the number and timing of the sessions should also be analyzed. The skilful use of the intervention techniques and protocol adherence need also evaluation and represent one important component of fidelity. (Dumas et al. 2001; Hogue et al. 2005)

While the knowledge of preventive interventions is generally increasing, little is still known about the fidelity of preventive programmes. Durlak (1998) reported that less than 5 percent of more than 1200 prevention studies reported data on program fidelity. Although this review was published

more than 10 years ago, since then the situation has not improved much. To the best of my knowledge, there are very few studies on fidelity in the field of mental health promotion and mental disorder prevention. Particularly, no studies on fidelity have been performed in programmes aiming at prevention of children's risk when the parent's suffer from mental illness.

Fidelity analyses, however, have been performed in a few psychiatric intervention programmes, covering for example various psychotherapeutic protocols. The reported fidelity assessments have concerned for example treatments for depression (Hill, O'Grady & Elkin 1992; Startup & Shapiro 1993), alcoholism (Caroll et al. 1998) or adolescent drug abuse (Hogue et al. 1998). Moreover, there are previous studies on fidelity in certain prevention programmes, such as prevention for substance abuse. For example, Hogue et al. (2005) examined the intervention fidelity in a family-based preventive intervention for adolescents at high risk for drug use and related behavioural problems: they used a multidimensional family prevention programme (MDFP). They concluded that the adherence to MDFP was good, and it represented its core intervention principles. Dumas et al. (2001) describe the key conceptual and methodologic issues associated with intervention fidelity in their prevention trial (Early Alliance). The project evaluated the effectiveness of family, peer, and school interventions to promote competence and reduce risk for conduct disorder, substance abuse, and school failure assessed by the consultants. They found that the number of sessions varied a lot in the family intervention, but rather than lack of adherence to protocol this variability reflected events that were beyond the consultants' control, such as absence of students on the session day which can make it impossible to run a peer group. Even though the consultant performances varied between different interventions, the authors concluded that the interventions were performed with good fidelity.

Forgatch's et al. (2005) studied using the Fidelity of Implementation Rating System (FIMP), an observation-based measure assessing competent adherence to a study protocol. They assessed the FIMP's component adherence to the Oregon model of Parent Management Training (PMTO). They found that high FIMP ratings predicted change in observed parenting practices from baseline to 12 months. They piloted the model with 20 stepfamilies participating in the interventions. Audio or videotapes were collected and coded for adherence. FIMP covered five dimensions regarding adherence to study protocol (clinical skill, knowledge, structure, teaching skill and overall effectiveness). They found that the psychometric properties of the FIMP scores and evaluation of

their predictive validity was high. In addition, the FIMP suggested that using this rating system will improve fidelity of the intervention which predicts also efficacious treatment outcomes.

Dusenbury et al. (2003) performed a literature review on the fidelity assessments in studies that aimed at preventing drug abuse at schools. In the review, the indicators of fidelity were defined as adherence to study protocol, amount of sessions, quality of program delivery, participant responsiveness and programme differentiation. The review indicated that the reported definitions and measures of fidelity varied largely across different studies. Therefore, Dusenbury et al. proposed that universally agreed criteria for implementing interventions with fidelity should be developed. They also suggested that the measurement of fidelity should be extensively developed and the factors that influence the fidelity of implementation should be studied. Finally, fidelity of implementation in evaluation studies should be assessed.

Feasibility of interventions is seldom described in research articles or studies. In the Longman Dictionary of Contemporary English (2005) "a plan, idea, or method that is feasible is possible and is likely to work". Feasibility means "the state or degree of being easily or conveniently done" (Oxford Dictionary 2003). A current work practice and procedure carried out or dealt with successfully e.g. in the mental health services can be a feasible method. Like Mueser and Fox (2002) reported how family intervention used for dual disorders provided clinicians ability to implement the programme, and successfully engaged families in treatment. Procedures of parenting programmes shall be developed to ensure the essential elements of evidence-based programmes to be implemented in a reliable way for a variety of practice settings so that they will produce their intended effects. Therefore, fidelity of implementation reveals important information about the feasibility of an intervention by confirming how likely it is that the intervention can be implemented with high levels of fidelity. (Dusenbury et al. 2003; Olds et al. 2007)

Evidence about feasibility and fidelity of preventive working methods is still limited to a very small number of interventions with restricted scope of generalizability and transferability (Rotheram-Borus & Duan 2003). The limited resources; time, space, or staff necessary to achieve the outcomes in services, often constitute an obstacle to developing and utilizing the effective interventions. Therefore, only few of the existing interventions have been implemented in the large scale (Rotheram-Borus & Duan 2003), even though prevention is observed to be far more inexpensive

than treatment in services (Rogers 2002). That is why there is an increasing need for development and use of preventive methods as well the necessity to create and collect information existing in useful prevention practices in health care services.

The present study is intended to be a contribution to the ongoing evaluation of two preventive interventions, The Family Talk Intervention and The Let's Talk about Children Discussion, accomplished in adult psychiatric services. The study therefore aims at describing the clinicians' experience based on two structured preventive interventions regarding logbooks that show the intervention protocol. These experiences can provide information on the process of implementing preventive interventions, and on the feasibility of the interventions from the point of view of the clinicians. The present study can also add to the literature on intervention fidelity in circumstances where an intervention is exported to another field of expertise than adult psychiatric services.

The present study is part of "The Effective Family Programme" at the National Institute for Health and Welfare, formerly Finnish National Research and Development Centre for Welfare and Health (STAKES).

2 LITERATURE REVIEW

The literature review is divided into three subsections. The first subsection will reflect on the children of mentally ill parents and parenthood. The second subsection discusses preventive interventions, in particular, and concentrates on the previous work on families with a mental disorder (mainly depression in different aspects or forms), and this subsection ends by reviewing evaluation of the scientific evidence on preventive family-based interventions implemented in clinical settings. The third subsection will review literature on the factors that have been noted to affect utilisation of preventive interventions, and literature on aims and obstacles facing the clinician when working with families.

The literature used in this review was searched using PubMed including Medline and CINAHL,

PsychINFO, the Cochrane Library, PsiTri, Academic Search Elite, Science Direct, Social Services Abstracts, Sociological Abstracts and SocINDEX with full text. The following keywords were used for relevant materials: prevention, promotion, family-based, child-centred, feasibility and fidelity of the intervention, and implementing prevention. The search was limited to articles published after 1980. Also relevant studies referred to in the articles found through the search were included in the review. The search included studies and articles published mainly in English, some in Finnish and in Swedish.

2.1 Children of parents with mental illness

2.1.1 Challenges for intergenerational transmission

The psychiatric disorders of parents and the intergenerational chain have been studied actively during the past decade. Aims include parental disorders, effects of genes in getting ill, explanation models and protective factors to cope without getting ill. Nowadays, people have started to study how to break the intergenerational transmission, decrease the burden of families and prevent children's disorders. Most studies on the effect of parental illness on children concentrate on parental depression, which is the most common psychiatric disorder in adults.

During the last two to three decades discussion about resilience, awareness, and intergenerational transmission in mental health has grown and preventive efforts are considered to be particularly important for families with depression in several generations (Solantaus 2005; Weissman et al. 2006.) Children living with parents having mental health problems have an increased risk to have mental problems themselves (e.g. Beardslee et al. 1998, 2007; Goodman & Gotlieb 2002; Merikangas et al. 1998; Niemi et al. 2004; Radge-Yarrow et al. 1992; Weissman et al. 1992, 2006) as well as a substantially high risk for developing a wide range of behavioural and cognitive disorders (Yuh et al. 2006). Children with mentally ill parents have a 20–70 percent higher risk to develop a major psychiatric disturbance themselves, compared to 5–20 percent in children with parents who do not have mental disorders (Hammen & Brennan 2003; Schubert & McNeil 2003; Beardslee et al. 1998; Downey and Coyne 1990). A parent's bipolar affective disorder increases the children's risk to have a mood disorder as well an anxiety disorder (Todd et al. 1996), whereas a parent's panic disorder has a relation to the children's panic disorder and other anxiety disorders (Beidelm & Turner 1997; Biederman et al. 2001) as well as depression (Biederman et al. 1991). When a parent has schizophrenia children have an increased risk for psychosis, depression, bipolar

affective disorder and substance problems (Schubert & McNeil 2003). Weissmann et al. (2006) in their 20-year follow-up study have also presented an increased risk for depression, anxiety disorder and substance addiction (alcohol, drugs) in the groups of adult children of mentally ill parents. In addition, they reported decreased general working demand or coping at work and increased risk of somatic illnesses such as heart, vein and nervous-muscular illnesses among depressive parents' children. (Weissmann et al. 2006)

Researchers have recently been interested in genes and psycho-neurological issues. Levinson (2006) reviewed that the adult relatives of a person with a history of depression have at least twice the risk for a depressive disorder compared to the population in general. Sullivan et al. (2000) estimated that about 37 percent of the risk for developing a depressive disorder is genetic. This risk reflects the interaction between genes and the psycho-social environment (e.g. Caspi 2002, 2003; Paavonen et al. 2009). Recent longitudinal studies have shown that genes alone do not account for the risk of emotional problems for children, but that they interact with environmental factors (e.g. Rutter et al. 2006). This means that genetic factors alone do not determine the onset of psychiatric disorders and by modifying environmental risk factors, such as the influence of mental disease on parenthood, the risk of these disorders may be decreased.

Most studies on parental depression and especially post partum depression concern mothers only. (e.g. Riley et al. 2008; Solantaus & Paavonen 2009). There are, however some researchers, e.g. Ramschandani et al. (2005), who have studied father's depression. They pointed out that the consequences of depression in the postnatal period for boys depend on which of the parent has problems in the family. It seems that more behavioural problems are related to fathers' depression while emotional problems are more likely related to mothers' depression. Chang et al. (2007) have found that when the father actively compensates for limitations in a depressed mother's functioning, the child's risk of problem behaviour may be reduced. Kane and Garber (2004) have studied the interaction and consequence of father's symptoms in a child's development. In their study fathers' depression is related to children's emotional and behavioural problems. The literature on psychiatric disorders other than depression in the father is scarce. The father's role in families with a mentally ill parent is an important topic and more studies are definitely needed.

2.1.2 Sustaining parenthood

Many environmental risk factors have been related to children in families' with mental illnesses. Events and emotions disrupting family relationships and cohesion also reduce connections outside the family, negatively impacting the well-being, health and functioning of every family member and the family as a whole (Sills et al. 2007). Parents suffering from mental health problems often face difficulties in parenting, in the way of communication and in keeping social networks. For example, depressed parents have difficulties in responding positively to their children's efforts to attract attention (e.g. Oyserman et al. 2004; Savvidou et al. 2003). Depressed mothers also have difficulties in upholding mutual interaction with their children (e.g. Downey & Coyne, 1990; Radge-Yarrow 1998). According to Leinonen (2004), a parental mental health problem often represents a comprehensive risk to the quality of parenting. However, children are in their parents' minds even if a parent has depression and/or is hospitalized (e.g. Kaakinen et al. 2007). All these reasons increase the need of working tools for preventive interventions with the adults.

One important environmental risk factor during childhood for mental health problems is deprived parenthood. Parents might face different strains which affect their capacity to function in their role as parents (Fudge et al. 2004). Lacking parental support and parental mental illness during pregnancy and early childhood can lead to child's depression later in life, whereas secure interaction and family social support can reduce such risks (WHO 2005, 51). Other documented factors that decrease parenthood are promotive and preventive interventions which focus on promoting protective factors (e.g. positive parenting, parental sensitivity or family social network) in families with parental problems (e.g. Beardslee et al. 2007). These are some of the reasons for a big challenge in breaking the intergenerational transmission of mental health problems.

2.2 Preventive interventions and programmes in mental health

2.2.1 Prevention and the development of preventive intervention

The challenge of describing and marking off the knowledge base for preventing mental health problems is complicated by the use of multiple definitions of prevention. In public health, the classic categories of primary, secondary, and tertiary prevention have gained wide acceptance but a narrower definition of prevention based on the US Institute of Medicine (IOM) has been widely embraced in the field of mental health. The IOM model of prevention (1994) presents a continuum of health care that includes prevention, treatment, and maintenance. There are three classifications

for interventions in the IOM model: *universal interventions* recommended for the entire population, *selective interventions* recommended only for groups with increased risk, and *indicated interventions* recommended only for high-risk individuals and persons experiencing early symptoms of a disorder. (Dorfman & Smith 2002) The present study mainly focuses on interventions targeted at families with mentally ill (depressive) parents. The following two subsections will first present preventive interventions in general and thereafter family-based interventions.

2.2.2 Preventive interventions in different contexts

Several studies demonstrate promotion of child development and prevention of problems possible. Effective preventive interventions exist to help and support children of parents with a mental health disorder or addictive disorder. Interventions have been utilized in various services (e.g. Catalano et al. 1999; Hinden et al 2005; Kumpfer et al. 2003; McComish et al. 2003; Nye et al. 1999; Sanders 2000; Spoth et al. 1999). There are both group-based cognitively oriented interventions to prevent depression in adolescents of depressed parents (Clarke et al. 2002; Garber et al. 2009) and group-based parent training for preventing mental health disorders in children (e.g. Cross & Grady, 2002). Mueser and Fox (2002) conducted a family intervention programme including focus groups for families with a member having bipolar disorder. They had groups for relatives, mental health professionals, and clients. They successfully examined the perceptions of different stakeholders about how families could get help, obstacles that interfere with progress, and what families need to know. According to Riley et al. (2008*)* family-based programme based on groups for parents and adults reduces risk and promotes resilience for children among families affected by maternal depression. In addition, structured peer group programmes for children and parents with parental mental health problems have also been developed (e.g. Söderblom 2005). The meta-analysis by Horowitz and Garber (2006) indicated three family-based interventions targeting children or adolescents who are not yet clinically ill (Sandler et al. 1992; Shochet et al. 2001; Gillham & Reivich 1999). However, none of these programmes focused on children of depressed parents.

Preventive interventions and their implementation should be based on evidence-based practices or best practices in health services to describe feasibility of the methods (Kellam & Langevin 2003; Riley et al. 2008; Rogers 2002; Schoenwald & Henggeler 2003; Solantaus & Toikka 2006). According to Clisson et al. (2008) the infrastructure of mental health services influence the adoption and implementation of evidence-based preventive practices. The Livet and Wandersman review

(2005) included many empirical studies across a wide range of fields (e.g. including mental health) and writers found many organizational elements of infrastructure, essential for implementation of preventive practices. Those essential elements included the time reserved for preventive work and or need assessment of the target community and strategies for implementation and assuring sustainability of preventive programmes. The times reserved for preventive work and or for need assessment of the target community and strategies for implementation and assuring sustainability of preventive programmes are included among the essential organizational elements referred to in the review.

2.2.3 Family-interventions in mental health services for adults

Traditionally, the adult mental health services are individually-based. To implement family-based and child-centred preventive interventions, a paradigmatic shift is needed from the traditional patient-professional relationship to sharing experiences and to focus on the communication and relationship between the members of a family where a parent suffers from mental illness (e.g. Solantaus 2005; Solantaus & Beardslee 1996). Current evidence supports increased emphasis on family-oriented psychiatric practice (Haru 2006) and some studies have shown the value of prevention strategies for parents' depression (e.g. Beardslee et al. 2003, 2007; WHO 2004).

In the following table are presented some examples of family-based and child-centred interventions in adult psychiatric services. Family-based interventions for parents suffering from depression have been studied for many years (e.g. Beardslee et al. 1996, 1997a, 1997b, 2003, 2007; Solantaus & Toikka 2006; Solantaus et al. 2009). Magliano's et al. (2006) explored the effectiveness of a psycho-educational family intervention for schizophrenia from the perspective of patient and relatives. In addition, Pihkala and Johansson (2008) have studied which factors affect on parent willingness to accept family intervention. Podorefsky et al. (2001) have described essential elements of intervention used with a high-risk urban sample among ethnic minority families with parental depression. D'Angelo et al. (2009) studied adaptation of a preventive programme for depression for use with predominantly low-income Latino families. All these interventions aim to increase understanding among family members by setting the task on a clinician to help the parents. The clinician's task is to help the parents to open up discussion about difficult issues with their children. Table 1 gives a summary of results of structured family-interventions when a parent suffers from depression.

Table 1 A summary of the effective structured family interventions for children of mentally ill parents

Authors	Study Question	Subjects	Intervention	Design	Results/Findings
Beardslee, W.,Wright., E., Gladstone, T., and Forbes, P. (2007)	What are the long-term effects of two forms of preventive intervention designed (1) to decrease some risk factors inherent in the presence of parental mood disorder and (2) to increase factors demonstrated to be protective when a parent suffers from mood disorders?	105 families, including 21 families from the pilot sample and 84 families enrolled after the pilot period; families with at last on child aged 8-15 and at least one parent who had experienced an episode of affective disorder	Six to 10-session clinician-facilitated intervention with family, parents, and children; two lectures by physicians	Random assignment; pre-intervention, post-intervention assessment and follow-up assessment at 4.5 years	Clinician-based intervention families had more gains in parental child-related behaviours and attitudes, and in child-reported understanding of parental disorder. Child and parent family functioning increased for both groups, and internalizing symptoms decreased for both groups. No significant group differences
Beardslee, W.,Gladstone, T., Wright., E. and Cooper, A. (2003)	Does participating in these preventive programs (1) result in parental change in child-related behaviours and attitudes about depression and its impact on the family and (2) does parental change produce change in children's self-understanding and in depressive symptomatology?	93 families including 121 children; families at last one child aged 8-15 of parents with mood disorder	Six to 11-session clinician-facilitated intervention with family, parents, and children; two lectures by physicians	Random assignment; pre-intervention, post-intervention assessment and follow-up assessment at ~1 and 2.5 years post-intervention	Decreased risk factors (e.g., family conflict and lack of parental focus). More changes in parents in the clinician-facilitated intervention. Increased understanding in children of parental illness in both conditions. No significant effect of children's change in internalizing symptomatology
Beardslee, W., Wright, E., Salt, P. et al. (1997)	What are the long-term effects of two forms of preventive intervention designed (1) to increase families' understanding of parental affective disorder and (2) to prevent depression in children?	36 health maintenance organization; families with a non-depressed child aged 8–15 and a parent who had experienced an episode of affective disorder	Six to 10-session clinician-facilitated intervention with family, parents, and each child; two lectures by physicians	Random assignment; pre- and post-intervention assessment with follow-up about 1.5 years after enrolment	More changes in parents and children in the clinician-facilitated intervention group
Beadslee, W., Salt, P., Versage, E. et al. (1997)	Is it necessary for families to link cognitive information to family life experiences for sustained changes in behaviour and attitudes to occur?	37 health maintenance organization families with at last one child aged 8-15 and at least one parent who had experienced an episode of affective disorder	Six to 10-session clinician-facilitated family intervention,two lectures in group format with no children present	Random assignment; pre-intervention, post-intervention assessment and follow-up assessment at 17 months	Increased behaviour and attitude changes among participants in clinician-facilitated intervention
Beardslee, W., Wright, E., Rothberg, P.,Salt P and Versage, E. (1996)	What is the long-term impact of two interventions to diminish risk children in families with a parent who has an affective disorder?	28 health maintenance organization families with child aged 8–14 and parent with past episode of affective disorder	Six to 10-session clinician-facilitated intervention with couple, individual, and family meetings; two lectures by physicians	Random assignment; pre-intervention assessment and post-intervention assessments at 3 to 6 weeks, 9 to 12 weeks and 24 months	Linking cognitive information to families' life experiences produced long-term behaviour and attitude changes

D'Angelo, E., Llerena-Quinn, R., Shapiro, R., Colon, F., Rodriguez, P., Gallagher, K. and Beradslee, W. (2009)	Is the intervention safe and feasible to be adapted for use with predominantly low-income, Latino families, is the intervention adapted with fidelity	Nine Latino families in Boston; families with child aged 7–17 and parent with past episode of bipolar disorder	Six session manualized series of meetings, clinician-facilitated intervention with parents and children	Pre- and post-assessment by clinical interviewers independent from the intervention content, self-reports	The intervention was successfully adapted for use with an urban, Latino sample, intervention was safe and can be taught to preventionists to deliver it with fidelity
Pihkala, H. and Johansson, E. (2008)	What depressed parents considered as obstacles and facilitating factors for accepting Beardslee family intervention	Ten parents from two psychiatric clinics and one primary health care centre in northern Sweden; families with child aged 7-17 and parent with depression	Six to eight session clinician-facilitated intervention with family, parents, and each child delivered during the past year or have been invited but refused participation	Interview by semi-structured technique, data were analyzed according to grounded theory	Opening up a dialogue about the illness with the children was demanding. The process from the parents' point of view was important, and to focus on fear of exposure and issues to be handled. Shame and quilt were painful for mothers. The importance of explicit information, such as individual interviews with each child and the possibility of home visits when children participate in sessions were crucial.
Podorefsky, D., McDonald-Dowdell, M., Beardslee, W (2001)	What is the long-term impact of two interventions to diminish risk of children among ethnic minority families living under adverse conditions and with a parent who has an affective disorder?	Primary care and mental health workers in Dorchester; 32 single-parent families with at last one child aged 8-15 of parents with mood disorder	Five to eight session clinician-facilitated intervention with family, parents, and children; two sessions didactic group for parents by physicians	Random assignment; pre-intervention assessment	Increased factors demonstrated to be protective (e.g., increased involvement in outside activities, supportive adult/family relations, and increased family understanding)
Solantaus, T., Toikka, S., Alasuutari, M., Beardslee, W., and Paavonen, J. (2009)	Are two preventive interventions safe and feasible for families with depressed parents? How was the family experienced?	16 health care units in the eight regional organizations treating adult patients	A one or two session discussion conducted by a clinician with parents or a six session intervention conducted by a clinician	Random assignment, post-intervention assessment	Two interventions were safe and feasible to implement and were delivered with fidelity. Family members reported positive working relationship and benefits, increased understanding and self-esteem

The articles in Table 1 demonstrate that many preventive interventions for mental health have been evaluated and most are shown to be effective. Many of the interventions produced positive health-related outcomes and some of the articles also included the cost impact of the intervention. The fidelity to the family-based intervention and feasibility with the families were also studied in some studies, but the clinician's role delivering the intervention was not considered.

2.3 Clinicians' role and experience in implementing preventive interventions

2.3.1 Implementation of preventive interventions

There is little evidence available about the effectiveness of preventive programmes in adult psychiatric services or in communities (Ennet et al 2003) which may have impact on implementing preventive interventions. Wandersman's (2003) study of community capacity is a good example of implementing prevention to every day practices. The clinicians face the challenge of adapting prevention interventions to their own setting. Their challenge is often complicated by the lack of attention to dissemination issues by programme developers (Magliano et al. 2006; Schoenwald & Hoagwood 2001) and by attempts to implement best practices without consideration of external validity, or generalizability, or its suitability to the local public health care settings (Green 2001). Wandersman and Florin (2003) concluded that in order to significantly implement preventive intervention and improve the quality of prevention and concentrate on the gap between theory and practice, attention shall be focused on the competence of local prevention practitioners. A better understanding of all kinds of preventive interventions, in general, will directly facilitate bridging the gap between theory and practice.

Publication of reports and research on family-based preventive interventions evaluated by clinicians working in the adult psychiatric services has gradually been started in recent times. The clinicians working with mentally ill parents could give useful information about implementing preventive programmes. Nonetheless, very few researchers have reported on the clinicians' experience. Beardslee (1998) wrote that it is important for clinicians to recognize opportunities for the prevention of mental disorder in clinical practice, and to participate in developing programmes. In clinician-based intervention, like Beadrslee's intervention, a combination of specificity and flexibility in delivery of the intervention enable clinicians from a variety of working environments and backgrounds to use preventive interventions. Beardslee & MacMillan (1993) presented a case-study on how they evaluated the compatibility of two approaches, these being clinician-based

intervention and psychoanalytic therapy. They analysed the principles and process of the intervention essential for the clinician when delivering the intervention. Clinicians from a variety of orientations modified and conducted complicated interventions and provided counselling during family crises and in coping with chronic stress (Podorefsky et al. 2001). Researchers suggested building partnerships with clinicians which result in successful transposition of interventions to different settings.

In Toikka's and Solantaus's (2006) study clinicians rated spousal and children's understanding very positive and reported the importance of good working relationship with parents. The clinicians experienced the methods to be useful and the methods increased their satisfaction and joy at work. Johansson (2009) reported that the clinicians' understanding of family situation and a parent's mental illness, use of psychoeducative family-based interventions and use of family-focused working methods have been increased in adult psychiatric services. In a study by Magliano et al. (2006) 96 percent of the clinicians using preventive psychoeducative interventions reported positive impacts between mentally ill parents and other members of their families. This takes place even though the integration of interventions to everyday work had been difficult because of longstanding working habits and the demands of work. Mueser and Fox (2002) described how professionals can work more effectively with families. The clinicians expressed satisfaction with the curriculum, structure, and flexibility of the family programme.

Beardslee et al. (2007) described in their study the intervention protocol and contents. They also described intervenors that were trained rigorously in the intervention strategies, being licensed social workers or clinical psychologists. They observed that planning for dissemination is essential and strategies could be used by a wide range of clinicians. Beardslee et al. (2003) described fidelity of the clinician-based protocol in the intervention by using raters, who were not clinicians using the intervention with the families. Raters found strong reliability (>.96) for the clinicians' work in the family members' meetings. Also overall adherence to the intervention protocol was high and percentual differences among raters were not significant. In stead D'Angelo et al. (2009) developed a rating form to rate a randomly selected tape-recorded session for a therapist's fidelity to the intervention protocol. Two randomly selected taped sessions for each of the three preventionists were evaluated 92.6 percent of the content elements for the manualized intervention was delivered.

Most previous studies reported the clinicians' evaluation of the parents' involvement for the family intervention. Clinicians recognizing opportunities for the prevention of mental disorder in clinical practice, and principles and process of the intervention were also studied. The clinicians rated both family members' understanding and the clinicians' understanding of family situation and parent's mental illness. The family-based interventions were used by the clinicians from a variety of orientations who experienced the methods to be useful. Planning for dissemination of the intervention was observed essential. Only a few previous studies have described the clinician-reported experiences about feasibility of the intervention. Table 2 describes previous studies on family-based interventions in mental health including reports and experiences of the clinician.

Table 2 Evidence of previous studies on family-based interventions in mental health

Clinician-reported experiences	**Previous studies on clinicians' experiences**
Clinicians' fidelity or adherence to the methods	Beardslee et al. 2007; Beardslee 1998; Beardslee and MacMillan 1993; D'Angelo et al. 2009; Magliano et al. 2006; Toikka and Solantaus 2006
Feasibility of the intervention to the adult psychiatric services	Mueser and Fox 2002; Podorefsky et al. 2001; Solantaus et al. 2009; Toikka and Solantaus 2006
Openness	No previous study
Motivation	No previous study
Working relationship	No previous study
Satisfaction	Mueser and Fox 2002; Toikka and Solantaus 2006

2.3.2 Elements influencing to the working orientation

The feasibility of preventive parenting programmes will depend on how well parents' concerns and motivations are integrated into the programme design and how effective clinical methods for behavioural change are employed by the professionals. Also clinical skills and that the clinicians are convincing are important elements (Olds et al. 2007).

Discussing mental illness with families is often difficult. Families and clinicians need to discuss shame and sense of guilt. Protective impact of dialogue on children in families with parental depression is documented in many studies (e.g. Beardslee et al. 2007, 2003, 1998; Garber et al. 2009; Podorefsky et al. 2001; Solantaus et al. 2009).

The clinicians working in adult psychiatric services may also have obstacles during conversations

with family members other than the patient. The clinician might have ideas such as: I'm an intruder, I don't have experience of talking to children or I fear loosing contact with the patient. Table 3 contains information about the aims and obstacles clinicians need to internalize and pay attention to when working with families.

Table 3 Aims of paying attention and to be internalized by the clinician during the preventive interventions (retold by van Doesum 2002).

Aims of talking			**Obstacles to talking**		
Clinicians	Children	Parents	Clinicians	Children	Parents
gives information	to get resources and coping skills to the children to solve the problems, strengthen social skills and assertiveness	aids the parents in finding tools to support development of his/her child	have a feeling as an intruder	do I increase the children's fear or feeling of guilt or shame by accusing their parents	do I increase the parents' feeling of guilt
offers emotional support to the family members	to support the parents in helping their children to understand the mental problem of the parent	to take into consideration that the children may be a delicate issue to the parents	have lack of experience in talking to the children	do I help the children to understand the parents' feelings or decrease unrealistic beliefs	do I increase the parents' fear of burdening the children and how to decrease it
talks how he/she can deal with the parent	to aid the parents to guide their children to spend time in a stimulating and supporting environment	to take into consideration issues of respect for parents which differ from interfering	feel biased to some of the family member	do I decrease the children's suspicion	do I decrease the parents' fear of loosing the children
gives brochures	to aid the parents to reduce the children's exposure to stressful circumstances	to guide parents to become aware of possible problems with the children (reduce denial)	have fear of loosing contact with the patient	do I increase the children's distance of understanding	do I increase the parents' feeling of shame and how to decrease it

recognition of the situation	to increase the parents' and the children's awareness of the risk and protective factors	To aid the parents to notice how the children are doing and if there are possible problems	have fear of aggression	do I increase the children's fear of making a fool of themselves	do I increase the parents' fear of magnifying problems
supports the parent in the role as a parent	help the children to notice that parent can manage without the illness	To support the parents in giving positive feedback to the children	lack of supportive interaction	do I increase the children's fear of not being involved	do I decrease the parents' ability to motivate the children in joining the intervention
check the children	relief to the parents to aid their children in not becoming ill themselves	relief to the parents' concern for the children	have a strong attitude	do I increase the children's fear of magnifying the problems and how to decrease it	do I increase stigma and how do I decrease it

Open communication and understanding

Lack of knowledge and understanding of parent's mental illness can disturb the co-operation and dialogue between clinician and family members. The clinician may think that if children do not know about parental problems, talking about them increases the children's burden. The clinicians may not understand why they need to talk to children, what to say to them and when to say it. It is a specific issue for clinicians to take in consider that parents want the best for their children, but questions about children can also make parents feel bad (e.g. Beardslee et al. 2003; Podorefsky et al. 2001; Solantaus & Beardslee 1996). Therefore, it is important to consider how to focus attention on the manner of talking to children, how to show respect to the parent and, especially, how to support the parent in telling necessary issues to the children.

Open communication and understanding of parental problems in the family and social involvement in age-appropriate out-of-home activities for the children, such as school, peers and hobbies, are factors known to be related to children's resilience (e.g. Beardslee & Podorefsky, 1988; Solantaus & Beardslee, 1996). The clinician should offer emotional support to family members as well as to talk about how family members can deal with each other and support each other, and also how to support the patient/parent in the role as a parent. The clinician should give the family the

information it needs (Beardslee unpublished; Solantaus 2005; van Doesum 2002).

Preventive family interventions are a new approach and a new way of working in adult psychiatric services. Therefore, open communication and understanding between the clinician and the family members, respect of the parents, emotionally safe atmosphere during the discussion, and focus on relationships among family members are the basic principles guiding the clinicians' work with the families.

Respect of the parents

Mental health problems have an effect on relationship skills between family members in everyday life. Preventive intervention must be a respectful and non-stigmatising way of discussing parental mental problems, parenting and children. The working environment shall be positive and supportive. Any pressure can be harmful. Preventive interventions must create a hopeful perspective for the family's future. (Beardslee unpublished; Solantaus and Beardslee 1996.). The patient's own therapist should conduct the preventive intervention. But, having a new person than treating clinician to be contacted may be a positive experience for the parents. Intervention must be based on mutual trust and confidence. Professionals must be sensitive to parents' defence or denial when working with mentally ill parents. (Pihkala & Johansson 2008)

Safe environment and relationships

Children's well-being and parenting are sensitive issues for a parent, especially if one is not performing optimally. Mutual understanding and respectful atmosphere between the family members and the clinicians make discussion about difficult matters possible. The clinician needs to find out if the children are informed and supported in the family, and which kind of capacity the children have to cope with the family situation. The clinician must make sure that children are safe and that they do not have mental health problems and are not in need of treatment. The clinician has to guide to relevant services when there is need of child protection or psychiatric help. (Beardslee unpublished; Solantaus & Beardslee 1996; Solantaus & Toikka 2006)

In summary, promising methods for helping parents and families exist but little is known about the effectiveness, feasibility or theoretical background of the preventive interventions. Clinicians face several challenges (like being open and understanding for the mentally ill parents) when discussing

the issues with their patients. They should be able to build an atmosphere of trust enabling family members to be open and to motivate participation in their preventive intervention. There are alternatives for how to co-operate in the practical field. One option is to find a programme with methods established to be feasible and conducted with fidelity by the clinicians (Rotheram-Borus & Duan 2003).

3. EFFICIENT FAMILY PROGRAMME

3.1 Background

The National Institute for Health and Welfare, formerly The National Research and Development Centre for Welfare and Health (STAKES) and the Ministry of Health and Social Affairs in Finland have recognised the need for preventative services in families with mentally ill parents. Also, according to the Finnish Child Welfare Act (chapter 2, §7), the needs for care and support of dependent children are to be taken care of when a parent receives mental health services in all types and at all levels of health care: primary health care, psychiatric services and substance abuse services.

The purpose of the Effective Family Programme is to promote preventive approaches and to build up co-operation between services for adults and children. The programme aspires to bring about changes at different activity levels such as individual, patient, organization and community and also at the national and population levels. At the individual or professional level this means attitude change, new clinical skills and change in working routines. Acceptance and demand of child focused work could be raised at patient level. At the organizational level in adult psychiatric services there should be acceptance of child focused work and recourses for that kind of work. Decision makers' acceptance and support is needed on the community level whereas networking with different professionals and educational levels are national level issues to be answered. In addition, at the population level awareness is required of problems in child development when parents are mentally ill. (Solantaus and Toikka 2006; Solantaus 2005)

3.2 Programme Method Family

The Family Talk Intervention was developed by Dr. Beardslee and his team in the USA (Beardslee

et al, 1993; Focht & Beardslee 1996; Solantaus & Beardslee 1996), whereas the parent-focused Let's Talk about Children Discussion used in the present study and further developed in 2006 (http://info.stakes.fi/toimivaperhe/FI/index.htm) was developed in 2002 by Dr. Solantaus in Finland. This Effective Family Programme consists of Method Family including these two interventions, Family Network Meeting, peer groups and booklets.

3.2.1 The Family Talk Intervention

The Family Talk Intervention, fully described in the manual "Cognitive psychoeducational intervention. Manual for the Beardslee Preventive Family Intervention" (Beardslee, 1997, unpublished), was designed to promote family functioning and to prevent child (adjustment) problems. The intervention involves both parents and children and includes 6−8 sessions depending on family size, takes place weekly or at shorter or longer intervals, at the family's request. Each session is detailed with agenda, objectives and rationales. Every session takes approximately 45 minutes. Parental illness, family communication, children's responses and child wellbeing are discussed first with parents and children, and then the parents meet again to plan a family session. Every child above 7 years was met alone. The family session brings the family together to discuss parental mental illness and possible other family concerns under the parent's leadership. In a follow-up session the parents review the process and plan the future. Protocol and brief definitions of the seven dimensions of FTI are presented in Table 4.

Table 4 Protocol and description of The Family Talk Intervention (Beardslee unpublished)

Session	Participants	Aim	Description of intervention
1	Parents	Introduction of the intervention	Framing the intervention, elicit history of parents illness and defining goals for the intervention, identification of family's main concern and establishment of the therapeutic alliance
2	Parents	Illness experience and psychoeducation	Illness experience of non-ill, psychoeducational component: resilience and risk factors to children, parents' perspective on child functioning
3	Child/children	Become familiar with children's thoughts and questions	Purpose of intervention at a conceptual level the child can understand, assess functioning, assess understanding of parental illness, elicit concerns and questions to be discussed at family meeting

4	Patient and spouse / Parents	Planning the family meeting	Review impression of child functioning, discuss questions children wanted to discuss, plan format of family meeting
5	Whole family	Opening the discussion and answering to children's questions	Review information about depression and resilience, allow opportunity for every family member to ask questions, encourage sharing of individual perspectives, clarify differing perceptions
6	Parents (and children)	Review and plans for the future	Parents' impression of meeting, review any information needed, and emphasize importance of the intervention as beginning of a process that the family can continue, note availability of the clinician for consultation at any time. Involve the parents in a review of their goals and accomplishments of the intervention with emphasis on the positive, also what was not accomplished and address any concern that arose during the intervention
7 or more	Parents (and children)	Reinforcing the tenets of the intervention	Encourage the family to use the tenets of the intervention, review and reinforce the psychoeducational material needed, assess the family's functioning since last meeting, inquire whether and how participation in the intervention has helped the family, address questions and concerns, planning the future

Leading principles and methods for the clinicians in The Family Talk Intervention were

1. Affective disorder is an interactive disorder.
2. The importance of communication and understanding in the family consist of building family narrative and validation of everyone's experiences.
3. Giving psychoeducation where professional knowledge is linked to family experience.
4. Respect of parents is important.
5. Keeping focus on prevention and promotion where a working alliance stress is on clinician and family.
6. Focus on the future by keeping discussion on resilience, strengths and hope.

(Beardslee 2003; Beardslee et al. 1993; Focht & Beardslee 1996)

3.2.2 The Let's Talk about Children Discussion

The Let's Talk about Children Discussion is a short psychoeducational intervention with one or two parents, and it does not require time or training. The clinician only meets the parent with mental illness and the spouse, depending on the parents' will. The meeting could be held at the clinic or at

the parents' home.

The purpose of the LT was to provide a possibly minimal approach as a control for the FTI in the trial. A non-intervention group was unethical. Therefore, minimum intervention was developed. The manual for the LT includes the following guidelines and principles of the intervention. The LT took minimal resources, one or two discussions, at least 15 minutes and at most 45 minutes. After the short discussion about children the clinician can continue with other matters concerning the parent.

Important content of talking about children in the LT was to start discussing everyday matters like how the child was doing at home, at day care or at school. Also discussing about friends and hobbies may help the parent/s think about the child.

Leading principles and methods inform to the parents' in the Let's Talk about Children Discussion are

1. It would be good for the children to understand the point of a parent's problem and illness as told by the parent
2. Friendships and hobbies are important to the children
3. Adults outside the family are also important to the children
4. Parents can ask questions about their children also during other sessions later on

(Solantaus and Beardslee 1996)

3.2.3 Family Network Meeting and Vertti peer groups

An Effective Family Network Meeting developed by Väisänen and Niemelä (2005) in an adult psychiatric clinic was created to respond to connecting services as well as the family's own network. Families with parental mental illness may have many different needs from services such as day care, school or child psychiatry. In addition, there may be unemployment and housing problems in need of support from social services. The social network around the child might also be minimal and may need activation. All participants meet in the Network Meeting to provide their share of support to the family and to activate all participants needed. The Network Meeting can be organised and preventive interventions initiated after the family members are safe and their basic needs have

been taken care of. (Väisänen & Niemelä 2005)

In addition, one family tool is a preventive group method called “Vertti peer groups” for children and their parents which is organised by family organisations together with health and social services. This peer group programme and family intervention include the same methodic elements (Inkinen & Söderblom 2005).

3.2.4 Booklets

Giving information and brochures can help parents revert to many important issues. Available materials for the families were: self-help leaflets for parents “How can I Help My Children? A Guidebook to Parents with Mental Problems” (Solantaus & Ringbom, 2002) and the other was a depression guide which gave basic information about the illness.

4 AIM OF STUDY

4.1 Aim of study

The present study deals with successful implementation of child mental health measures in psychiatric services for adults. The aim of the study is to establish whether professionals having no or very little basic training in prevention or in clinical work with children can be trained and are able to carry out child-centered preventive methods with fidelity, and whether the methods are feasible to be practised in these services. The study informs about the methodological and pragmatic change in health services towards family-centered ways of working.

4.2 Specific Objectives

1. To evaluate the clinicians’ ability to carry out the methods according to the intervention manual.
2. To see if there are differences between professionals in ability to carry out the interventions.
3. To learn about the clinicians’ experiences concerning their skills to carry out the interventions and to evaluate the success of discussion on different topics in the session.
4. To evaluate the clinicians’ ability to build a trusting and confiding working relationship,

including family members and especially the children's role.

5. To evaluate the clinicians' ability to build a positive working relationship including family members' openness and motivation.
6. To help identify challenges for further training in the methods.
7. The Family Talk Intervention originates in the USA and the study provides information about its adaptation into the Finnish service system.

5 MATERIALS AND METHODS

5.1 Intervention training

Training the clinicians in FTI took two years including 17 days per year. The clinicians in FTI were trained by Research Professor Tytti Solantaus and supported by Professor William Beardslee using the manual of intervention. FTI training consisted of general education, training in methods and national and international collaboration and networking, as well as initiating and implementing work with parents and their families in health services. The FTI training included one full work day for each session type, supervision of cases and literature to explore. The contents of training days included aims and focus of the particular session, how to carry out the session and discussion on protective factors and pitfalls. Also ways of acting in case of concern for children were taught including immediate action and organizing a network meeting.

Clinicians shall master the principles underlying the intervention they will conduct and demonstrate proper use of relevant techniques. In their training for the intervention the clinicians conduct live practice sessions with families. The clinicians were also supervised individually or in pairs with the trainer and a group of colleagues participating in the training. Supervision could have relied on actual intervention material (i.e. videotapes of the family intervention session) and supervision was designed to address specific issues that may have hindered effective delivery of the intervention to families and, whenever appropriate, to revise procedures to maximize clinicians' competence through additional training.

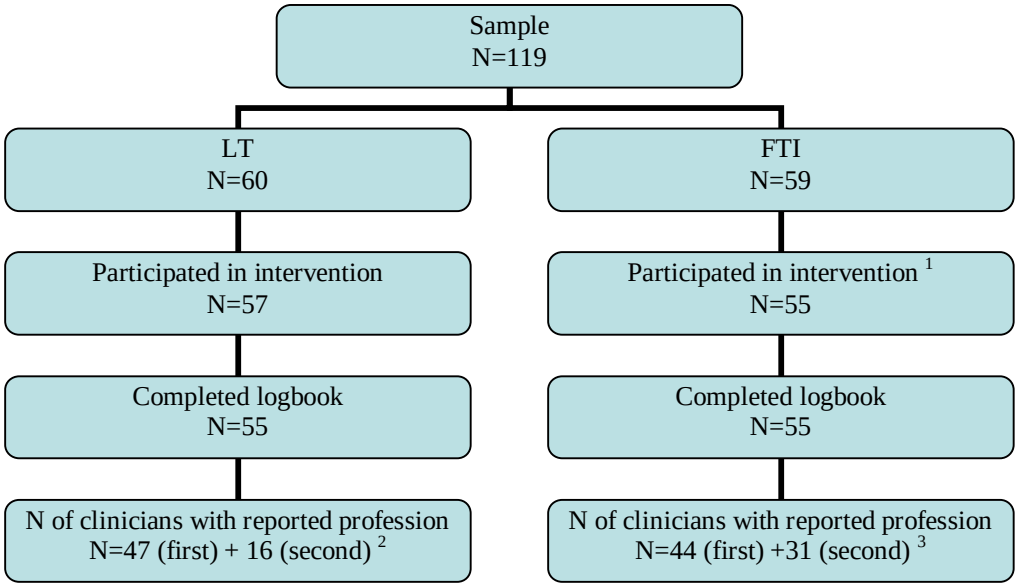
The control intervention did not attain such procedures. Training of the clinicians in the brief LT discussion took only three hours. The clinicians in LT were trained by a local clinician who had

participated in the national FTI clinician training programme. The LT training included the goals and contents of working, and instructions on how to carry out one or two sessions with the parents. A guide book for parents with mental problems authored by Solantaus and Ringbom (2002) was taught in both method trainings.

5.2 Sample and procedure

The study comprises of the clinicians (n=138) who carried out the FTI and the LT interventions in the trial. The clinicians carried out the interventions with their own patients if the patients were randomized into an intervention type the clinician was trained to do. Otherwise, a colleague trained in the particular intervention in question carried it out. The initial number of families was 119, while 110 participated in the interventions.

Figure 1 Flow chart of the sample



1) In two additional families the intervention was interrupted.
2) Total number of clinicians in the LT 63 (if evaluated using reported profession filled out by most of the clinicians).
3) Total number of clinicians in the FTI 75 (if evaluated using reported profession filled out by most of the clinicians).

The clinicians recruited the patients and the families. Patients with any of the various ICD-10 categories of mood disorder as their primary diagnosis according to their medical records were invited to join the study if they had at least one child aged between eight and sixteen not in treatment for mental disorder. Exclusion criteria included ongoing family therapy, life-threatening disease of the parent or the child, need for child protection and ongoing custody dispute. Comorbidity with both psychiatric and medical illness was allowed, excluding schizophrenia. Dual

and single parent families were invited to participate.

The clinicians provided verbal and written information about the study and the rights of all family members to refuse and/or withdraw participation at any point in the study. Parents and children over 15 signed informed consent forms, which was according to Finnish regulations. The parents were instructed to also inform the younger children of their rights to refuse and/or withdraw from the study. The families were then randomized in STAKES into two intervention groups using computer-based block randomization with block sizes of six to eight. The result was given to the treating clinician by phone. The particular intervention was then scheduled for the family.

The intervention was approved by the Ethics Committee of the Helsinki and Uusimaa Hospital District.

5.4 Measures

The clinicians filled out a logbook of each intervention and sent it to the research team once the intervention was finished. The purpose of logbooks was 1. to help clinicians adhere to the intervention protocol, 2. to document intervention fidelity and 3. feasibility. The logbooks of all 110 interventions were retuned (55 of the FTI and 55 of the LT). The logbooks of both interventions are included in Appendices 1 and 2.

Fidelity. The logbooks of the FTI listed all intervention sessions. According to Beardslee (1984), the FTI is carried out with fidelity if the Family Session is included. However, I also wanted to see to what extent the clinicians adhered to the intervention manual in carrying out the intervention sessions. Therefore, the logbook also included the list of the specific themes identified for discussion in each intervention session in the intervention manual. The clinicians were expected to tick yes or no depending on whether they had covered that particular theme.

There were five themes including 12 items in the first Parent Session, six themes including 21 items in the second Parent Session, six themes including 15 items in the Child Sessions, four themes including seven items in the Planning Session, three themes including nine items in the Family

Session, and six themes including 16 items in the Follow-up Session.

Themes included in the method in the FTI intervention were elicited

1. introduction of the clinician and intervention, confidentiality, permission to contact treating person, goals for the intervention and whether any guidebooks given were processed in the first Parents Session
2. how did session 1 feel, how the family has been since session 1, summary of the structure and aims of the intervention, the meaning of clinician meeting with the children, parent's permission in children's meeting, and parent's fears concerning the children's meetings and psycho education on symptoms or causes for the parent's illness and children's protective factors were processed in the second Parents' Session
3. intervention aims and stages were explained, clarifying the importance of attending the intervention, confidentiality and children's expectations for the intervention were processed in the Child Session
4. what shall be discussed in the Family Session, and who shall bring up the subjects in the Family Session were processed in the Planning Session
5. both parents' and children's earlier agreed upon subjects to be discussed were processed in the Family Session
6. summary of worries and aims achieved or not achieved during the intervention, aims that were not achieved, matters requiring further clarification, strengthened family resources, and agreements on how to move on after the intervention were processed in the Follow-up Session

Themes included in the contents in the FTI intervention were elicited

1. medical history of the parent, what mental health problems have meant to patient and spouse, what have children seen or experienced, meaning of experiences to children, mapping parents' worries were processed in the first Parents' Session
2. spouse's experience of patient's illness, what has spouse's illness meant to everyone in the family, if both parents are patients, were experiences discussed, what issues have the children experienced in the spouse's opinion, what was the significance of experiences to

the children in spouse's opinion, child's strengths, worries about the child, child's success in school or day care, friendships and hobbies, parents' fears of discussing issues concerning parent's illness, as well as discussion about protective factors of the children were processed in the second Parents' Session

3. the children's functional level concerning protective factors (school and hobbies), has the child any trusted adult, functional level at home (relationship with parents and between siblings, housework), what has the child seen, felt and how has the child acted, child's understanding of parent's problems and how does parent's problem affect the child in his or her opinion, as well as what did the child want to talk about in the Family Session were processed in the Child Session
4. the children's experiences of meeting with the clinician, parents experiences of the clinician's meeting with the children, the clinician's observations of the child including protective factors and possible worries and questions were processed in the Planning Session
5. the parents were able to explain difficulties to the child, sharing of individual views was encouraged, everyone was given a chance to ask questions, different experiences were discussed, encouraged family members to conversation, and psychoeducative material about symptoms and treatment of the illness were given, coping by children and possible general information needed in the family were processed in the Family Session
6. the clinician's view on how the family has managed since the Family Session, each family member's experiences of the Family Session, parent's experiences of the intervention, consequences of the intervention, advantages and disadvantages of the intervention, the family was encouraged to conversation, clarify the need for continuous conversation about parental mental illness, and intervention as a beginning of a family process were processed in the Follow-up Session

Themes included in the method in the LT intervention were elicited: were the guidebooks, "What is up with our parents"? –booklet and "The Guidebook of Depression" given in the First Session. There was not any other theme included in the method of the intervention. The LT was carried out with fidelity if children were discussed in at least one session. There were no demands on the contents of the discussions.

Feasibility. Information of the clinician's relationship to the parent was inquired, the response alternatives being patient's doctor/nurse/therapist, some other member of the treating team or some other member from outside the treating team. The clinician's occupation was inquired in an open question. Furthermore, the time frame of the intervention was charted out, as well as family members and clinicians (one or two) who participated in the intervention and the setting for the sessions (office or at home).

The FTI being a much more elaborate and intensive intervention, here was a "How did it go? – question after every theme that was listed in the logbook. These questions describe quality as assessed by the clinician. The options were elicited: "How was the procedure of the intervention introduction carried out?", "How was the patient's own experience discussed?", "How were children's experiences in the patient's opinion discussed?", "How were parents' worries charted out?", and "How was the goal of the intervention set?" with five-point Likert scale options: excellent (5) /good (4) /satisfying (3) /sufficiently (2) /poorly (1). Because of the limited number of individuals reporting assessments other than excellent or sufficiently, a trichotomic variable for modelling purposes was computed as follows: well (3) /satisfyingly (2) /poorly (1).

To assess the nature of *working relationship* in both interventions, the clinicians answered the following question "How was the working relationship in the session?" with five-point Likert scale options very good (5) /good (4) /neutral (3) /quite bad (2) /bad (1). Because of the number of individuals reporting assessments other than quite bad and bad, a trichotomic variable was computed: very good (3) /good (2) /neutral (1).

To assess the clinician's ability to build a trusting relationship with the family members, the clinicians were requested to report their perceptions about family members' motivation and openness. *Motivation* was elicited: "How motivated was the mother/father/child in the session?" with five-point Likert scale options very motivated (5) /motivated (4) /quite motivated (3) /neutral (2) /not motivated at all (1). Because of the number of individuals reporting assessments other than motivated and not motivated at all, a trichotomic variable was computed: very motivated (3) /quite motivated (2) /neutral (1).

The clinicians' perception of family members' *openness* was elicited: "How open was the mother/father/child in the session?", again with five-point Likert scale options very open (5) /open (4) /quite open (3) /not open, not remote (2) /not open at all (1). Because of the numbers of individuals reporting assessments other than open and not open at all, a trichotomic variable was computed: very open (3) /quite open (2) /neutral (1).

Both logbooks invited the clinician to make an assessment on how well the discussions were carried out. In the LT logbook there was one question "Were you *satisfied* with how the discussion went?" with five-point Likert scale options very satisfied (5) / satisfied (4) /quite satisfied (3) /not satisfied, but not dissatisfied either (2) /dissatisfied (1). Because of the numbers of individuals reporting assessments other than satisfied and dissatisfied, a trichotomic variable was computed: very satisfied (3) /quite satisfied (2) /neutral (1). A question about satisfaction was only asked in the LT.

5.5 Statistical methods

The items concerning fidelity and feasibility in the logbooks were categorized. The items concerning fidelity were dichotomized into yes (the item was discussed during the session) and no (the item was not discussed during the session). The statistical analyses of the present study were conducted in three stages. First, the distributions of variables (for continuous variables means and standard deviations (SD), for dichotomous variables percentages) were studied. Regarding the fidelity of the interventions: means and medians of intervention time frame were calculated. To compare whether the working relationship/motivation/openness in parents' and children's sessions were dependent on the profession of the clinician, I compared mean scores using ANOVA or the Kruskall-Wallis test. If the outcome variable was not normally distributed, a non-parametric test was used. However, only mother's motivation and openness could be tested in the FTI because of the smaller number of fathers (n=27-36). In the third stage I calculated Pearson correlation coefficients to compare whether working relationship, motivation and openness between family members were similar. $P<0.01$ was considered statistically significant and $p<0.05$ statistically almost significant. Statistical analyses were performed using SPSS statistical software 13.0 or 17.0

6. RESULTS

6.1 Intervention fidelity

To ensure fidelity to the Family Talk Intervention and the Let's Talk about Children intervention, a detailed evaluation of the sessions was conducted. The fidelity evaluation focused on all sessions across 138 clinicians representing sessions from both the FTI and the LT interventions. Content and method fidelity of the interventions were examined.

According to the Family Talk Intervention logbooks, all interventions were carried out through the complete intervention protocol including the two meetings with the parents, the individual meetings with the children, the Planning Session, the Family Session and the Follow-up Session. There were also additional meetings in five families. In two families there was an additional Parent Session, two families additionally had a Parent Session and a Follow-up Session. With one family there was a Parent Session and a Planning Session.

The clinicians reported whether related items were discussed after every session in the FTI. Method and content related items of the intervention varied in every session. Table 5 presents items discussed and not discussed in the 1st Parent Session.

Table 5 Frequency (N, %) of the method and content related items (n=47-53) discussed in the 1st session of the FTI

SESSION 1	Items discussed	Items not discussed	
Method	**N**	**N**	**%**
Introduction of clinician	52	1	98 %
Introduction of intervention	53	0	100 %
Confidentiality	50	2	96 %
Permisson to contact treating person	48	5	91 %
Goals of intervention	46	5	90 %
Help children guide	46	5	90 %
Depression guide	38	9	81 %
	Content discussed	Content not discussed	
Content	**N**	**N**	
Medical history	53	0	100 %
Mental health problem's meaning to patient and spouse	50	2	96 %

What have children experienced	49	2	96 %
Meaning of experience to children	48	3	94 %
Parent's worries	47	5	90 %

In the *1st Parent Session* the method related items (n=7) were covered well in ≥ 90% of the cases. Themes concerning the content items were also covered very well with the exception that 10% of the clinicians did not discuss parents' worries. The depression guidebook, however, was given to the parents in 81% in the first meeting.

In the *2nd Parents' Session* nearly all method related items (n=8) were covered in over 90 % with the families. Results are shown in Table 6. Aims of the intervention were covered with 94% families. Parent's fears concerning children's meeting were covered however in 81% and giving psychoeducation concerning reasons for parent's illness were covered nearly the same in 80% of the families.

There was more variance between the different content related items. The item concerning spouse's opinion on what children have experienced was discussed with 83% of the families. Protective factors were covered in 82% of the families. Spouse's experience of patient's illness was covered in 80%. There were seven families where both parents were having depression. Experience of situation where both parents are patients was discussed in 50% of the families.

Table 6 Frequency (N, %) of the method and content related items (n= 10-54) discussed in the 2nd session of the FTI

SESSION 2	Items discussed	Items not discussed	
Method	**N**	**N**	**%**
How did session 1 feel	53	1	98 %
How has the family been since session 1	50	2	96 %
Aims of the intervention	44	3	94 %
Meaning of clinicians meeting children	49	4	92 %
Parent's permission for meeting children	50	3	94 %

What do parents wish to be discussed in children's meeting	50	4	93 %
Parent's fears concerning children's meetings	30	7	81 %
Psychoeducation: symptoms	48	4	92 %
Psychoeducation: reasons	41	10	80 %
Psychoeducation: protective factors	51	3	94 %

	Content discussed	Content not discussed	
Content	**N**	**N**	%
Spouse's expereince of patient's illness	35	9	80 %
What has spouse's illness meant	36	8	82 %
If both parents are patients, experience of that situation	10	10	50 %
What have children experienced in spouse's opinion	33	7	83 %
What is the meaning of experiences to children, spouse's opinion	32	8	80 %
Child's strenghts	50	4	93 %
Worries about child	53	1	98 %
Success in school/ day care	52	2	96 %
Child's friends, hobbies	51	2	96 %
Parents fears of discussing illness with children	48	5	91 %
Protective factors	42	9	82 %

In the *3rd Child Session* all method and content related items (n=15) were covered at least 94% as described in Table 7. In method related items discussion about confidentiality was covered 100% with the children. Similarly, the content related items were covered also very well. For example the children's functional level such as protective factors (school, friends and hobbies) were assessed in 98% with the children. Items covered at least 94% were relationship between siblings, how does the parent's problem affect the child and what does the child want to talk in the Family Session.

Table 7 Frequency (N, %) of the method and content related items (n= 46-53) discussed in 3rd session in the FTI

SESSION 3

	Items discussed	Items not discussed	
Method	**N**	**N**	**%**
Intervention's aims and stages	51	1	98 %
Importance if attending was explained	52	1	98 %
Confidentiality	53	0	100 %
Child's expectations	51	2	96 %

	Content discussed	Content not discussed	
Content	**N**	**N**	**%**
School	51	1	98 %
Hobbies	52	1	98 %
Does the child have trusted adult	52	1	98 %
Relationship with parents	51	2	96 %
Relationship between siblings	46	3	94 %
Housework	51	2	96 %
What has the child seen and experienced	51	1	98 %
How has child felt and acted	50	1	98 %
Child's understanding of parent's problems	51	2	96 %
How does parent's problem affect the child in his or her opinion	50	3	94 %
How does the child want to talk in the family session	50	3	94 %

In the 94% of the *4th Planning Session* with the parents covered what aims to discuss and who shall bring up the subjects in the Family Session. Contents of items (n=5) such as planning the Family Session were covered very well. The clinicians' observations of the child and child's worries and questions were covered with all families. The results of the Planning Session are shown in Table 8.

Table 8 Frequency (N, %) of the method and content related items (n= 51-52) discussed in the 4th session in the FTI

SESSION 4

	Items discussed	Items not discussed	
Method	**N**	**N**	
What to discuss in the Family Session	49	3	94 %
Who shall bring the subjects up in the Family Session	48	3	94 %
	Content discussed	**Content not discussed**	
Content	**N**	**N**	
Children's experiences of meeting the clinicians	51	1	98 %
Parent's experience of clinicians meeting with children	50	2	96 %
Clinician's observations of the child	52	0	100 %
Repeated protective factors	51	1	98 %
Brought up child's worries and questions	52	0	100 %

SESSION 5

	Items discussed	Items not discussed	
Method	**N**	**N**	
Parent's subjects	50	0	100 %
Child's subjects	46	1	98 %
Psychoeducation: Symptoms, treatment	49	3	94 %
Psychoeducation: children's coping	49	3	94 %
Psychoeducation: general information	50	1	98 %
	Content discussed	**Content not discussed**	
Content	**N**	**N**	
Sharing individual views was encouraged	50	1	98 %
Everyone was given a chance to ask questions	51	1	98 %
Different experiences	45	6	88 %
Encouraged family members to conversation	50	2	96 %

In the *5th Family Session* at least 94% of method related items (n=5) were covered. The parent's subjects to be discussed in the Family Session were covered with all families and children's subjects were covered with 46 families. Psychoeducation given during the Family Session was covered with most of the families. Nearly all content items were covered very well but discussed items about different experiences in the family were covered only in 88% of the families (n=45), as shown in Table 9.

Table 9 Frequency (N, %) of the method and content related items (n= 47-52) discussed in the 5th session in the FTI

SESSION 5	Items discussed	Items not discussed	
Method	**N**	**N**	
Parent's subjects	50	0	100 %
Child's subjects	46	1	98 %
Psychoeducation: Symptoms, treatment	49	3	94 %
Psychoeducation: children's coping	49	3	94 %
Psychoeducation: general information	50	1	98 %
	Content discussed	Content not discussed	
Content	**N**	**N**	
Sharing individual views was encouraged	50	1	98 %
Everyone was given a chance to ask questions	51	1	98 %
Different experiences	45	6	88 %
Encouraged family members to conversation	50	2	96 %

In the *6th Follow-up Session* the method related items (n=6) were covered also very well. Aims that were not achieved during the intervention were discussed ≥94%. The content related items (n=9) were covered with nearly all the families. How has the family been since Family Session, parent's experiences of the intervention as well as advantages and disadvantages were covered with all the families. Continuous conversation was covered in 92% of the families. Discussed method and content related items are shown in Table 10.

Table 10 Frequency (N, %) of the method and content related items (n= 47-52) discussed in the 6th session in the FTI

SESSION 6	Items discussed	Items not discussed	
Method	**N**	**N**	
Summary of worries	51	1	98 %
Summary of aims	52	0	100 %
Aims that were not achieved	48	3	94 %
Things that need more clarifying	48	2	96 %
Strenghtened family's resources	51	1	98 %
Agreed how to move on from here	48	1	98 %
	Content discussed	**Content not discussed**	
Content	**N**	**N**	
How has the family been since family session	51	0	100 %
Family member's experience of family session	50	1	98 %
Parent's experiences of intervention	50	0	100 %
Children's experiences of intervention	48	2	96 %
Consequences of intervention	50	0	100 %
Advantages and disadvantages of intervention	50	0	100 %
Family was encouraged to conversation	51	1	98 %
Need for continuous conversation	47	4	92 %
Intervention as a beginning of a process	49	2	96 %

The shorter *Let's Talk about Children Discussion* was carried out with fidelity as there was a discussion about children in all families. Discussion about children was delivered in all families. "How can I Help My Children? A Guidebook to Parents with Mental Problems" was given to 87% of the parents and a little fewer (81%) of the parents received the depression guidebook.

6.2 Feasibility of the Interventions

6.2.1 The clinicians' occupation in the patient intervention process

The clinicians' occupation in the two intervention groups is documented in Table 11. The clinicians comprise Medical Doctors (MD), Registered Nurses, an Occupational therapist (n=1) and Mental health nurses (n=2), Psychologists and Social workers. Most of the clinicians working with parents or families were Registered Nurses. As well, the additional clinician working with the families was mainly a Registered Nurse.

Table 11 Clinician's occupation in the two interventions

Occupation clinician 1	**LT**		**FTI**		**Occupation clinician 2**	**LT**		**FTI**	
	n	%	n	%		n	%	n	%
MD	4	9	5	11	MD	0	0	1	3
Registered Nurse	20	43	30	68	Registered Nurse	12	75	25	81
Mental Health Nurse or Occupational therapist	3	6	0	0	Mental Health Nurse or Occupational therapist	0	0	0	0
Psychologist	13	28	4	9	Psychologist	2	13	1	6
Social Worker	7	15	5	11	Social Worker	2	13	4	13
Total	47	100	44	100	Total	16	100	31	100

The clinicians' role for the patient in intervention process was documented. The options were patient's doctor, nurse, therapist or other member of the treating team and those outside the treating team. In every intervention there is at least one clinician. If there is some other clinician, he or she is called second clinician. The clinicians' roles in the two interventions are presented in Table 12.

Table 12 Clinicians' role for the patient in the two interventions

Relationship	**LT**		**FTI**		**Tot**	
Clinician 1	n	%	n	%	n	%
patient's doctor	1	2	2	4	3	3
patient's nurse	2	5	16	29	18	18
patient's therapist	3	7	14	25	17	17
other member of treating team	7	16	10	18	17	17
outside treating team	31	70	14	25	45	45
Total	44	100	56	100	100	100
Clinician 2						
patient's doctor	0	0	1	5	1	2
patient's nurse	0	0	2	11	2	4
patient's therapist	2	7	0	0	2	4
other member of treating team	3	11	5	26	8	17
outside treating team	22	81	11	58	33	72
Total	27	100	19	100	46	100

According to the logbooks, most of the clinicians carrying out the LT intervention were from outside the treating team. Instead, most of the first clinicians carrying out the FTI intervention were from the treating team, and a smaller amount of the second clinicians were from the treating team.

In the LT, 60% (n=40) of the clinicians worked alone, whereas 40% (n=23) of the clinicians worked in pairs. In 76% (n=42) of the families the parents were met only once. In the FTI in 67% (n=57) the clinicians worked alone and 33% (n=18) of the clinicians worked in pairs. All FTI and LT interventions were held in clinical settings.

6.2.2 Time frame of the intervention

The Family Talk Intervention consisted of 6 to 8 sessions in 55 families. The time interval from first to last session ranged from 35 days to 235 days (mean 89 days, Md = 76 days).

The LT took place in 1 to 2 sessions in 55 families. There was only one session with 42 families. The mean time interval ranged from 7 days to 71 days (mean 33 days, Md = 23 days) with those 13 families which had two sessions.

6.2.3 The clinicians' relationship in the patient intervention process

The clinicians assessed the working relationship as well as the family member's motivation and openness in the **FTI** which are shown in Table 13. All the professionals' reported the working relationship to be very good, but Social Workers reported the best. Similarly, mother's motivation was reported very well by all occupations. Because of the smaller number of fathers (n=27-36) in the FTI their motivation and openness has not been reported.

Table 13 Mean of the working relationship, motivation and openness in the FTI.

FTI	MD	RN	Psycho-logist	Social worker	Total	p
Working relationship n=45	1.3 (0.3)	1.7 (0.4)	2.3 (0.9)	1.4 (0.2)	1.7 (0.5)	0.004
Working relationship child n=43	2.0 (0)	2.1 (0.9)	2.3 (1)	1.6 (0.5)	2 (0.8)	0.655
Motivation mother n=44	1.3 (0.4)	1.4 (0.5)	1.4 (0.6)	1.1 (0.2)	1.4 (0.5)	0.578*
Motivation child n=45	2.1 (0.8)	2.2 (0.8)	2.4 (0.5)	1.5 (0.5)	2.1 (0.8)	0.205
Openness mother n=44	1.2 (0.4)	1.6 (0.5)	1.4 (0.5)	1.3 (0.4)	1.5 (0.5)	0.084*
Openness child n=45	2.1 (0.5)	2.4 (1)	2.9 (0.9)	2 (0.7)	2.3 (0.9)	0.474

MD= Medical Doctor, RN= Registered Nurse
* Kruskall-Wallis, otherwise Anova
Standard Deviation (SD)

The different professionals experienced satisfaction and working relationship, as well the family members' motivation and openness in the **LT** are shown in Table 14. Psychologist, Occupational therapist or Mental Health Nurses and Registered Nurses reported satisfaction and working relationship being good with the parents. The mother's motivation was reported very good with all the clinician's regardless of Occupational therapist or Mental Health Nurses. Either due to the very small class frequency p was not computed with fathers in the LT.

Table 14 Mean of the satisfaction, working relationship, motivation and openness in the LT

LT	MD	RN	Ot or mhn	Psycho-logist	Social worker	p
Satisfaction n=46	2.1 (0.2)	1.8 (0.6)	2 (0)	2.2 (0.4)	2.2 (0.8)	0.426
Working relationship n=45	2 (0)	1.7 (0.7)	1.3 (0.6)	2 (0.5)	2 (1.1)	0.466
Motivation mother n=45	2 (0.8)	1.6 (0.6)	2.3 (1.5)	2.2 (0.6)	1.8 (0.4)	0.169
Motivation father n=25	2.3 (0.5)	2.1 (0.8)	1 (0)	2.6 (0.7)	1.5 (0.7)	**
Openness mother n=44	2 (0.8)	1.8 (0.7)	2.3 (1.5)	1.9 (0.8)	2 (0.7)	0.913
Openness father n=24	2.4 (0.5)	2.5 (0.5)	1 (0)	2.6 (0.8)	1 (0)	**

** due to very small class frequency p was not computed (n=1-2 in 2/5 of the classes)
MD= Medical Doctor, RN= Registered Nurse, Ot= Occupational therapist, mhn= mental health nurse
Standard Deviation (SD)
ANOVA

6.2.4 Quality as assessed by the clinician

"How did it go" –questions describe the clinicians' experiences of the quality of their work in the FTI. Quality issues were reported by the clinician after every meeting. The experiences of the clinicians' ability to deal with the questions after every theme listed in the logbook are shown in following Figures 2 to 6. All in all, the clinicians assessed the quality of every session to be good, even if the items varied session by session.

Both *Parents' Sessions* (1st and 2nd) are reported together in Figure 2. All items were carried out and reported to be good in nearly 60%. The best experience concerned the introduction of the intervention (94%). Less good experiences were reported on spouse's views of children's experience (64%) and children's experiences in patient's opinion (59%). The poorest experiences were reported on setting the goals, experience of giving psychoeducation and mapping parent's worries.

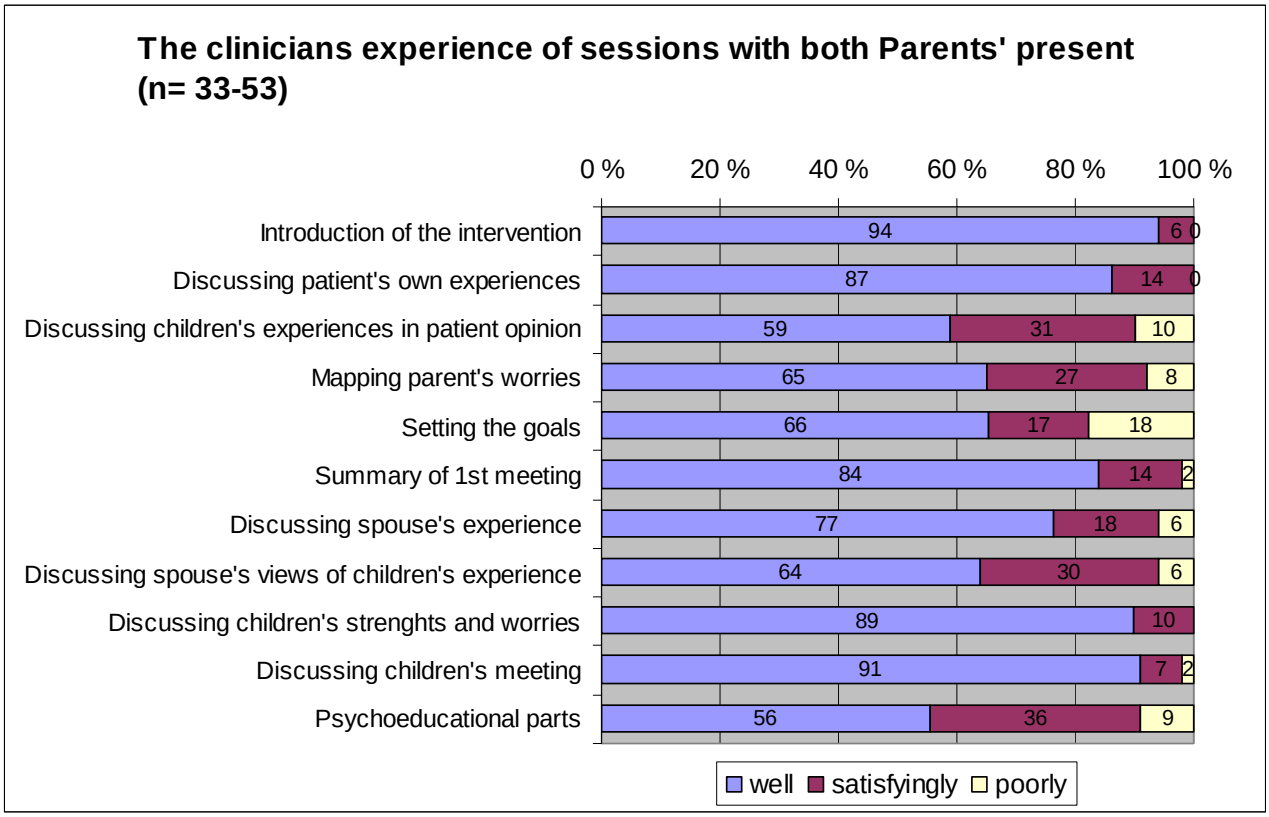


Figure 2 Parents' (1st and 2nd) Sessions in the FTI intervention

In the 3rd, the *Child's Session* (n=50) discussing leisure time (94%) and school (92%) were experienced best. Less well experienced was discussing the subjects of the family session. As well, the most poorly experienced also was discussing child's experience. Information about the experiences of the child's session is presented in Figure 3.

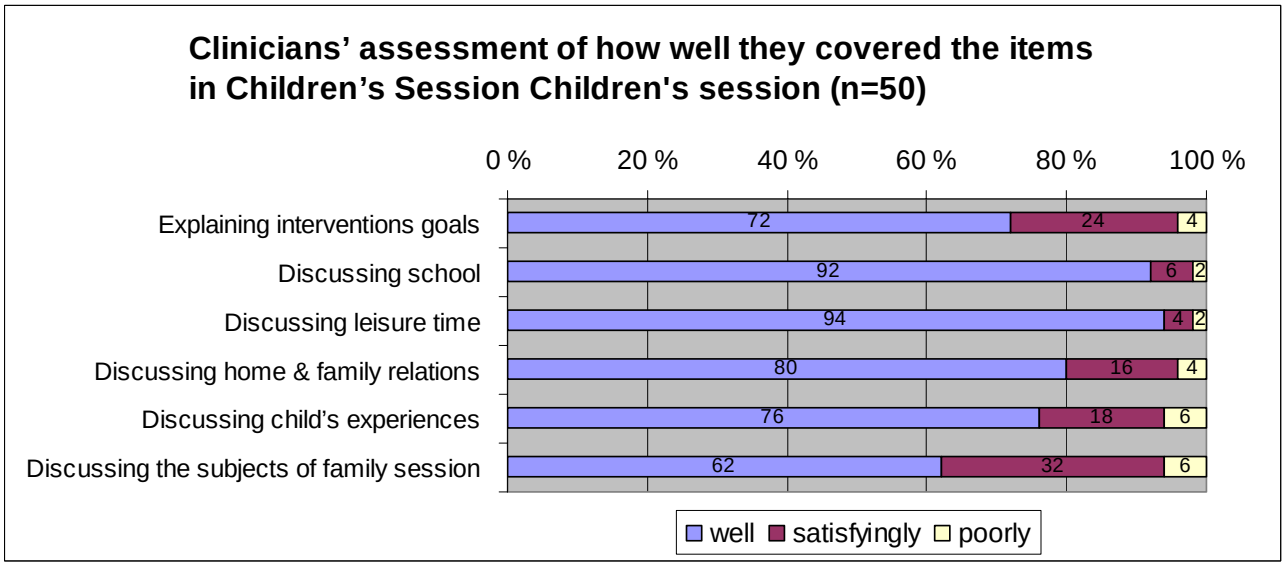


Figure 3 Children's (3rd) Session in the FTI intervention

In the 4th, *Planning Session* the most well experienced item was discussing a child's questions and worries (38%), and the most poorly experienced was discussion about planning the family session (21%). Information about the Planning the family Session is presented in Figure 4.

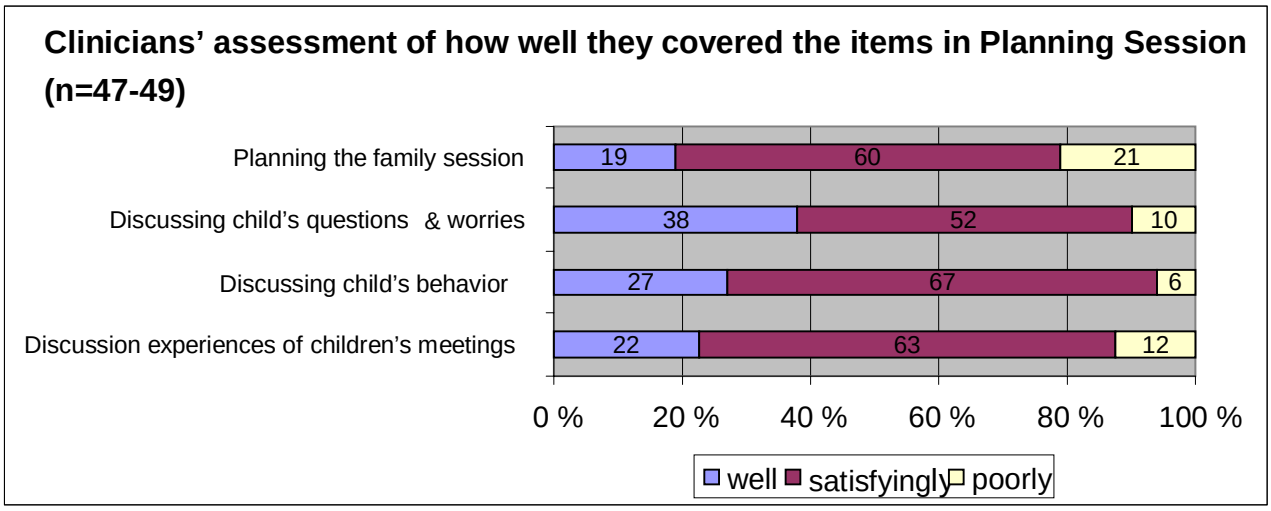


Figure 4 Planning (4th) Session in the FTI intervention

In the 5th *Family Session* most well experienced was discussing agreed upon subjects (28%) and nearly the same was assessed for sharing own experiences. The most poorly experienced was concerned psychoeducation (28%). Information about the Family Session is presented in Figure 5.

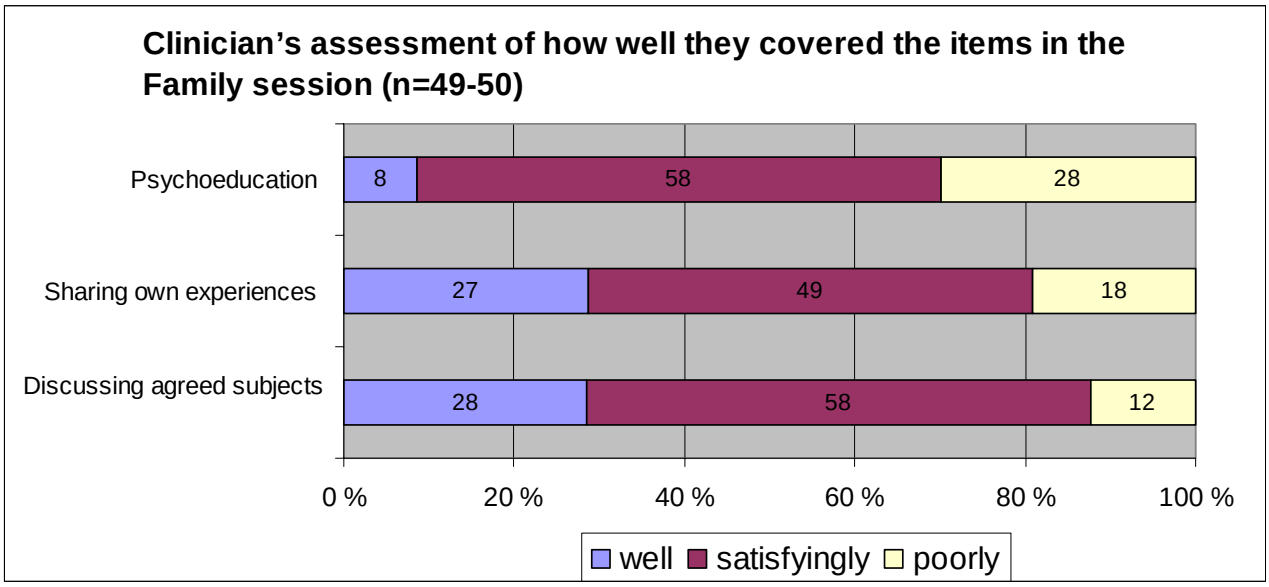


Figure 5 Family (5th) Session in the FTI intervention

In the last 6th *Follow-up Session* the best experienced was agreeing on how to move on after the intervention (39%) and the most poorly experienced was discussing experiences of the family session (15%). Information about the Follow-up Session with the parents is presented in Figure 6.

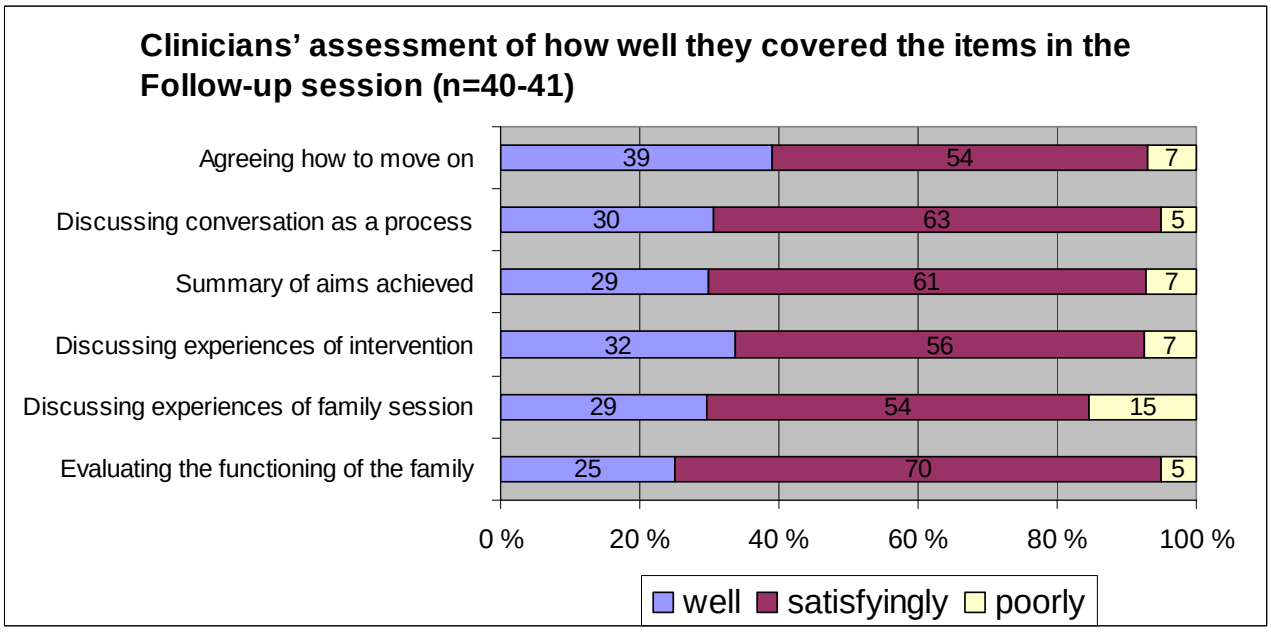


Figure 6 Follow-up (6th) Sessions

6.2.5 Working relationship, motivation and openness in the FTI

Next, the clinicians' ability to build a positive *working relationship* and to encourage family members' openness and motivation were reported. Figure 7 shows the clinicians` assessment of the working relationship in all six sessions. The clinician reported the working relationship good in at least 80% of all sessions with the family members. The less well reported ability to build the working relationship 29% (n=15) was in the Planning Session (4th) and most neutral was the Child's Session (3rd). No negative experience of the working relationship between the clinician and the family members was documented during the intervention.

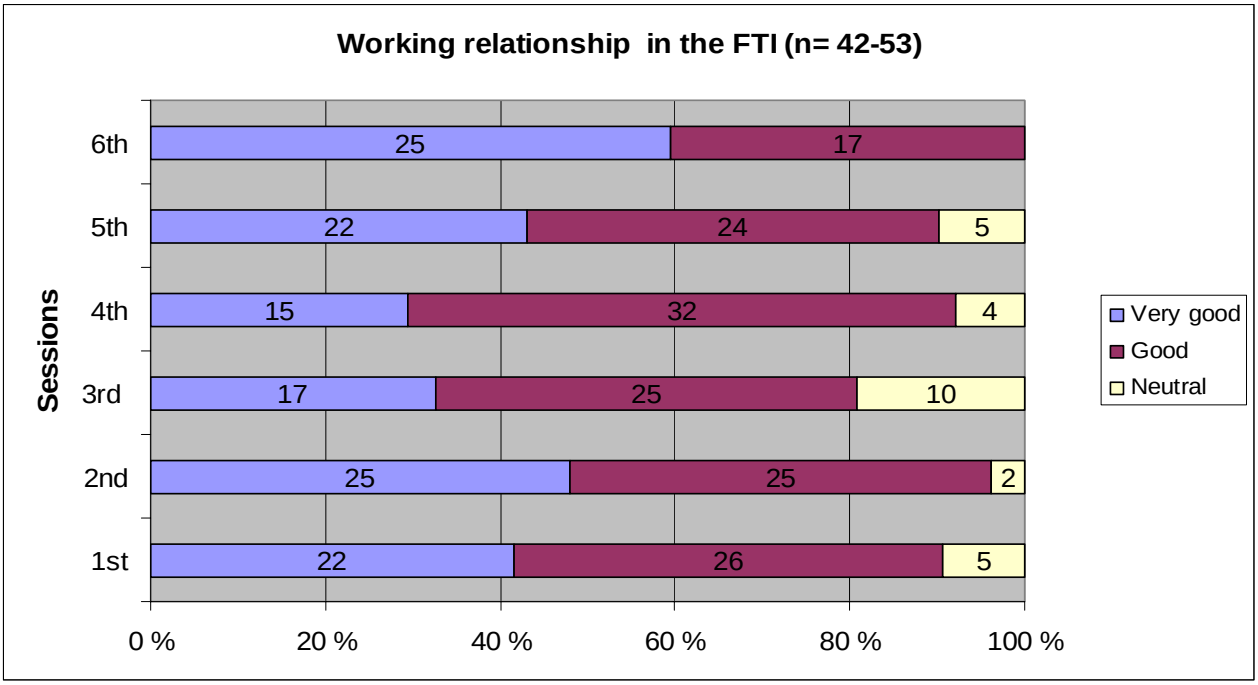


Figure 7 Level of working relationship in the FTI including all sessions

The clinicians' ability to encourage the mothers' *motivation* shown in Figure 8 was very good with 31%. Instead, the clinicians' ability to encourage fathers' motivation was very good in at least 16%. The child's motivation was encouraged at least in 14% in the Child's Session (3rd) and the Family Session (5th). Only single parents' motivation was reported neutral except in the Family Session (5th) where every family member's motivation was reported neutral.

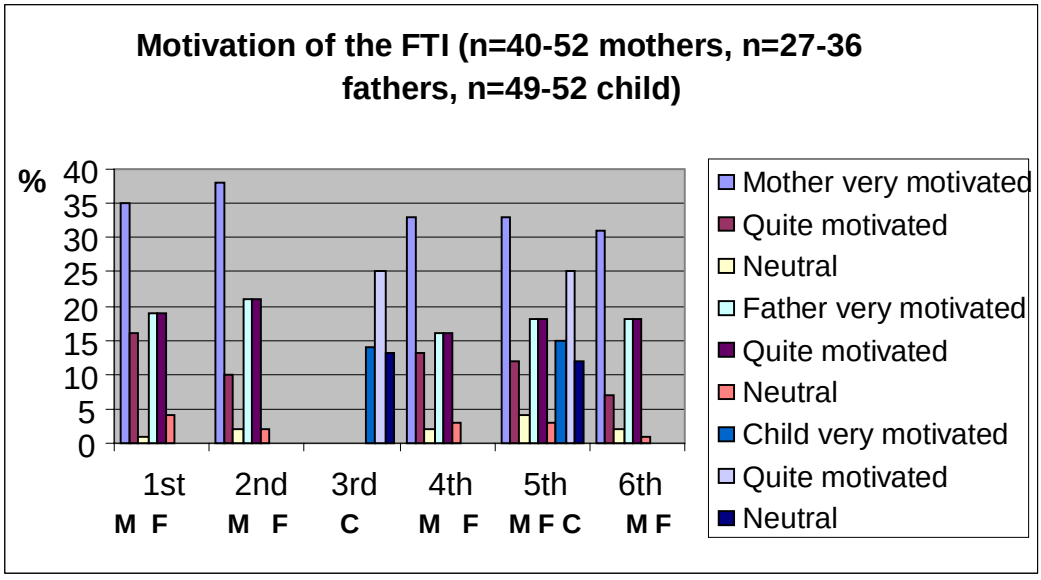


Figure 8 Level of motivation by sessions (1–6) in the

The clinicians' ability to encourage the mothers' *openness* shown in Figure 9 was very good (30%) nearly in all sessions. The fathers were reported very open in approximately 17% of the sessions. The child's openness was reported parallel in both the Child's Session and the Family Session (5th). Fathers were reported more often neutral than mothers.

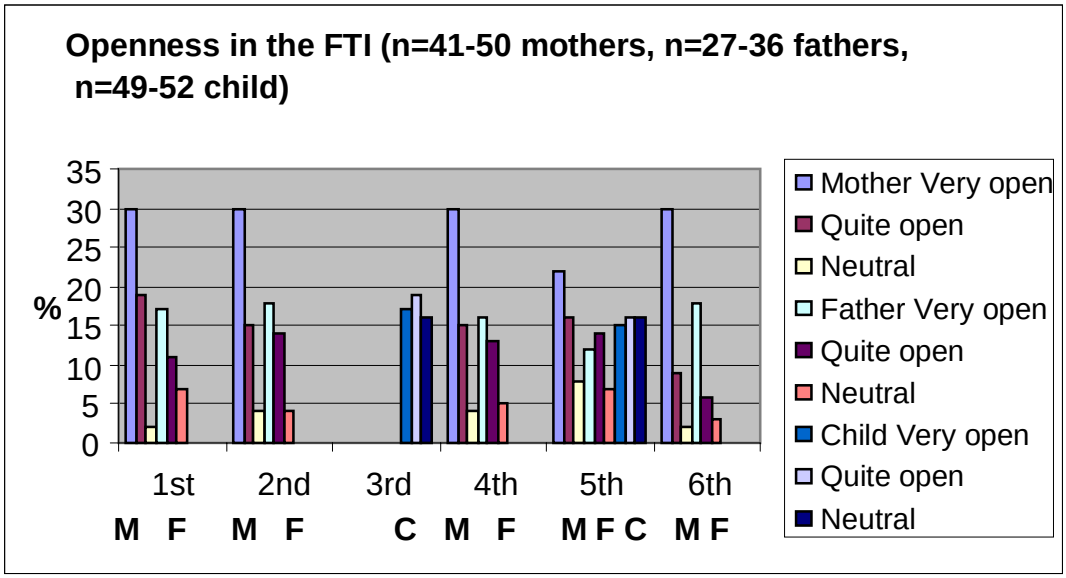


Figure 9 Level of openness by sessions (1−6) in the FTI

The mean of the sessions 1 to 6 of reported motivation and openness of the family members is shown in Table 15. The mean of the mothers' motivation was assessed very motivated, quite motivated or neutral (mean=34/12/12) and openness (mean=28/15/4) including all sessions. The mean of the fathers' motivation was assessed very motivated, quite motivated or neutral (mean=18/18/3) and openness (mean=16/12/5) including all sessions. The mean of the child's motivation was assessed very motivated, quite motivated or neutral (mean=15/25/13) and openness (mean=16/18/16) including all sessions.

Table 15 Motivation and openness of all family members in Sessions 1−6 in the FTI

Motivation		Mean of Sessions 1-6	n	Openness		Mean of Sessions 1-6	n
Very motivated	mother	34	31−38	Very open	mother	28	22−30
Quite motivated		12	16−21	Quite open		15	9−19
Neutral		2	14−15	Neutral		4	15−17
Very motivated	father	18	7−16	Very open	father	16	9−19
Quite motivated		18	16−21	Quite open		12	6−14
Neutral		3	25	Neutral		5	16−19
Very motivated	child	15	1−4	Very open	child	16	2−8
Quite motivated		25	1−4	Quite open		18	3−7
Neutral		13	12−13	Neutral		16	16

6.2.6 Satisfaction, working relationship, openness and motivation in the LT

In describing the results the reader shall pay attention to the different number of assessed participants. The smaller numbers dealt with the 2nd Session and the bigger number with the 1st Session.

Satisfaction in the LT

The satisfaction –question was assessed by the clinician after one to two sessions only in the LT. The clinicians reported how satisfied they were with the way they discussed the intervention items shown in Figure 10. The clinicians reported that parents were at least quite satisfied in over 60% of the cases. Both very satisfied and neutral were reported to be at similar level less than 20%. There were no negative experiences of the satisfaction between clinicians and parents in the 2nd session. In all, there was no difference between how satisfied the clinicians were with the way they discussed the items during the LT.

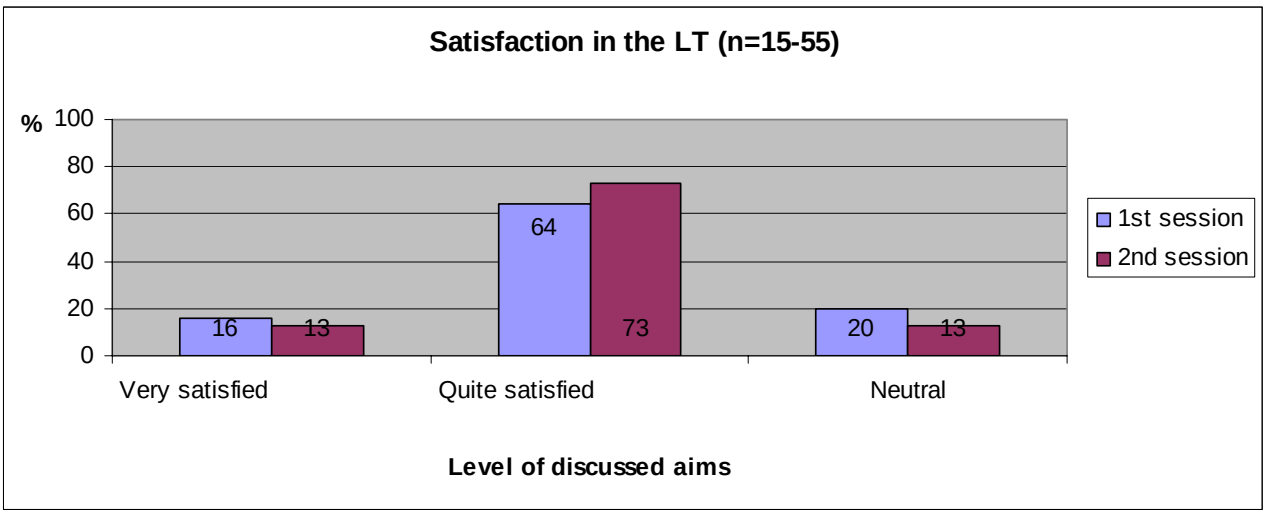


Figure 10 Clinicians' experience of parents' satisfaction in the LT in both sessions 1 and 2

Working relationship in the LT

The clinicians' ability to build a positive working relationship with the parents in the LT is shown in Figure 11. The clinicians reported what kind of a working relationship they had with the way they discussed the intervention items. The clinicians reported parents' working relationship being more often very good (33%) in the first session than in the second session (14%). Instead, good working relationship was reported more often (86%) in the second session than in the first session

(54%). There was no negative experience of the working relationship between clinicians and parents in the 2nd session.

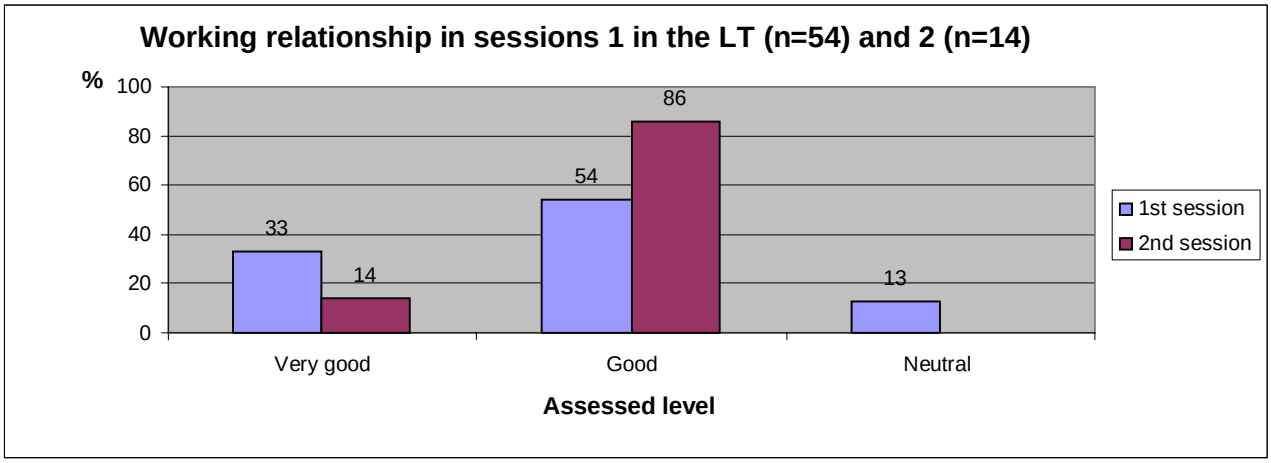


Figure 11 Level of working relationship in the LT in sessions 1 and 2

Motivation in the LT

The clinicians evaluated their ability to encourage family members' motivation. The level of motivation is shown in Figure 12. The clinicians were asked to report the motivation of the parents. The clinicians' ability to encourage the mothers to be very motivated succeeds in at least 30% of both sessions. Instead, the fathers' motivation level was reported better in the first session. No mother or father was reported to be not motivated at all during the intervention.

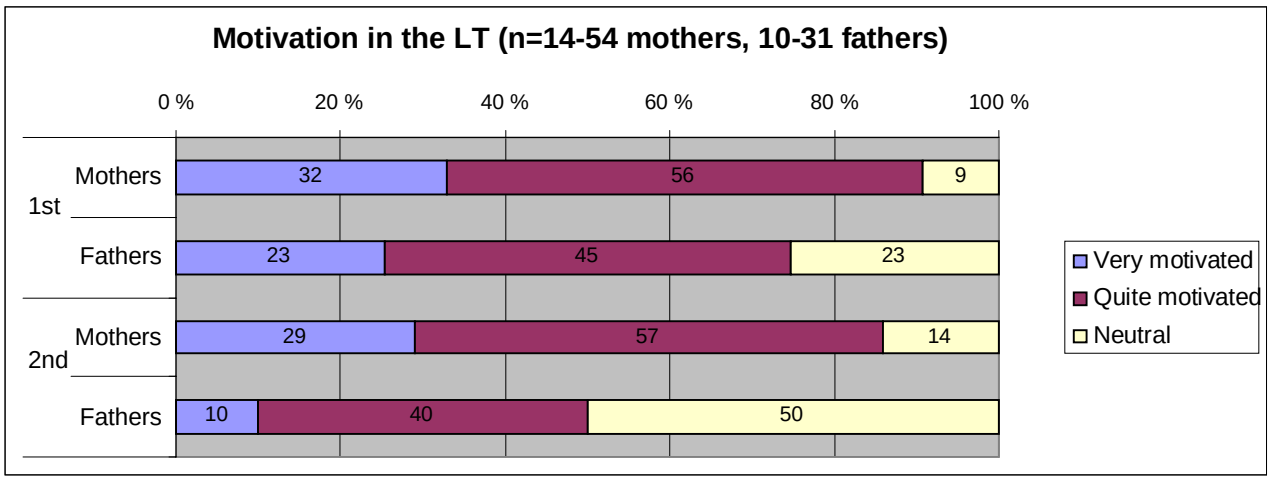


Figure 12 Level of motivation in the LT in sessions 1 and 2

Openness in the LT

The clinicians evaluated their ability to encourage family members' openness. The level of openness in shown in Figure 13. The clinicians were asked to report the openness of the parents. Mothers were slightly better reported to be very open than fathers who were in nearly 50% of the interventions reported neutral. No mothers or fathers were reported to be not open at all.

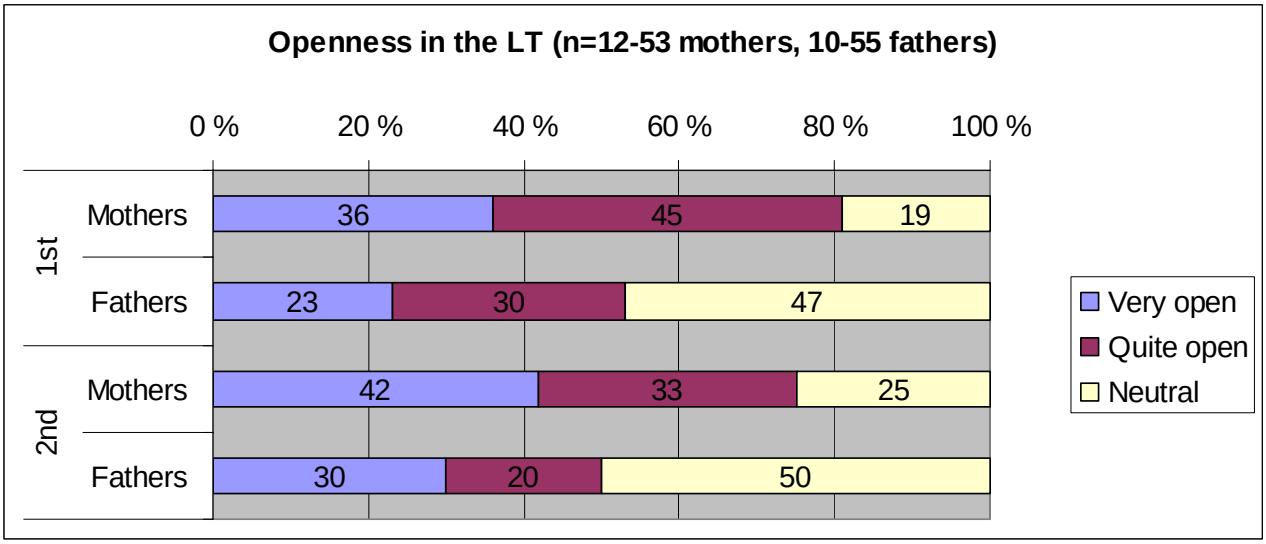


Figure 13 Level of openness in the LT in sessions 1 and 2

6.2.7 Factors influencing the working relationship, motivation and openness in FTI

The clinicians' ability to build a trusting and confident working relationship with family members was reported only in the FTI because there were no children's sessions in the LT. The clinicians were asked to report how the family members appear in relation to each other. The clinicians' responses to the questions concerning working relationship in the Parents' Session was assessed in relation to working relationship, motivation and openness in the Child's own Sessions (3rd). As is shown in Table 16, the p-value did reach to become statistically significant in parents' working relationship ($p<0.39$) in the Family Session and ($p<0.50$) in the Follow-up Session and there was a trend between parents' working relationship and children's working relationship in their session. Motivation in child's session also reached to become statistically significant in working relationship ($p<0.47$) to the Follow-up Session and there was a trend in the Family Session ($p<0.34$). Openness in Child's Session reached statistically significant in working relationship ($p<0.43$) to the Follow-up Session.

Table 16 Clinicians' responses to the questions concerning working relationship in Parents' Session to the working relationship, motivation and openness in 3rd, Child's own Sessions (n=50-52).

	Session 1 Parents' WR	Session 2 Parents' WR	Session 4 Parents' WR	Session 5 Parents' WR	Session 6 Parents' WR
Childs's working relationship	**0.31***	0.19	0.26	**0.39****	**0.50****
Child's motivation	0.21	0.07	0.18	**0.34***	**0.47***
Child's openness	0.23	0.12	0.25	0.25	**0.43****

Correlation sig. (2-tailed) *p<0.05, **p<0.01
WR means working relationship

The significance of parental working relationship the parents are involved in to the motivation and openness of the child in the Family Session (5th) was compared with in all sessions (Table 17). The motivation and openness of the child was reflected better to the parents' working relationship in the 5th Family Session as well in the 6th Follow-up Session. The working relationships in the 1st and 2nd Parent's Sessions were not related to the child's motivation and openness in the Family Session, but the motivation and openness of the child have an effect on the next sessions' working relationship with the parents.

Table 17 Clinicians' responses to the questions concerning working relationship in Parents' Session to the child's motivation and openness in the Family Session (n=50-52).

	Session 1 Parents' WR	Session 2 Parents' WR	Session 4 Parents' WR	Session 5 Parents' WR	Session 6 Parents' WR
Child's motivation	0.24	0.16	**0.45****	**0.67***	**0.42****
Child's openness	0.24	0.17	**0.45****	**0.43****	**0.45****

Correlation sig. (2-tailed) **p<0.01
WR means working relationship

Factors influencing motivation

The significance of the parent's motivation involved in to the motivation and openness of the child in the Family Session (5th) was compared with in all sessions (Table 18). The motivation and openness of the child was reflected better to the mother's motivation in the 1st Parents' Session, in the 4th Planning Session, in the 5th Family Session as well in the 6th Follow-up Session. The father's motivation was not related to the child's motivation and openness at all. The openness of the child in the Family Session was not related at all to the motivation with the parents during the intervention.

Table 18 Clinicians' responses to the questions concerning motivation in parents' own meetings (1-2), the Planning Session (4) and the Family Session (5) to the motivation and openness with the child in the Family Session (n=50-52).

		Session 1 Parents' motivation	Session 2 Parents' motivation	Session 4 Parents' motivation	Session 5 Parents' motivation	Session 6 Parents' motivation
Child's motivation	Mother	**0.26***	0.13	**0.3***	**0.33***	**0.39***
	Father	0.28	0.37	0.12	0.29	0.12
Child's openness	Mother	0.24	-0.17	0.14	0.06	0.25
	Father	0.32	0.32	0.09	0.18	0.22

Correlation sig. (2-tailed) *p<0.05

6.2.8 Factors influencing openness

The significance of parents' openness involved in to the motivation and openness of the child in the Family Session (5th) was compared with in all sessions (Table 19). The motivation of the child was reflected better to the both parents' motivation in the 1st Parents' Session when the openness of the child reflected better to the 1st father's Session. The other sessions concerning parents' openness varied. In the 2nd Parents' Session the motivation and openness of the child was reflected better to the father's openness, as well in the 5th Family Session. The mother's openness was not related to the child's openness at all during the intervention. The openness of the mother and father has an effect on the Child's Session and the Family Session.

Table 19 Clinicians' responses to the questions concerning openness in parents' own meetings (1-2), the Planning Session (4) and the Family Session (5) in relation to child's motivation and openness in the Family Session (n=50-52).

		Session 1 Parents' openness	Session 2 Parents' openness	Session 4 Parents' openness	Session 5 Parents' openness	Session 6 Parents' openness
Child's motivation	Mother	**0.34***	0.20	**0.33***	0.29	**0.37***
	Father	**0.37***	**0.35***	0.17	**0.44***	0.15
Child's openness	Mother	0.27	0.10	0.20	0.15	0.25
	Father	**0.37***	**0.36***	0.26	**0.37***	0.39

Correlation sig. (2-tailed) *p<0.05

7. DISCUSSION

7.1 Intervention fidelity

Recommendations have been given for developing a consistent methodology for measuring and analyzing fidelity of implementation (Dusenbury et al. 2003). The first step is identification of the critical elements of an effective programme (McGrew et al. 1994).

In the present study, two different interventions were delivered and their critical elements and usefulness was assessed by the clinicians. All completed logbooks (n=100) included in the study were returned. We studied how well the central elements were covered in clinical work as reported by the clinicians. The central elements of the FTI intervention are summarized in the manual, whereas in the LT minimal objectives are given for the clinicians. Therefore the fidelity of the LT could be assessed only by reporting whether the clinicians had discussed about children with the parents during the intervention and because there was a discussion about children in all meetings with families, the LT intervention was deemed to be delivered with fidelity. There is no content specification in the intervention manual of LT, so the clinicians can choose the topics they discuss with the parents.

In the present study the fidelity of the FTI were evaluated from four different perspectives: 1) fidelity to the methods in general, 2) completeness of implementation (by assessing how well the clinicians adhered to the study protocol) 3) clinicians' commitment, and 4) intervention differentiation (by assessing whether critical elements distinguishing the intervention were discussed or not discussed). After every session the clinician reported the elements they had covered during the session and how well it had gone. They also estimated the fidelity of discussed items. In practice, the assessment of the fidelity of the FTI consisted of evaluating how well the clinicians adhered to the study protocol. Assessment of both methods and contents of the intervention in the FTI was appropriately carried out by the clinicians. The study results show that checking fidelity varies between different items. Despite the variation in some individual items, some other items were covered total 100% in some of the sessions, and more than 90 % of the items were discussed in all sessions. This suggests that generally the fidelity of the logbook was good.

Giving information to the families is important (Solantaus 2005; Solantaus & Beardslee 1996.) The flexibility of the intervention provided families with increased information through psychoeducation about a range of issues that might concern them. Most of the clinicians gave Help children guide books to the families (90% in the FTI and 87% in LT) and depression guide (81% in the FTI and the LT). Thus, information was given during the interventions; at least 94% by the clinicians who were used to work with adults only, seemed to relate positively to working with children.

Discussions on the protective factors (like child's school, friends, and hobbies) are important themes in psychoeducation. Protective factors were covered in 82% of the families, whereas with nine families they were not discussed at all. However, worries about the child were discussed nearly with all the parents. Overall, the results suggest that talking about the confidentiality with the child, the clinician's observation of the child or bringing up child's worries are easier issues to be discussed than the issues regarding spouse's experiences.

Spouse's experience seemed to be somehow a challenging theme for the clinician's. These themes were discussed in the 2nd Parents Session being how to discuss spouse's experience of patient's illness, what has spouse's illness meant, what have the children experienced in spouse's opinion and what is the meaning of experiences to children in spouse's opinion. In spite of over 80% assessment it seemed more challenging to take into account to discuss about these themes.

Talking about mental illness to the children is not easy for parents, especially if both parents are patients (e.g. Beardslee et al. 2003). The clinician's assignment is to help the parents open up discussion about difficult issues (D'Angelo 2009) and they need to be willing to do it (Pihkala & Johansson 2008). There were seven families where both parents were patients, and the issues regarding both parents being patients seemed to be difficult to take in consideration: experiences of that situation were discussed in only half of the families. This may indicate that it is more difficult to take into account both of the parents when they both are depressed. Moreover and rather surprisingly, the response frequency in the item was larger than the number of families with both parents being depressed. It might mean that there were families where both parents were patients but had other illnesses than depression.

The necessary elements for promoting intervention fidelity include training and supervision on using the manuals or logbook. However, use of manuals does not necessary guarantee competent implementation of the method (Forgatch et al. 2005). In the present study assessment of the fidelity has been described by assessing the content's of the interventions as well as the method's. Effective implementation of intervention means delivering an intervention in a manner closely corresponding to the conceptual model and encouraging the clinician's competence.

In the present study the adherence to study protocol varied over time. In future, it is important to increase clinicians' awareness of the importance of protocol adherence. In addition, giving them practical feedback to sustain their strengths and addressing areas in which improvements are needed may helpful in improving the intervention fidelity. These viewpoints are important to acknowledge in future forthcoming research projects and in practical training in adult psychiatric services.

7.2 Feasibility of the intervention

The feasibility of the intervention will be improved if the clinicians understand the theory of the family-based and child-focused interventions. The clinicians' engagement and behavioural change and when they carefully carry out the intervention ascertain programme feasibility (Olds et al. 2005).

The clinicians' relationship and profession in the patient treatment process

The specific objectives describing the feasibility of the present study were designed to establish if there are differences between professionals in their ability to carry out the interventions, to learn about the clinicians' experiences concerning their skills to carry out the interventions and to evaluate the success of discussion on different topics in the session.

Most of the clinicians' delivering the two interventions were Registered Nurses. Psychologists and Social workers were the next general professions delivering the interventions. This structure of professions reflects typical staff structure in the Finnish adult psychiatric services where the professions other than Registered Nurses are singular.

In the LT, the majority (70%/80%) of the clinicians were not part of the treating team. This may suggest that there is no need to have a treating relationship when carrying out the intervention.

Moreover, it seems to be possible to make the intervention part of the treatment process in the psychiatric unit. Nonetheless, these methods appear to be easily achieved and delivered for all treating personnel for those who are interested in preventive working methods.

In the LT, most of the clinicians conducted the intervention alone (60%) and most of the parents were met only once (76%). Only 13 of 44 families were met twice. The LT is planned to require minimal resources, as it includes only one or two discussions. In that perspective, it seems that this minimal intervention can be delivered with one clinician, and only one meeting seems to be enough for the families. All of the LT interventions were held in clinical settings and thus the significance of the location cannot be taken into consideration.

In the FTI, 75% of the interventions were carried out by clinicians from the treating team. This suggests that the intervention can be applied during the patient's treatment. The clinicians who are treating the patient can combine family prevention to treatment of the patient which was also included in the original model in the USA (e.g. Beardslee 1993). Most of the clinicians (67%) conducted the intervention alone, and only 18 of 56 of the clinicians were reported to work in pairs. Therefore the intervention seems to be feasible in adult psychiatric services regardless of the lack of resources and limited time to spend with the patient.

There were five families with whom additional sessions were delivered during the FTI intervention. This may suggest that the clinicians were flexible and that they were able to follow the working rhythm of the families by adjusting the intervention according to the family's needs. All FTI interventions were carried out in clinical settings.

Time frame of intervention

The time frame of the interventions was not set exactly. In the present study, the time frame of the interventions varied largely across families, ranging from 35 to 235 days in the FTI. When training the FTI, the sessions are usually set to be delivered once a week. The minimum expected time to run the FTI was 42-49 days without the Follow-up Session. Two families interrupted the FTI. In the future it would be important to evaluate whether the interruptions reflected for example different needs of the families or the clinician's need to change the working approach with the family.

The time frame varied also in the LT ranging from 7 to 71 days if there were two sessions. The minimum expected time to run the LT was 15 minutes. A longer time frame was reported in more than one session.

The variability in the number of sessions was possibly due to the clinicians' efforts to be flexible for the families. Another reason for the varying time frames can be the special point of holidays for example Christmas time. The third reason may have been the holidays spent by the clinicians. In any case, each family is an individual entity, and the working process may vary.

I believe that the clinicians must adapt timing and approach to match intervention characteristics and not only agree that the components should be true to the theory and goals like Dumas et al. (2001) defined. In both interventions, as in all programmes operating through strong working alliances, the clinicians must spend time being sociable and responsive to family issues, especially when issues are pressing or recurring.

The clinicians' relationship in the patient's intervention process

The different professionals' experiences on the working relationship and the family member's motivation and openness were studied in the FTI intervention. Almost all professions reported having very good relationships with the families, but the Social workers reported the highest scores on working relationships. The Medical Doctors and the Registered Nurses also reported very good working relationships while the Psychologist mostly reported good working relationships. This suggests that the clinician-patient relationships were generally good.

Mother's motivation and openness were assessed very good by all the clinicians. Experiences about the fathers' motivation and openness were difficult to report because the small number of fathers. The father's role in families with mentally ill parent is an important issue (Kane & Garber 2005). More studies are needed to help and open up issued concerning father's role in the families.

Similar results were also reported in the LT. Satisfaction and working relationship and parents' motivation and openness was experienced to be good by Psychologist, Occupational therapist or Mental Health Nurses and Registered Nurses. Both parents' motivation and openness were usually reported to be very good, but mother's motivation and openness tended to be a little better

according to all clinicians regardless of occupation. There were no differences between the occupations, meaning that the basic education seems to be adequate for having and using family interventions also in the context of adult psychiatry.

It was interesting to observe that even though each profession reported good working relationship, motivation and openness with mothers and children, the Social worker reported the best rates in all areas. This may suggest that they are more experienced in working with a child or that their education provide more skills to work with the children.

The present study strengthens the results of earlier studies on how the clinicians are more used to work with the adults and meeting the child is a rather new way of working in adult psychiatric services (e.g. Korhonen et al. 2008; Solantaus and Toikka 2006; Solantaus et al. 2009). These interventions have proven to be feasible for a variety of professionals to deliver an intervention in adult psychiatric services.

Quality as assessed by the clinician in the FTI

"How did it go" –questions describe the feasibility of the intervention and the clinician's experiences of the quality of their work in how clinicians were able to deal with the questions after every theme listed in the logbook.

Introduction of the intervention or discussing leisure time and school with the children were the best covered items. It seem to be more challenging to discuss children's experiences according to a patient's opinion, spouse's views of children's experience and child's own experiences. This suggests that the difficulty to discuss the child's experiences need to be recognised and acknowledged when taking these interventions to the adult psychiatric context. The most poorly reported were setting the goals, experience of giving psychoeducation as well as challenges for charting out parent's worries. Clinical skills and being convincing are important working elements. This may suggests the need of education how to plan and deliver one's way to work with the families.

The present study suggests that items were carried out and covered carefully in the Parent's Sessions and the Children's Sessions in the FTI by the clinicians. However, most of the items were

covered satisfyingly (≥50%) in the Planning Session, the Family Session and the Follow-up Session where the items assessed well or poorly varied. All in all, every session was experienced to be very well even if the contents of the items varied in every session. None of the questions were reported excellent or sufficient. This means that the intervention training has been adequately good.

Olds et al. (2007) describe that feasibility of parenting programmes depends on how well parents' concerns and motivations are integrated into the programme design. A challenge of written manuals or logbooks is that instructions may be applied inflexibly and hinder rather than foster change in the clinician's working habits. This is particularly true of applied interventions if they are delivered in ways that ignore the family members' specific needs and preferences when the purpose is to ease their concerns.

This may suggests how difficult it is to focus on family members' position and to support parents to help their children. These results strengthen for example Beardslee et al. (1998) view how important it is for clinicians to recognize opportunities for using preventive methods in clinical practice.

Prevention is based on building resilience in families. This means striving in spite of adversity (Rutter 2000). On the professional level attitude change means acceptance of child focused work, new clinical skills, change in routine management of patients and cooperation with colleagues. The required changes are awareness and attitudes as well as the skills of the clinicians.

Working relationship, motivation and openness in the FTI and the LT

The clinicians were able to build a positive working relationship and openness and motivation with the family members. In the present study the working relationship, motivation and openness with the families were reported to be good.

The working relationship was reported in at least 80% of all sessions in both interventions. Understanding the experience of depression in a family has impact on building an active working relationship including motivation and openness (Beardslee et al. 1996). No negative experience of the working relationship between the clinician and parents was reported during both interventions.

The present study showed that the openness was reported otherwise very good but the 2nd Parents' Session in the FTI came a bit lower. Children were reported to be more neutral than the parents. Mothers were reported more open and motivated than fathers in both interventions. Fathers openness was assessed to be neutral or negative (48%) in the LT. Instead, no mother or father was reported to be not motivated or not open at all in both interventions.

The intervention delivery was good because most of the themes were covered in the sessions. This suggests that the clinicians mastered well both interventions. It is not possible to compare both interventions similarly because they are qualitatively different. All these factors of preventive interventions need to be assessed when working with parents with depression in adult psychiatric clinics (Solantaus 2005). This may suggest good commitment to the intervention for the parents and the clinician. A limitation to reporting is that the figures of the interventions varied for each session and, that being the case, the results cannot be fully comparable but they can be informative.

Factors influencing the working relationship, motivation and openness in the FTI

Factors influencing to the clinicians' ability to build a trusting and confident working relationship was assessed. In the present study the clinicians were asked to report how the family members are in relation with each other. The majority of the clinicians were able to build a trusting and confident working relationship with family members in the FTI. Children were not supposed to be met in the LT.

The clinicians' reported the working relationship in the Parents' Session (1st and 2nd) in relation to working relationship, motivation and openness in the Child's own Sessions (3rd). Good parental working relationship in the Family Session was linked with the working relationship and the Follow-up Session. The parents' working relationship and a child's working relationship were also correlated. Motivation in the Child's Session was also statistically significant in the Follow-up Session and there was a trend on motivation in the Family Session. This may suggest that meeting parents and preparing sessions are important for the forthcoming child's session. Moreover, the motivation and openness of the child can have an effect on the next sessions' working relationship with the parents. This may suggest that children have experienced easier to be relaxed and satisfied

at home which reflects upon the parents' forthcoming sessions and improves their working relationship.

The relationship between working relationships of the parents was involved in the motivation and openness with the child in the Family Session. The motivation and openness in the Child's Session were strongly related to the working relationship with the parents in the Planning, Family and Follow-up Sessions. This may suggest that parents are satisfied with the Planning Session support and strengthens the parents' working relationship in the Family Session and the Follow-up Session. It seems that the more open the child is the better the parents' working relationship is. The study may also show the significance of the clinician's ability to build a good working relationship.

The mother's motivation and the child's motivation were correlated in the Family Session. Instead the father's motivation was not correlated with the child's motivation or openness at al. This may suggests that the child reflect more the mother's different moods. Whereas, the parental openness during the intervention and the child's motivation and openness in the Family Session were correlated expect the child's openness and the mother's motivation. Instead the correlation was better between the father's openness and the child's motivation and openness in all but the 4th Planning Session and the 6th Follow-up Session. The openness of the child in the Family Session was not related to the openness with the mother during the intervention. This may suggests the importance of father's role in the family.

The father's openness was more important in relation to the child's openness while mother's openness was unrelated to it. This is consistent with the findings to Chang et al. (2007) study where father's positive involvement was important for the children. Although, their study did not report the effects of openness, the fathers were asked e.g. about talking and listening to the children and knowing where and what they are doing. Their results showed that the more fathers were compensating depressed mother's functioning, the more the children's risk of problem behaviour could be reduced.

The results show the relevance of meeting children. Also planning of all sessions with the parents emphasized the working relationship and children's motivation and openness. When parents were

motivated the children were also motivated in the Family Session. It seems the children reflect their parents' feelings and motivation. In the study results it can be observed how meaningful opening up issues and how helpful the discussion are for family members.

The present study showed that the clinicians' careful assessment provide parallel results. The two interventions evaluated in the present study increase open communication and understanding of parental illness in families, which are also important protective factors for child development (Beardslee & Podorefsky, 1988; Beardslee et al. 1993; Fraser et al. 2006). It can be difficult to combine child and parent care working methods or approaches to the health care systems because the clinicians are often trained to focus on either children or parents, but not on both.

It is important that interventions do not cause any harm to any family members. The study results showed positive experiences which was in line with the original results from the US study (Beardslee et al. 1993).

Magliano et al. (2006) have observed that it may be difficult to change longstanding working culture even when the clinicians have reported positive impacts in relationships between mentally ill and family members. Likewise, many studies have stated that opening up dialogue and support from professionals is essential when concrete help for finding words and formulations are needed in the families. In the present study results can be observed how meaningful is opening up issues, and how helpful the discussion can be for family members. The preventive interventions seemed to be feasible in adult psychiatric services thus they may result in significant reductions in the incidence of mental illnesses on children with a mentally ill parent. The present study showed that it is possible to evaluate the clinicians' ability to build a trusting and confiding working relationship, including family members' and especially children's role, and the clinicians' ability to build a positive working relationship including family members' openness and motivation although this require further research.

7.3 Ethical questions

The present study consists of the FTI compared in a randomized setting with the LT method. The LT was used as a control for the FTI because it would have been unethical not to offer families

some form of intervention. The LT was designed to be the minimum necessary to meet the legislative imperative and it was required to be the minimum "practice as usual".

According to the WHO (2005), implementation of a preventative intervention is ethically acceptable if the intervention can decrease risk and strengthen protective factors. In addition, there is an ethical reason to help patients (e.g. Ethical guidelines for nurses, 2001) and decreasing risk includes to all of the clinicians' education and professional skills. These interventions showed their usefulness' and can therefore be considered for use and implementation in adult psychiatric clinics.

The clinicians reported the new working methods to be sustained in the future. In the future sustainability and development of the work, continuous training and national networking are needed. Also by influencing managers and leaders to be committed (in new methods?) could lead to increased use of the preventive working. In addition, written guidelines and influencing managers and leaders would also solidify an ethically good background for preventive and promotive work in adult psychiatry.

8 LIMITATIONS OF THE STUDY

In interpreting the results of the present study, several limitations have to be borne in mind. Using manuals does not always guarantee competent application of a method. According to Forgatch et al. (2005) intervention delivery must be evaluated for fidelity the programme content and processes or otherwise one cannot explain whether the intervention can be repeated reliably. Failures in establishing fidelity can limit the conclusions that can be drawn from any outcome evaluation. When the interventions are not implemented as intended they are less likely to be effective. In the present study the clinicians might have been reluctant to use the logbooks for monitoring their adherence of intervention in clinical setting or some might have been worried not to deliver the intervention with fidelity and they may have had difficulties in focusing clearly on the family members with whom they were working.

A significant difference between the interventions was observed in the practical implementation of the study protocol. One common characteristic of a problematic trial was identified: the difference

of interventions. One should try to estimate the difficulty level of any intervention. If the interventions differ significantly, extra care should be taken to ensure that the intervention protocol is as simple and straightforward as possible. In the present study the LT protocol was simple and easy to use.

The sample of the study was quite small. More families participating in the trial would have increased the number of the logbooks and would thus have provided a more representative sample. The possibility of response bias on the clinicians' part should be considered, although this would apply equally for both interventions.

The interventions were carried out in natural settings in adult psychiatric clinics. The feasibility of the interventions was charted out as they were practised in clinical routine. That may have an effect on the procedure. One should be careful particularly when comparing the clinics with each other. Even thought the family intervention has been tested in several previous studies, and a logbook process in the present study, conceptual differences in carrying out interventions between the clinics are possible. Various characteristics of individual organizations may have had a powerful influence on whether or not programmes were adopted and the extent to which they would be implemented with fidelity.

One limitation was that the logbooks were not formulated for use such as research material concerning the clinicians' point of view at the beginning. The questions and items were planned to describe the fidelity process but they were limited and not planned to offer specific research material. It is the responsibility of research to demonstrate that the content and the process of the intervention is the same across participants throughout the study (Dumas et al. 2001).

Earlier study observed that it was challenging to integrate new interventions to the ongoing working methods (Solantaus & Toikka 2006). The present study did not formally evaluate the nature of the alliance between the clinician and the family members. The interaction with the clinician and the role of the family member, as well as the understanding and explanation of terms and concepts by clinicians from different backgrounds may differ and cause variation among participating clinicians.

More specific information about the experience of the clinicians' assessment may have been found by using qualitative methods e.g. interviews.

Failure to assess fidelity to the interventions means that one cannot be fully confident that the intervention and its described components lead to positive assessments by the clinicians. However, the intervention was manualized and had a clear structure, which reduces the likelihood of major variation from the intended intervention. The reader should assess the study with the foregoing (methodological) limitations.

My position as a researcher was that of an "insider", because I was familiar with the particular interventions and, in addition, had personal experience of conducting these interventions. This helped me to understand the assessment process but, on the other hand, it might have engaged me being openly evaluative. The study material was also in Finnish and translating it into English might have influenced the description of the results of the present study.

9 CONCLUSIONS

Clinicians in adult psychiatric services face significant challenges addressing mental health problems and other challenges. The present study gives some empirical evidence to show that two preventive interventions conducted with fidelity help the clinicians to also pay attention to children of mentally ill parents. It is also observed that the methods are feasible in the Finnish family and service culture. Successful adaptation of the FTI could be devised in a different country compared to the original in the USA.

It should be observed, however, that a focus on preventive interventions, as defined here, does not address all the factors contributing to the gap between science and practice. For example, the political climate surrounding psychiatric services of prevention policy, the feasibility of evidence-based preventive programmes, time to use, and the funding of services can greatly impact local clinicians' ability to implement preventive interventions. In the future parents with depression are likely to be present in settings other than mental health clinics while seeking services for their children, the interventions should be used by those who treat adults, children and families in a wide variety of settings.

Building preventive working methods for adult psychiatric services can be the means to improve the quality of prevention and achieve positive outcomes regarding preventive methods. Therefore, we need to better understand preventive methods and their relationships to preventive practices and work in psychiatric services. These results are encouraging and suggest that these methods are worth using in psychiatric services. Future studies should use larger number of families and clinicians specifically when measuring the quality of working relationship experienced by both the family members and the clinicians. Earlier experiences convince that the interventions provide important and necessary data about the safety, feasibility and fidelity for the later conduct of randomized clinical trials as well as dissemination efforts and key elements of high quality implementation (e.g. Beardlsee et al. 2007; D'Angelo et. al 2009; Solantaus et al. 2009). Because controlled research supports the effects of these two interventions, clinicians would have valuable new tools for helping families with mental disorder.

As a final consideration, I appreciate that the clinician is in part an advocate for the family. More attention to the role of advocacy in working with families with severe challenges or diseases is needed. Nonetheless, perhaps most important is that families find their ways to open up discussion about difficult issues and the adult psychiatric services have methods to be offered to the families.

REFERENCES

Beardslee, W., Wright, E, Gladstone, T. and Forbes, P. (2007). Long-term effects from a randomized trial of two public health preventive interventions for parental depression. Journal of Family Psychology, 21(4), 703–713.

Beardslee, W., Gladstone, T., Wright, E. and Cooper, A. (2003) A family-based approach to the prevention of depressive symptoms in children at risk: evidence of parental and child change. Pediatrics 112 (2), 119–31.

Beardslee, W. (1998). Prevention and clinical encounter. American Journal of Orthopsychiatry 68, 521–533.

Beardslee, W., Wright, E., Salt, P. (1997a). Examination of children's responses to two preventive intervention strategies over time. Journal of the American Academy of Child and Adolescent Psychiatry 36, 196–204.

Beardslee, W., Salt, P., Versage, E. (1997b). Sustained change in parent receiving preventive interventions for families with depression. The American Journal of Psychiatry 154(4), 510-515.

Beardslee, W., Wright E., Rothberg P., Salt P and Versage, E. (1996). Responses of families to two preventive intervention strategies: long-term differences in behavior and attitude change. Journal of American Academy in Child Adolescence Psychiatry 35, 774–782.

Beardslee, W. and MacMillan, H. (1993). Psychosocial preventive intervention for families with parental mood disorder: strategies for the clinician. Journal of Developmental Behavioral Pediatrics 14(4), 271–276.

Beardslee, W. and Podorefsky, D. (1988). Resilient adolescents whose parents have serious affective and other psychiatric disorders: The importance of self-understanding and relationships. American Journal of Psychiatry 149, 63–69.

Beidelm, D. and Turner, S. (1997). At risk for anxiety: I. Psychopathology in the offspring of anxious parents. Journal of the American Academy of Child & Adolescent Psychiatry 36, 918–924.

Biederman, J., Hirchfeld- Becker, D. Rosebaum, J., Herot, C., Friedman, D., Snidman, N., Kagan, J. and Faraone, S. (2001). Further evidence of association between behavioural inhibition and social anxiety in children. American Journal of Psychiatry 158, 1673–1679.

Biederman, J., Rosebaum, J., Bolduc, E., Faraone, S., Hirchfeld, D. (1991). A high risk study of young children of parents with panic disorder and agoraphobia with and without comorbid major depression. Psychiatry Research 37, 333–348.

Caspi, A, Sugden, K., Moffitt, T., Taylor, A., Craig, I., Harrigton, H, MaClay, J., Mill, J., Martin, J., Braithwaite, A, and Poulton, R. (2003). Influence of life stress on depression: moderation by the polymorphism in the 5-HTT gene. Science 301, 386–389.

Caspi, A., MaClay, J., Moffitt, T., Mill, J., Martin, J., Craig, I., Taylor, A. and Poulton, R. (2002). Role of genotype in the cycle of violence in maltreated children. Science 297, 851–854.

Catalano, R., Gainey, R., Fleming, C. Haggerty, K and Johnson, N. (1999). An experimental intervention with families of substance abusers: one-year follow-up of the focus on families' project. Addiction 94(2), 241–254.

Chang, J., Halpern, C. and Kaufman, J. (2007). Maternal depressive symptoms, father's involvement, and the trajectories of child problem behaviour in US national sample. Archives of Pediatrics & Adolescent Medicine 161(7), 697–703.

Clarke, G., Hornbrook, M., Lynch, F., Polen, M., Gale, J., Beardslee, W., O'Connor, E. and Steeley, J. (2002). A randomized trial of a group cognitive intervention for preventing depression in adolescent offspring of depressed parents. Archives of General Psychiatry 58(12), 1127–1134.

Clausson, E. and Berg, A. (2008). Family intervention sessions: one useful way to improve schoolchildren's mental health. Journal of Family Nursing. 14(3), 289–313.

Cross, D. and Grady, J. (2002). Group-based parent training for preventing mental health disorders in children. Issues in Mental Health Nursing 23(4), 327–345.

Cuijpers, P., Van Straten A. and Smith, F. (2005). Preventing the incidence of new cases of mental disorders: A meta-analytic review. Journal of Nervous and Mental Disease, 19382, 119–125.

D'Angelo, E., Llerena-Quinn, R., Shapiro, R., Colon, F., Rodriguez, P., Gallagher, K. and Beardslee, W. (2009). Adaptation of the preventive intervention program for depression for use with predominantly low-income Latino families. Family Process 48, 269–291.

Dorfman, S. and Smith, S. (2002). Preventive mental health and substance abuse programs and services in managed care. Journal of Behavioural Health Services & Research 29(3), 233–258.

Downey, G. and Coyne, J. (1990). Children of depressed parents: an integrative review. Psychosocial Bulletin 108, 50–76.

Dumas, J. Lynch, A., Laughlin, J. Smith, E. and Prinz, R. (2001). Promoting intervention fidelity: Conceptual issue, methods, and preliminary results from the EARLY ALLIANCE prevention trial. American Journal of Preventive Medicine 20, 38–47.

Durlak, J (1998). Why program implementation is important. Journal of Prevention and Intervention in the Community, 17, 5–18.

Dusenbury, L., Brannigan, R., Falco, M. and Hansen, W. (2003). A review of research on fidelity of implementation: implications for drug abuse prevention in school settings. Health Education Research 18(2), 237–256.

Ennet, S., Ringwalt, C., Thorne, J., Rohrbach, L., Vincus, A. and Simons-Rudolph, A. (2003). A comparison of current practice in school-based substance abuse prevention programs with meta-analysis finding. Prevention Science 4, 1–14.

Finnish Child Welfare Act No. 2, (2007). Available at http://www.finlex.fi/fi/laki/ajantasa/2007/20070417. [Accessed 5 May 2007]

Finnish Nurses Association (2001). Ethical guidelines of nurses. Available at http://www.sairaanhoitajaliitto.fi/sairaanhoitajan_tyo/ohjeita_ja_suosituksia/sairaanhoitajan_eettiset_ohjeet/ethical_guidelines_of_nursing/. [Assessed 3 June 2008].

Forgatch, M., Patterson, G. and DeGarmo, D. (2005). Evaluating fidelity: Predictive validity for a measure of competent adherence to the Oregon Model of Parent Management Training. Behaviour of Therapy 36(1), 3–13.

Fudge, E., Falkov, A. Kowalenko, N. and Robinson, P. (2004). Parenting is a mental health issue. Australian Psychiatry 12(2), 166–171.

Garber, J., Clarke, G., Weersing, V., Beardslee, W., Brent, D., Gladstone, T., DeBar, L., Lynch, F., D'Angelo, E., Hollon, S., Shamsedden, W. and Iyengar, S. (2009). Prevention of depression in at-risk adolescents. A randomized controlled trial. Journal of American Academy in Child Adolescence Psychiatry 301(21), 2215–2224.

Gillham, J. and Reivich, K. J. (1999). Prevention of depressive symptoms in school children: A research update. Psychological Science 10, 461–462.

Goodman, S.H. & Gotlieb, I.H. (2002) Transmission of risk to children of depressed parents: integration and conclusions. In: Goodman, S.H., Gotlieb, I.H., (Eds.) Children of Depressed Parents: Mechanisms of risk and implications for treatment. American Psychological Association Washington DC, 13–36.

Green. L. (2001). From research to "Best Practices" in other settings and populations. American Journal of Health Behaviour 25, 165–178.

Hammen, C. and Brennan, P. (2003). Severity, chronicity, and timing of maternal depression and risk for adolescent offspring diagnoses in a community sample. Archives of General Psychiatry 150, 608–613.

Haru, A. (2006). Family psychiatry: from research to practice. American Journal of Psychiatry 163(6), 962–968.

Hill, C., O'Grady, K. and Elkin, I. (1992). Applying the Collaborative Study Psychotherapy Rating Scale to rate therapist adherence in cognitive-behaviour therapy, interpersonal therapy, and clinical management. Journal of Consulting and Clinical Psychology 60, 73–79.

Hinden, B. Biebel, K. and Nicholson, J. (2005). The invisible children's project: key ingredients of an intervention for parents and their families: Identifying common elements to build the evidence base. Journal of Behavioural Health Services & Research 33(1), 21–38.

Hogue, A., Liddle, H., Singer, A. and Leckrone, J. (2005). Intervention fidelity in family-based prevention counselling for adolescent problem behaviours. Journal of Community Psychology 33(2), 191–211.

Hogue A., Liddle, H., Rowe, C. (1998). Treatment adherence and differentiation in individual versus family therapy for adolescent substance abuse. Journal of Counseling Psychology 45, 104–114.

Inkinen, M. and Söderblom, B. (2005) Käsikirja ohjaajille: Lapset ja vanhemmat vertaisryhmässä, kun vanhemmilla on mielenterveyden ongelmia. [Handbook for practitioners: children and parents in peer groups when the parent is mentally ill], Helsinki.

Johansson, M. (2009). Psykoedukatiivisten perheinterventioden yhdentyminen kliiniseen työhön. Omaiset mielenterveystyön tukena, Uudenmaan yhdistys ry. Tutkimusraportti 2009. Oriental xPress Oy, Espoo. 7–12, 124–135.

Kaakinen, S, Koskinen, M and Seppänen, A. (2007). Äidit ja isät perheinterventiossa. [Mothers and fathers in a family intervention.] Perheterapia. [Finnish Journal of Family Therapy.] 23(1), 19–26.

Kane, P. and Garber, J. (2004). The relations among depression in fathers, children's psychopathology, and father-child conflict: A meta-analysis. Clinical Psychology Review 24(3), 339–360.

Kellam, S. & Langevin, D. (2003) A framework for understanding 'evidence' in prevention research and programs. Prevention Science 4(3), 137–53.

Korhonen, T., Vehviläinen–Julkunen, K. and Pietilä, A-M. (2008). Implementing child-focused family nursing into routine adult psychiatric practice: hindering factors evaluated by nurses. Journal of Clinical Nursing 17, 499–508.

Kumpfer, K., Alvarado, R. and Whiteside, H. (2003). Family-based interventions for substance use and misuse prevention. Substance Use and Misuse 38(11–13), 1759–1787.

Leinonen, J. (2004). Families in struggle. Child Mental Health and Family Well-being in Finland During the economic Recession of the 1990s: The Importance of Parenting. Stakes, Research Report 143.

Lehtinen,V. Solhman, B. and Kovess-Masfety, V. (2005). Level of positive mental health in the European Union: Results from the Eurobarometer 2002 survey. Clinical Practice and Epidemiology in Mental Health. Available at http://creativecommons.org/licenses/by/2.0 [Accessed 2 October 2008].

Levinson, D. (2006). The genetics of depression: A review. Biological Psychiatry 60(2), 84– 92.

Livet, M. & Wandersman, A. (2005). Organizational functioning: Facilitating effective interventions and increasing the odds of programming success. In D. M. Fetterman & A. Wandersman (Eds.), Empowerment evaluation principles in practice. New York. Guildford Press, 123–154.

Longman Dictionary of Contemporary English (2005). Fourth Edition, England. La Tipografica Varese.

Magliano L., Fiorillo A., Malangone C., De Rosa C., Favata G., Sasso A., Prezioso M., Pezzenati L., Gentile F., Casale L., Bondi E., Test G., Di Lella M., Biscussi E., Degl'Innocent F., Bellini R., Di Nunzio R., Matrella L., Salmeri R., Cantone R., Gargiulo L., Esposito A., Delcuratolo V., Giannini M., Maresca L., Cavaliere G., Scandone B., Folla M., Raffaeli M., Innocente P., Dagianti F., Lucania S., Scorsino A., Bardicchia F., Cerullo G., Curreli R., Miscali S., Scordato M., Campo G., Maj M. & Gruppo Di Lavoro. (2006). Family psychoeducational interventions for schizophrenia in routine settings: impact on patients' clinical status and social functioning and on relatives' burden and resources. Epidemiologia e Psychiatria Sociale 15(3):219–27.

McComish, J., Greenberg, R.,Ager, J., Essenmacher, L., Orgain, L. & Bacik, W. (2003). Family-focused substance abuse treatment: a program evaluation. Journal of Psychoactive drugs 35(3), 321–331.

Merikangas, K., Dierker, L. and Szatmari, P. (1998). Psychopathology among offspring of parents with substance abuse and/or anxiety disorder: a high-risk study. Journal of Child Psychology and Psychiatry 39, 711–720.

Mueser, K. and Fox, L. (2002). A family intervention program for dual disorders. Community Mental Health Journal 38(3), 253–270.

Murray, C. and Lopez, A. Eds. (1996). The global burden of disease: A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020 (Summary). Geneva, Switzerland: Word Health Organization, 1–43.

Niemi, L.T., Suvisaari, J.M., Haukka, J.K., Wrede, G. and Lönnqvist, J.K. (2004) Cumulative incidence of mental disorders among offspring of mothers with psychotic disorder. Results from the Helsinki High-Risk Study. British Journal of Psychiatry 185 11–7.

Nye, C. Zuckerm, R. and Fitzgerald, H. (1999). Early family-based intervention in the path to alcohol problems: rationale and relationship between treatment process characteristics and child and family outcomes. Journal of Studies on Alcohol Supplement, 10–21.

Olds, D., Sadler, L. and Kitzman, H. (2007). Programs for parents of infants and toddlers: recent evidence from randomized trials. Journal of Child Psychology and Psychiatry 48(3/4), 355–391.

Oyserman, D., Bybee, D., Mowbray, C. and Kahng, K. (2004). Parenting self-construal of mothers with a serious mental illness: Efficacy, burden and personal growth. Journal of Applied Social Psychology 34(12), 2503–2523.

Oxford Dictionary of English (2003). Second edition, Oxford University Press. La Tipografica Varese.

Paavonen, J., Solantaus, T. and Paunio, T. (2009). Psykiatristen häiriöiden alkulähteellä: geenit ja ympäristötekijät vuorovaikutuksessa. [Origin of psychiatric disorders: genes and environment in interaction]. Suomen lääkärilehti [The Finnish Medical Journal]. In print.

Pihkala, H, and Johansson, E. (2008). Longing and fearing for dialogue with children: depressed parent's way into Beardslee preventive family intervention. Nordic Journal of Psychiatry 62(5), 399−404.

Podorefsky, D., McDonald-Dowdell, M. and Beardslee, W. (2001). Adaptation of preventive intervention for a low-income culturally diverse community. Journal of American Academy of Child and Adolescent Psychiatry 40(8), 879–887.

Radke-Yarrow, M. Nottelman, E., Martinez, P., Fox, M., Belmony, B. (1992). Young children of affectively ill parents: A longitudinal study of psychosocial development. Journal of American Children and Adolescent Psychiatry 31, 68–77.

Ramchandani, P. Stein, A. Evans, J. and O'Connor, T. (2005). ALSPAC study team. Parental depression in the postnatal period and child development: a prospective population study. The Lancet 365, 2201–2205.

Riley, A., Valdez, C., Barrueco, S., Mills, C., Beardslee, W., Sandler, I. and Rawal, P. (2008). Development of a family-based program to reduce risk and promote resilience among families affected by maternal depression: Theoretical basis and program description. Clinical Children and Family Psychological Review 11, 12–29.

Rogers, E. (2002). Diffusion of preventative innovations. Addictive Behaviours 27, 989–993.

Rotheram-Borus, M-J. & Duan, N. (2003). Next generation of preventive interventions. Journal of American Academy of Child and Adolescent Psychiatry 42(5), 518–526.

Sandler, I., West, S., Baca, L., et al. (1992). Linking empirically based theory and evaluation: The family bereavement program. American Journal of Community Psychology 20, 491–521.

Sanders, M. (2000). Community-based parenting and family support interventions and prevention of drug abuse. Addictive Behaviours 25(6), 929–942.

Savvidou, I., Bozikas, V., Hatzigeleki, S. and Karavatos, A. (2003). Narratives about their children by mothers hospitalized on a psychiatric unit. Family Process 42(3), 391–402.

Schoenwald, S. & Henggeler, S. (2003) Current strategies for moving evidence-based interventions into clinical practice. Cognitive and Behavioural Practice 10**,** 275–7.

Schoenwald, S. & Hoagwood, K. (2001). Effectiveness, transportability, and dissemination of interventions: What matters when? Psychiatric services 52, 1190–1196.

Schubert, E. and McNeil, T. (2003). Prospective study of adult mental disturbance in offspring of women with psychosis. Archives of General Psychiatry 60, 473–480.

Shochet, I., Dadds, M., Holland, D., Whitefield, K., Harnett, P., and Osgarby, S. (2001). The efficacy of a universal school-based program to prevent adolescent depression. Journal of Clinical Child Psychology 30, 303–315.

Sills, M., Shetterly, S, Xu, S., Magid, D. and Kempe, A. (2007). Association between parental depression and children's health care use. Pediatrics 119(4), 829–836.

Smith, J., Rost, K., Nutting,P., Libby, A., Elliott, C. and Pyne, j. (2002). Impact of primary care depression intervention on employment and workplace conflict outcomes: Is value added? The Journal of Mental Health Policy and Economics 5, 43–49.

Solantaus, T., Toikka, S., Alasuutari, M., Beardslee, W., and Paavonen, J. (2009). Safety, feasibility and family experiences of preventive interventions for children and families with parental depression. In Press: International Journal of Mental Health Promotion. November 2009.

Solantaus, T. and Paavonen, J. (2007). Mielenterveysongelmien siirtyminen sukupolvien yli – epidemiologiaa ja dynamiikkaa. [Intergenerational transmission of mental health problems - epidemiology and dynamics.] Perheterapia. [Finnish Journal of Family Therapy.] 23(1), 6–12.

Solantaus, T. and Toikka, S. (2006). The Effective Family Programme: Preventative services for the children of mentally ill parents in Finland. International Journal of Mental Health Promotion 8(3), 35–42.

Solantaus, T. (2005) Vanhemman mielenterveyden häiriö ja lapsi: mitä terveydenhuollossa tulee tietää ja tehdä. Osa 1. [Parental mental disorder and child: what must be known and done in health care.] Suomen Lääkärilehti [The Finnish Medical Journal] 38(60), 3765–770.

Solantaus, T. & Ringbom, A. (2002) Miten autan lastani? Opas vanhemmille, joilla on mielenterveyden ongelmia. [How can I help my child? A guidebook for parents who suffer from mental problems]. Helsinki: Edita.

Solantaus, T. & Beardslee, W.R. (1996) Kun äiti tai isä sairastaa depressiota: interventio lasten psyykkisten häiriöiden ehkäisemiseksi [When mother or father suffers from depression: intervention to prevent children's psychiatric disorders]. Duodecim 112, 1647–56.

Spoth, R., Redmon, C., and Lepper, H. (1999). Alcohol initiation outcomes of universal family-focused preventive interventions: one- and two-year follow-ups of a controlled study. Journal of Studies of Alcohol Supplement 1999, 103–111.

Startup, M. and Shapiro, D. (1993). Therapist treatment fidelity in prescriptive vs. exploratory psychotherapy. British Journal of Clinical Psychology 32, 443–456.

Sullivan, P., Neale, M. and Kendler, K (2000). Genetic epidemiology of major depression: Review and meta-analysis. American Journal of Psychiatry 157(10), 1552–1562.

Söderblom, B. (2005). Barnets och föräldrars depression - behovet av förståelse och vikten av kommunikation. Barnet i en stödgrupps intervention med sina depressiva föräldrar. Pro gradu - dissertation. [Depression of child and parents – need for understanding and the importance of communication. Child in a support group intervention with his/her depressive parents] Master's thesis. Social och Psykologiska Institutionen. Statsvetenskapliga fakulteten, Helsingfors Universitet.

Toikka, S. and Solantaus, T. (2006). The Effective Family Programme II: Clinicians' Experiences of Training in Promotive and Preventative Child Mental Health Methods. International Journal of Mental Health Promotion 8(3), 27–33.

Väisänen, L. & Niemelä, M. (2005) Vanhemman mielenterveyden häiriö ja lapset. Lapsikeskeinen näkökulma psykiatrisessa sairaalassa - Osa 2. [Parental mental disorder and children – a child-centred standpoint in a psychiatric hospital] Suomen Lääkärilehti [The Finnish Medical Journal] 39(60), 3889–3893.

Wandersman, A. (2003). Community science: Bridging the gap between science and practice with community-centered models. American Journal of Community Psychology 31, 227–242.

Wandersman, A. and Florin, P. (2003). Community interventions and effective prevention. American Psychologist 58, 441–448.

Weissmann, M., Wickramaratne, P., Nomura, Y., Warner, V., Pilowsky, D. and Verdeli, H. (2006). Offspring of depressed parents: 20 years later. American Journal of Psychiatry 163, 1001–1008.

Weissmann, M., Fendricht, M., Warner, V. and Wickramaratne, P. (1992). Incidence of psychiatric disorder in offspring at high and low risk for depression. Journal of American Academy of Child and Adolescent Psychiatry 31, 640–648.

WHO Regional Office for Europe (2005). Mental health: facing the challenges, building solutions. Report from the WHO European Ministerial Conference on Mental Health in Helsinki. Denmark. Available at http://www.euro.who.int/document/E87301.pdf [Accessed 2 October 2006].

World Health Organization (2004). Prevention of Mental Disorders: Effective Interventions and Policy Options: Summary Report of the World Health Organisation. Department of Mental Health and Substance Abuse. In collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht.

World Health Organization (2001). World health report. Mental health: New understanding, new hope, Geneva.

Yuh, J., Maloy, K., Kenney, K. and Reiss, D. (2006). General psychiatrists and their patients' children: Assessment and prevention. Psychiatric Quarterly 77(2), 97–118.

UNPUBLISHED

Beardslee, W. (1984/1997). Cognitive psychoeducational intervention. Manual for the Beardslee Preventive Family Intervention. Unpublished manuscript.

van Doesum, K. (2002). Talking to the children. RIAGG IJsselland, The Netherlands. Workshop in Helsinki, February 2002.

APPENDICES

Appendix 1

The logbook of The Family Talk Intervention

Lokikirja

Beardsleen perheinterventio

Lokikirjassa on osio joka istuntoa varten ja se on tarkoitettu täytettäväksi istunnon jälkeen. Jos istuntoja on standardia enemmän, täytetään jokaisesta ylimääräisestä istunnosta lomake 7. Lokikirjan avulla seurataan intervention kulkua.

Tietoja työntekijöistä

Työntekijä 1 · Työpaikka:_____

Olen potilaan

oma lääkäri / omahoitaja / terapeutti / muu hoitotiimin jäsen / olen hoitotiimin ulkopuolelta

Ammattini: _____

Työntekijä 2 (jos on kaksi työntekijää) Työpaikka:_____

Olen potilaan

oma lääkäri / omahoitaja / terapeutti / muu hoitotiimin jäsen / olen hoitotiimin ulkopuolelta

Ammattini:_____

Tietoja perheestä

Potilas

Koodinumero _____

Nimi _____

Avio-/avopuoliso

Koodinumero _____

Nimi _____

Potilaan tutkimus/hoito alkoi (ensim. käynti tällä hoitojaksolla) ____/____/_____

Potilaan päädiagnoosi: _____

Potilaan sivudiagnoosit: _____

Kumppanin päädiagnoosi (jos on): _____

Kumppanin sivudiagnoosit (jos on): _____

Lapset *(Henkilötunnus tutkimukseen osallistuvista 8-16 –vuotiaista lapsista.)*

	Nimi	**Tyttö/poika**	**Henkilötunnus**
Lapsi 1			
Lapsi 2			
Lapsi 3			
Lapsi 4			

Vanhempien tapaamisen sisällöt on jaettu kahteen istuntoon. Asioita voi kuitenkin käsitellä tarpeen mukaisesti, eli toisen istunnon asioita jo ensimmäisessä ja päinvastoin.

1. Istunto: Esittely, historia ja yhteistyön sopiminen

1. Päiväys ____/____/____ **2. Istunnon kesto** _____ min

3. Paikka □ koti □ toimipiste

4. Läsnä □ potilas □ puoliso □ muita _____

Työntekijöitä □ 1 □ 2

a. Intervention esittely

- Kliinikon esittely □ tehty □ ei tehty
- Intervention esittely: menetelmä, aikaraamit, tarkoitus □ tehty □ ei tehty
- Keskustelu luottamuksellisuudesta □ tehty □ ei tehty
- Lupa ottaa yhteyttä hoitavaan lääkäriin/terapeuttiin □ tehty □ ei tehty

b. Sairastuneen vanhemman (potilaan) omat kokemukset

- Sairaushistoria (painottaen viimeistä episodia) □ tehty □ ei tehty
- Mitä sairastuminen on merkinnyt itselle ja puolisolle □ tehty □ ei tehty

c. Potilaan näkemykset lasten kokemuksista

- Mitä asioita lapset ovat nähneet/kokeneet? □ tehty □ ei tehty
- Mikä merkitys niillä on ollut lapsille? □ tehty □ ei tehty

d. Vanhempien huolten kartoittaminen

□ tehty □ ei tehty

Huolet olivat 1._____

2._____

3._____

4._____

5._____

e. Intervention päämäärien määritteleminen

□ tehty □ ei tehty

Päämäärät 1._____

2._____

3._____

4._____

f. Opaskirjasten antaminen

5. Annettiinko kirjallista materiaalia?

Opas vanhemmille: "Miten autan lastani?" □ kyllä □ ei

Depressio, Potilasopas □ kyllä □ ei

g. Muita asioita, kommentteja

_____

_____

_____

ARVIO ISTUNNOSTA

6.Miten eri aiheiden käsittely meni?

	Erinomaisesti	Hyvin	Tyydyttävästi	Välttävästi	Heikosti
a. Intervention esittely	1	2	3	4	5
b. Potilaan omat kokemukset	1	2	3	4	5
c. Potilaan näkemykset lasten kokemuksista	1	2	3	4	5
d. Vanhempien huolten kartoittaminen	1	2	3	4	5
e. Päämäärien määritteleminen	1	2	3	4	5

7. Minkälainen oli työskentelysuhde tässä istunnossa?

Erittäin hyvä	hyvä	neutraali	huononpuoleinen	huono
1	2	3	4	5

12. Miten motivoituneita potilas/perheenjäsenet olivat?

Äiti:	1	erittäin motivoitunut	Isä:	1	erittäin motivoitunut
	2	melko motivoitunut		2	melko motivoitunut
	3	neutraali		3	neutraali
	4	ei kovin motivoitunut		4	ei kovin motivoitunut
	5	ei ollenkaan motivoitunut		5	ei ollenkaan motivoitunut

13. Kuinka avoimia potilas/perheenjäsenet olivat?

Äiti:	1	erittäin avoin	Isä:	1	erittäin avoin
	2	melko avoin		2	melko avoin
	3	siltä väliltä		3	siltä väliltä
	4	melko sulkeutunut		4	melko sulkeutunut
	5	hyvin sulkeutunut		5	hyvin sulkeutunut

2. Istunto: Psykoedukaatio ja lasten pärjääminen

1. Päiväys ____/____/____ **2. Istunnon kesto** _____ min

3. Paikka □ koti □ toimipiste

4. Läsnä □ potilas □ puoliso □ muita _____

Työntekijöitä □ 1 □ 2

a. Katsaus aikaisempaan istuntoon

- Miltä edellinen istunto ja sen asiat tuntuivat □ tehty □ ei tehty
- Miten perheellä on mennyt edellisen istunnon jälkeen □ tehty □ ei tehty
- Yhteenveto intervention päämääristä ja struktuurista □ tehty □ ei tehty

b. Puolison (toisen vanhemman) kokemukset

- Toisen vanhemman / puolison kokemus potilaan sairaudesta □ tehty □ ei tehty
- Mitä puolison sairastuminen on merkinnyt itselle, puolisolle, lapsille □ tehty □ ei tehty
- (Jos toinenkin vanhempi on sairas, omat ja perheen kokemukset.) □ tehty □ ei tehty

c. Puolison (toisen vanhemman) näkemys lasten kokemuksista

- Mitä asioita lapset ovat nähneet/ kokeneet? □ tehty □ ei tehty
- Mikä merkitys niillä on ollut lapsille? □ tehty □ ei tehty

d. Vanhempien näkemykset lasten vahvuuksista ja huolet lapsista

- Lapsen vahvuudet □ tehty □ ei tehty
- Huolet lapsesta □ tehty □ ei tehty
- Lapsen pärjääminen päivähoidossa tai koulussa □ tehty □ ei tehty
- Lapsen ystävyydet ja harrastukset □ tehty □ ei tehty
- Vanhempien pelot keskustella lasten kanssa sairaudesta/häiriöstä □ tehty □ ei tehty
- Keskustelu lasta suojaavista tekijöistä ja miten vanhemmat voivat tukea niitä □ tehty □ ei tehty

e. Keskustelu lasten tapaamisista

- Tapaamisen tarkoitus □ tehty □ ei tehty
- Vanhempien lupa □ tehty □ ei tehty
- Vanhempien toiveet keskustelun aiheista □ tehty □ ei tehty
- Vanhempien pelot liittyen tapaamisiin □ tehty □ ei tehty
  □ ei pelkoja

5. Saako joku lapsista ammattiapua vaikeuksiinsa?

□ ei □ kyllä, kuka?_____

missä?_____

f. Psykoedukaatio-osat

- Tietoja häiriön oireista □ tehty □ ei tehty
- Tietoja häiriön syistä □ tehty □ ei tehty
- Lasten pärjääminen ja suojaavat tekijät: ymmärrys, omat ihmissuhteet, ystävät, harrastukset □ tehty □ ei tehty

g. Muita asioita, kommentteja

_____

_____

_____

ARVIO ISTUNNOSTA

6. Miten eri aiheiden käsittely meni?

	Erinomaisesti	Hyvin	Tyydyttävästi	Välttävästi	Heikosti
a. Katsaus aikaisempaan istuntoon	1	2	3	4	5
b. Puolison kokemukset	1	2	3	4	5
c. Puolison näkemys lasten kokemuksista	1	2	3	4	5
d. Lasten vahvuudet ja huolet lapsista	1	2	3	4	5
e. Keskustelu lasten tapaamisista	1	2	3	4	5
f. Psykoedukaatio-osat	1	2	3	4	5

7. Minkälainen oli työskentelysuhde tässä istunnossa?

Erittäin hyvä	hyvä	neutraali	huononpuoleinen	huono
1	2	3	4	5

8. Miten motivoituneita potilas/perheenjäsenet olivat?

Äiti:	1	erittäin motivoitunut	Isä:	1	erittäin motivoitunut
	2	melko motivoitunut		2	melko motivoitunut
	3	neutraali		3	neutraali
	4	ei kovin motivoitunut		4	ei kovin motivoitunut
	5	ei ollenkaan motivoitunut		5	ei ollenkaan motivoitunut

9. Kuinka avoimia potilas/perheenjäsenet olivat?

Äiti:	1	erittäin avoin	Isä:	1	erittäin avoin
	2	melko avoin		2	melko avoin
	3	siltä väliltä		3	siltä väliltä
	4	melko sulkeutunut		4	melko sulkeutunut
	5	hyvin sulkeutunut		5	hyvin sulkeutunut

Istunto 3: Lapsen tapaaminen

1. Päiväys ____/____/____ **2. Istunnon kesto** _____ min

3. Paikka □ koti □ toimipiste

4. Läsnä □ lapsi/lapset (nimet)_____

□ muita _____

Työntekijöitä □ 1 □ 2

5. Työskentelyn apuna käytettiin

□ piirtämistä □ leikkiä □ pelejä □ muuta_____

a. Intervention päämäärän selittäminen

- Intervention päämäärä ja eri vaiheet. □ tehty □ ei tehty
- Selvitetty lapselle hänen osallistumisensa tärkeys. □ tehty □ ei tehty
- Keskustelu luottamuksellisuudesta. □ tehty □ ei tehty
- Keskustelu lapsen odotuksista istunnon suhteen □ tehty □ ei tehty

b. Lapsen toiminnantaso koulussa

- Miten koulu menee opillisesti, miten jaksaa tehdä läksyt, miten koulun sosiaaliset suhteet □ tehty □ ei tehty

c. Lapsen toiminnantaso vapaa-aikana: ystävät, harrastukset

- Onko ystäviä, onko harrastuksia, onko iloa ja menoa □ tehty □ ei tehty
- Onko ketään aikuista luotettua? □ tehty □ ei tehty

d. Lapsen toiminnantaso kotona ja kodin perhesuhteissa

- Suhde vanhempiin □ tehty □ ei tehty
- Sisarusten välit □ tehty □ ei tehty
- Kotitöiden tekeminen, minkälainen on lapsen vastuu □ tehty □ ei tehty

e. Lapsen kokemukset ja ymmärrys vanhemman sairaudesta

- Mitä lapsi on nähnyt ja kokenut ☐ tehty ☐ ei tehty
- Mikä on lapsen tunnereaktio, miten lapsi on toiminut ☐ tehty ☐ ei tehty
- Mistä lapsen mielestä vanhemman ongelmat johtuvat, miten lapsi ymmärtää ne ☐ tehty ☐ ei tehty
- Miten lapsi ymmärtää vanhemman ongelman vaikuttavan tai heijastuvan lapseen itseensä ja hänen toimintaansa. ☐ tehty ☐ ei tehty

f. Mistä seikoista lapsi haluaa/ei halua keskusteltavan vanhempien kanssa ja perheistunnossa

- Sovitaan keskusteltavista asioista ja kuka ottaa ne esille ☐ tehty ☐ ei tehty

Sovittu seuraavista keskusteltavista asioista:

_____

_____

_____

_____

g. Muita asioita, kommentteja

_____

_____

_____

ARVIO ISTUNNOSTA

6. Miten eri aiheiden käsittely meni?

	Erinomaisesti	Hyvin	Tyydyttävästi	Välttävästi	Heikosti
a. Intervention päämäärän selittäminen	1	2	3	4	5
b. Toiminnantaso koulussa	1	2	3	4	5
c. Toiminnantaso vapaa-aikana	1	2	3	4	5
d. Toiminnantaso kotona ja perhesuhteet	1	2	3	4	5
e. Lapsen kokemukset ja ymmärrys	1	2	3	4	5
f. Keskustelunaiheista sopiminen	1	2	3	4	5

7. Minkälainen oli työskentelysuhde tässä istunnossa?

Erittäin hyvä	hyvä	neutraali	huononpuoleinen	huono
1	2	3	4	5

8. Miten motivoitunut lapsi oli?

1 erittäin motivoitunut
2 melko motivoitunut
3 neutraali
4 ei kovin motivoitunut
5 ei ollenkaan motivoitunut

9. Kuinka avoin lapsi oli?

1 erittäin avoin
2 melko avoin
3 siltä väliltä
4 melko sulkeutunut
5 hyvin sulkeutunut

Istunto 3: Lapsen tapaaminen

1. Päiväys ____/____/____ **2. Istunnon kesto** _____ min

3. Paikka □ koti □ toimipiste

4. Läsnä □ lapsi/lapset (nimet)_____

□ muita _____

Työntekijöitä □ 1 □ 2

5. Työskentelyn apuna käytettiin

□ piirtämistä □ leikkiä □ pelejä □ muuta_____

a. Intervention päämäärän selittäminen

- Intervention päämäärä ja eri vaiheet. □ tehty □ ei tehty
- Selvitetty lapselle hänen osallistumisensa tärkeys. □ tehty □ ei tehty
- Keskustelu luottamuksellisuudesta. □ tehty □ ei tehty
- Keskustelu lapsen odotuksista istunnon suhteen □ tehty □ ei tehty

b. Lapsen toiminnantaso koulussa

- Miten koulu menee opillisesti, miten jaksaa tehdä läksyt, miten koulun sosiaaliset suhteet □ tehty □ ei tehty

c. Lapsen toiminnantaso vapaa-aikana: ystävät, harrastukset

- Onko ystäviä, onko harrastuksia, onko iloa ja menoa □ tehty □ ei tehty
- Onko ketään aikuista luotettua? □ tehty □ ei tehty

d. Lapsen toiminnantaso kotona ja kodin perhesuhteissa

- Suhde vanhempiin □ tehty □ ei tehty
- Sisarusten välit □ tehty □ ei tehty
- Kotitöiden tekeminen, minkälainen on lapsen vastuu □ tehty □ ei tehty

e. Lapsen kokemukset ja ymmärrys vanhemman sairaudesta

- Mitä lapsi on nähnyt ja kokenut ☐ tehty ☐ ei tehty
- Mikä on lapsen tunnereaktio, miten lapsi on toiminut ☐ tehty ☐ ei tehty
- Mistä lapsen mielestä vanhemman ongelmat johtuvat, miten lapsi ymmärtää ne ☐ tehty ☐ ei tehty
- Miten lapsi ymmärtää vanhemman ongelman vaikuttavan tai heijastuvan lapseen itseensä ja hänen toimintaansa. ☐ tehty ☐ ei tehty

f. Mistä seikoista lapsi haluaa/ei halua keskusteltavan vanhempien kanssa ja perheistunnossa

- Sovitaan keskusteltavista asioista ja kuka ottaa ne esille ☐ tehty ☐ ei tehty

Sovittu seuraavista keskusteltavista asioista:

_____

_____

_____

_____

g. Muita asioita, kommentteja

_____

_____

_____

ARVIO ISTUNNOSTA

6. Miten eri aiheiden käsittely meni?

	Erinomaisesti	Hyvin	Tyydyttävästi	Välttävästi	Heikosti
a. Intervention päämäärän selittäminen	1	2	3	4	5
b. Toiminnantaso koulussa	1	2	3	4	5
c. Toiminnantaso vapaa-aikana	1	2	3	4	5
d. Toiminnantaso kotona ja perhesuhteet	1	2	3	4	5
e. Lapsen kokemukset ja ymmärrys	1	2	3	4	5
f. Keskustelunaiheista sopiminen	1	2	3	4	5

7. Minkälainen oli työskentelysuhde tässä istunnossa?

Erittäin hyvä	hyvä	neutraali	huononpuoleinen	huono
1	2	3	4	5

8. Miten motivoitunut lapsi oli?

1 erittäin motivoitunut
2 melko motivoitunut
3 neutraali
4 ei kovin motivoitunut
5 ei ollenkaan motivoitunut

9. Kuinka avoin lapsi oli?

1 erittäin avoin
2 melko avoin
3 siltä väliltä
4 melko sulkeutunut
5 hyvin sulkeutunut

Istunto 4. Lapsen toiminnantaso ja perheistunnon valmistelu

1. Päiväys ____/____/____ **2. Istunnon kesto** _____ min

3. Paikka □ koti □ toimipiste

4. Läsnä □ potilas □ puoliso □ muita _____

Työntekijöitä □ 1 □ 2

a. Lasten ja vanhempien kokemus lasten tapaamisesta

- Lasten kokemukset □ tehty □ ei tehty
- Vanhempien kokemukset □ tehty □ ei tehty

b. Lapsen toimintakyky ja käyttäytyminen

- Kerro omat huomiosi lapsesta, sekä vahvuudet että mahdolliset ongelmat □ tehty □ ei tehty
- Kertaa tieto suojaavista tekijöistä nimenomaan tämän lapsen kohdalla (painottaen vanhempien kykyä rohkaista näitä ominaisuuksia omassa lapsessaan). □ tehty □ ei tehty
-

c. Keskustelu lapsen haluamista asioista

- Tuo esille lapsen huolen aiheet ja kysymykset □ tehty □ ei tehty

d. Perheistunnon suunnittelu

- Keskustellaan ja sovitaan käsiteltävistä asioista psykoedukaatio, erilaiset huolet ja muut aiheet □ tehty □ ei tehty
- Sovittu, kuka ottaa asiat esille □ tehty □ ei tehty

e. Muita asioita, kommentteja

_____

_____

_____

ARVIO ISTUNNOSTA

5. Miten eri aiheiden käsittely meni?

	Erinomaisesti	Hyvin	Tyydyttävästi	Välttävästi	Heikosti
a. Kokemukset lapsen/lasten tapaamisista	1	2	3	4	5
b. Lapsen toimintakyky ja käyttäytyminen	1	2	3	4	5
c. Keskustelu lapsen haluamista asioista	1	2	3	4	5
d. Perheistunnon suunnittelu	1	2	3	4	5

6. Minkälainen oli työskentelysuhde tässä istunnossa?

Erittäin hyvä	hyvä	neutraali	huononpuoleinen	huono
1	2	3	4	5

7. Miten motivoituneita potilas/perheenjäsenet olivat?

Äiti:	1	erittäin motivoitunut	Isä:	1	erittäin motivoitunut
	2	melko motivoitunut		2	melko motivoitunut
	3	neutraali		3	neutraali
	4	ei kovin motivoitunut		4	ei kovin motivoitunut
	5	ei ollenkaan motivoitunut		5	ei ollenkaan motivoitunut

8. Kuinka avoimia potilas/perheenjäsenet olivat?

Äiti:	1	erittäin avoin	Isä:	1	erittäin avoin
	2	melko avoin		2	melko avoin
	3	siltä väliltä		3	siltä väliltä
	4	melko sulkeutunut		4	melko sulkeutunut
	5	hyvin sulkeutunut		5	hyvin sulkeutunut

Istunto 5: Perheistunto

1. Päiväys ____/____/____ **2. Istunnon kesto** _____ min

3. Paikka □ koti □ toimipiste

4. Läsnä □ potilas □ puoliso

□ lapsi/lapset _____

□ muita _____

Työntekijöitä □ 1 □ 2

a. Keskustelu aikaisemmin sovituista aiheista

- Vanhempien aiheet □ tehty □ ei tehty
- Lasten aiheet □ tehty □ ei tehty

5. Vanhemmat pystyivät selittämään vaikeuksia lapsille

erittäin hyvin	melko hyvin	siltä väliltä	melko huonosti	huonosti
1	2	3	4	5

b. Perheenjäseniä kannustetaan kertomaan omista kokemuksistaan

Rohkaistaan yksilöllisten näkökulmien esille ottamista /jakamista □ tehty □ ei tehty

- Kaikille annetaan mahdollisuus esittää kysymyksiä □ tehty □ ei tehty
- Selvitetään eroavia kokemuksia □ tehty □ ei tehty
- Rohkaistaan perheenjäseniä keskustelemaan keskenään □ tehty □ ei tehty

c. Psykoedukatiivinen aines

- Tietoa oireista, hoidosta, jne tarpeen mukaan □ tehty □ ei tehty
- Lasten selviäminen ja pärjääminen □ tehty □ ei tehty
- Yleistieto suhteutettuna perheen kokemuksiin □ tehty □ ei tehty

d. Muita asioita, kommentteja

_____

_____

_____

ARVIO ISTUNNOSTA

5. Miten eri aiheiden käsittely meni?

	Erinomaisesti	Hyvin	Tyydyttävästi	Välttävästi	Heikosti
a. Keskustelu aiemmin sovituista aiheista	1	2	3	4	5
b. Omien kokemusten kertominen	1	2	3	4	5
c. Psykoedukatiivinen aines	1	2	3	4	5

6. Minkälainen oli työskentelysuhde tässä istunnossa?

Erittäin hyvä	hyvä	neutraali	huononpuoleinen	huono
1	2	3	4	5

7. Miten motivoituneita potilas/perheenjäsenet olivat?

Äiti:
1 erittäin motivoitunut
2 melko motivoitunut
3 neutraali
4 ei kovin motivoitunut
5 ei ollenkaan motivoitunut

Isä:
1 erittäin motivoitunut
2 melko motivoitunut
3 neutraali
4 ei kovin motivoitunut
5 ei ollenkaan motivoitunut

Lapsi:_____
1 erittäin motivoitunut
2 melko motivoitunut
3 neutraali
4 ei kovin motivoitunut
5 ei ollenkaan motivoitunut

Lapsi: _____
1 erittäin motivoitunut
2 melko motivoitunut
3 neutraali
4 ei kovin motivoitunut
5 ei ollenkaan motivoitunut

Lapsi:_____
1 erittäin motivoitunut
2 melko motivoitunut
3 neutraali
4 ei kovin motivoitunut
5 ei ollenkaan motivoitunut

Lapsi: _____
1 erittäin motivoitunut
2 melko motivoitunut
3 neutraali
4 ei kovin motivoitunut
5 ei ollenkaan motivoitunut

8. Kuinka avoimia potilas/perheenjäsenet olivat?

Äiti:
1 erittäin avoin
2 melko avoin
3 siltä väliltä
4 melko sulkeutunut
5 hyvin sulkeutunut

Isä:
1 erittäin avoin
2 melko avoin
3 siltä väliltä
4 melko sulkeutunut
5 hyvin sulkeutunut

Lapsi: _____
1 erittäin avoin
2 melko avoin
3 siltä väliltä
4 melko sulkeutunut
5 hyvin sulkeutunut

Lapsi:_____
1 erittäin avoin
2 melko avoin
3 siltä väliltä
4 melko sulkeutunut
5 hyvin sulkeutunut

Lapsi: _____
1 erittäin avoin
2 melko avoin
3 siltä väliltä
4 melko sulkeutunut
5 hyvin sulkeutunut

Lapsi:_____
1 erittäin avoin
2 melko avoin
3 siltä väliltä
4 melko sulkeutunut
5 hyvin sulkeutunut

Istunto 6: Katsaus perheistuntoon ja tulevaisuuden suunnittelu

1. Päiväys ____/____/____ **2. Istunnon kesto** _____ min

3. Paikka □ koti □ toimipiste

4. Läsnä □ potilas □ puoliso □ muita _____

Työntekijöitä □ 1 □ 2

a. Perheen toiminnan arvio

- Perheen kuulumiset. Miten perheellä ja perheenjäsenillä on mennyt perheistunnon jälkeen? □ tehty □ ei tehty

b. Perheen kokemukset perheistunnosta

- Äidin, isän ja kunkin lapsen kokemukset □ tehty □ ei tehty

c. Perheen kokemus interventiosta ylipäätään

- Äidin ja isän kokemukset □ tehty □ ei tehty
- Kunkin lapsen kokemukset □ tehty □ ei tehty
- Mitä seurauksia interventiolla on ollut? □ tehty □ ei tehty
- Oliko hyötyä? Oliko haittaa? □ tehty □ ei tehty

d. Katsaus sekä saavutettuihin tavoitteisiin että seikkoihin, joita ei käsitelty

- Katsaus tulovaiheen huoliin - tulivatko kaikki käsitellyksi? □ tehty □ ei tehty
- Katsaus tavoitteisiin - mitkä saavutettiin? □ tehty □ ei tehty
- Keskustelu tavoitteista, joita ei saavutettu □ tehty □ ei tehty
- Kysytään asioista, jotka vaativat vielä lisää selkiyttämistä - annettu niistä tietoa □ tehty □ ei tehty
- Vahvistetaan perheen voimavaroja ja perheen saavuttamia tavoitteita intervention aikana □ tehty □ ei tehty

e. Keskustelu prosessina

- Rohkaise vanhempia keskustelemaan keskenään ja lasten kanssa □ tehty □ ei tehty
- Selvitä jatkuvan keskustelun tarve: sairauden eri vaiheet, lasten eri kasvu- ja kehitysvaiheet □ tehty □ ei tehty
  □ tehty □ ei tehty
- Interventio prosessin alkuna □ tehty □ ei tehty

f. Jatkon sopiminen

- Sovi jatkosta, joko seurannasta tai kontaktin lopettamisesta □ tehty □ ei tehty

Jatkon suhteen tehdyt sopimukset:

_____

_____

_____

_____

5. Suositeltiinko jotain seuraavista asioista?

a. lapselle tutkimusta tai hoitoa psyykkisten ongelmien takia

□ ei □ kyllä, missä _____

b. perheelle perheterapiaa □ ei □ kyllä

c. perheelle sosiaalitoimen tukitoimia □ ei □ kyllä

d. tehtiinkö lastensuojeluilmoitus □ ei □ kyllä

g. Muita asioita, kommentteja

_____

_____

_____

ARVIO ISTUNNOSTA

6. Miten eri aiheiden käsittely meni?

	Erinomaisesti	Hyvin	Tyydyttävästi	Välttävästi	Heikosti
a. Perheen toiminnan arvio	1	2	3	4	5
b. Perheen kokemukset perheistunnosta	1	2	3	4	5
c. Kokemus interventiosta	1	2	3	4	5
d. Katsaus tavoitteiden saavuttamiseen	1	2	3	4	5
e. Keskustelu prosessina	1	2	3	4	5
f. Jatkosta sopiminen	1	2	3	4	5

7. Minkälainen oli työskentelysuhde tässä istunnossa?

Erittäin hyvä	hyvä	neutraali	huononpuoleinen	huono
1	2	3	4	5

8. Miten motivoituneita potilas/perheenjäsenet olivat?

Äiti:		Isä:	
1	erittäin motivoitunut	1	erittäin motivoitunut
2	melko motivoitunut	2	melko motivoitunut
3	neutraali	3	neutraali
4	ei kovin motivoitunut	4	ei kovin motivoitunut
5	ei ollenkaan motivoitunut	5	ei ollenkaan motivoitunut

9. Kuinka avoimia potilas/perheenjäsenet olivat?

Äiti:		Isä:	
1	erittäin avoin	1	erittäin avoin
2	melko avoin	2	melko avoin
3	siltä väliltä	3	siltä väliltä
4	melko sulkeutunut	4	melko sulkeutunut
5	hyvin sulkeutunut	5	hyvin sulkeutunut

— — — — — — — — — —

10. Mikäli interventio on keskeytynyt tai viivästynyt, täydennä alla olevat kohdat.

a. keskeytyminen syy _____

ajankohta_____

syy_____

b. viivästyminen

Appendix 2

The logbook of The Let's Talk about Children Intervention

Lokikirja
Lapset puheeksi – työmalli

Toimiva Perhe/Stakes
6.10.2004

I Lapset puheeksi - työmallin päämäärät

Tämä interventio on neuvonnallinen työmalli ja sen päämääränä on tukea vanhemmuutta ja lasten kehitystä perheissä, joissa vanhemmalla on mielenterveyden ongelmia. Tarkoituksena on myös kartoittaa perheen ja lapsen mahdollisesti tarvitsemat tukitoimet ja toimia sen mukaisesti.

II Lapset puheeksi – työmallin sisällöt

A. Kartoitetaan lapsen vahvuudet, ongelmat ja elämäntilanne

- Vanhempien huolet lapsesta
- Lapsen vahvuudet
- Lapsen kuulumiset: miten menee kotona, päivähoidossa, koulussa, kavereiden kanssa, harrastuksissa.

B. Annetaan vanhemmille eväitä lapsen kehityksen tueksi kertomalla

- että lasten olisi hyvä tietää, mistä vanhemman ongelmissa on kysymys.
- että ystävyyssuhteet ja harrastukset ovat lapsille tärkeitä
- että myös perheen ulkopuoliset aikuiset ovat lapsille tärkeitä
- että vanhemmat voivat myös myöhempien käyntiensä yhteydessä kysyä lapsiaan koskevia kysymyksiä.

(asiat löytyvät myös kirjasesta Opas vanhemmille)

C. Järjestetään perheelle ja lapsille tarvittavat tutkimukset, hoidot ja tuki esim. Neuvonpito-istunnon avulla.

III Työntekijällä on vapaus suorittaa interventio omalla tavallaan ottaen huomioon seuraavat ohjeet:

(1) Potilaalle annetaan opaskirjaset "Miten autan lastani?" sekä mahdollisesti omaa häiriötä koskeva potilasopas.

(2) Vähintään 1, yleensä 1 - 2 istuntoa. Keskustelun pituus vähintään 30 min.

(3) Ehdotetaan puolison/toisen vanhemman tulemista mukaan: potilas päättää asiasta.

(4) Istunnot tapahtuvat joko klinikassa tai perheen kotona

(5) Intervention suorittaja pitää lokikirjaa. Lokikirja on työntekijän työväline. Sen avulla voi seurata ja arvioida omaa työtä.

Tietoja työntekijöistä

Työntekijä 1 · Työpaikka:_____

Olen potilaan

oma lääkäri / omahoitaja / terapeutti / muu hoitotiimin jäsen / olen hoitotiimin ulkopuolelta

Ammattini: _____

Työntekijä 2 (jos on kaksi työntekijää) Työpaikka:

Olen potilaan

oma lääkäri / omahoitaja / terapeutti / muu hoitotiimin jäsen / olen hoitotiimin ulkopuolelta

Ammattini:_____

Tietoja perheestä

Potilas: Avio-/avopuoliso:

Nimi _____Nimi _____

Syntymäaika ___/___/____ Syntymäaika ___/___/____

Osoite: _____

_____

Puhelin: _____

Lapset	**Nimi**	**Tyttö/poika**	**Syntymäaika**
Lapsi 2			
Lapsi 3			
Lapsi 4			

Lapsi 5 jne

Potilaan tutkimus/hoito alkoi (ensim. käynti tällä hoitojaksolla) ___/___/_____

Potilaan päädiagnoosi: _____

Potilaan sivudiagnoosit: _____

Kumppanin päädiagnoosi (jos on): _____

Kumppanin sivudiagnoosit (jos on): _____

ISTUNTO 1

1. Päivämäärä ___/___/___ **2. Istunnon kesto** _____

3. Paikka ( ) koti ( ) toimipiste

4. Läsnä : ( ) äiti ( ) isä ( ) lapsi/lapset työntekijöiden lkm ( ) 1 ( ) 2

5.Annettiinko kirjallista materiaalia? Opas vanhemmille: "Miten autan lastani?" ( ) kyllä ( )ei

6.Mistä aiheista keskusteltiin?

7.Olitko tyytyväinen aiheiden käsittelyyn?

(ympyröi sopivin vaihtoehto)

( ) erittäin tyytyväinen

( ) hyvin tyytyväinen

( ) en tyytyväinen, en tyytymätön

( ) hyvin tyytymätön

( ) erittäin tyytymätön

8.Minkälainen oli työskentelysuhde tässä istunnossa?

( ) erittäin hyvä

( ) hyvä

( ) neutraali

( ) huononpuoleinen

( ) huono

9.Miten motivoituneita perheenjäsenet olivat?

Äiti:

( ) erittäin motivoitunut

( ) hyvin motivoitunut

( ) neutraali

( ) ei kovin motivoitunut

( ) ei ollenkaan motivoitunut

Isä:

( ) erittäin motivoitunut

( ) hyvin motivoitunut ( ) hyvin motivoitunut

( ) neutraali

( ) ei kovin motivoitunut

( ) ei ollenkaan motivoitunut

10.Kuinka avoimia perheenjäsenet olivat?

Äiti:

( ) erittäin avoin

( ) hyvin avoin

( ) siltä väliltä

( ) melko sulkeutunut

( ) hyvin sulkeutunut

Isä:

( ) erittäin avoin

( ) hyvin avoin

( ) siltä väliltä

( ) melko sulkeutunut

( ) hyvin sulkeutunut

Kommenttejasi

Mikäli tämä oli ainoa istunto, siirry kysymykseen nro 21

ISTUNTO 2

11. Päivämäärä ___/___/____ **12. Istunnon kesto** _____

13. Paikka ( ) koti ( ) toimipiste

14. Läsnä : ( ) äiti ( ) isä ( ) lapsi/lapset työntekijöiden lkm ( ) 1 ( ) 2

15.Annettiinko kirjallista materiaalia? Opas vanhemmille: "Miten autan lastani?"( ) kyllä ( ) ei

16. Mistä aiheista keskusteltiin?

17.Olitko tyytyväinen aiheiden käsittelyyn?
(ympyröi sopivin vaihtoehto)
( ) erittäin tyytyväinen
( ) hyvin tyytyväinen
( ) en tyytyväinen, en tyytymätön
( ) hyvin tyytymätön
( ) erittäin tyytymätön

18.Minkälainen oli työskentelysuhde tässä istunnossa?
( ) erittäin hyvä
( ) hyvä
( ) neutraali
( ) huononpuoleinen
( ) huono

19.Miten motivoituneita perheenjäsenet olivat?
Äiti:
( ) erittäin motivoitunut
( ) hyvin motivoitunut
( ) neutraali
( ) ei kovin motivoitunut
( ) ei ollenkaan motivoitunut

Isä:
( ) erittäin motivoitunut
( ) hyvin motivoitunut
( ) neutraali
( ) ei kovin motivoitunut
( ) ei ollenkaan motivoitunut

20.Kuinka avoimia perheenjäsenet olivat?
Äiti:
( ) erittäin avoin
( ) hyvin avoin
( ) siltä väliltä
( ) melko sulkeutunut
( ) hyvin sulkeutunut

Isä:
( ) erittäin avoin
( ) hyvin avoin
( ) siltä väliltä
( ) melko sulkeutunut
( ) hyvin sulkeutunut

Jatkotoimet ja muuta tärkeää

21. Suositeltiinko

	kyllä	ei
lapselle tutkimusta tai hoitoa psyykkisten ongelmien takia:	( )	( )
perheelle perheterapiaa:	( )	( )
perheelle sosiaalitoimen tukitoimia:	( )	( )
tehtiinkö lastensuojeluilmoitus:		

Minne lapsi/perhe ohjattiin? _____

22. Toivoiko potilas voivansa jatkaa keskustelua lapsesta tai lapsista ja perheestä interventiota seuraavilla käynneillä?

( ) kyllä ( ) ei

23. Muuta huomattavaa:

keskeytyminen ja sen syy _____

_____

viivästyminen ja sen syy _____

_____

muita tärkeitä seikkoja: _____

_____