

Are Different Professionals Ready to Support Children of Parents with Mental Illness? Evaluating the Impact of a Pan-European Training Programme

Giovanni Viganò, BS

Marja Kaunonen, PhD

Peter Ryan

Wendy Simpson, PhD

Ian Dawson

Izabela Tabak, PhD

Norbert Scherbaum, PhD

Stefano Zanone Poma, MD PhD

Abstract

A training package (pre-tested in a pilot phase) about supporting children who have parents with a mental illness and/or with substance misuse (COPMI) was developed and delivered to 131 different professionals from six different European Countries. A questionnaire about importance, awareness and competence on the issue (8 items on knowledge and 15 items on skills) was developed and completed by participants before and after the training. The training was evaluated by participants as generally very successful in terms of improving the importance, awareness and competence of their knowledge and skills, with a statistically significant difference in the pre-/post-analyses (no decreases occurred). Different professional groups performed differently in the pre-

Address correspondence to Stefano Zanone Poma, MD PhD, Department of Mental Health of the Local Health Authority of Rovigo, Centro Salute Mentale (ULSS 18), Viale Tre Martiri 89, 45100, Rovigo, Italy. Phone: +390425394643; Email: zanone.stefano@azisanrovigo.it.

Giovanni Viganò, BS, Synergia s.r.l. and Department of Decision Sciences, Università L. Bocconi, Milan, Italy.

Marja Kaunonen, PhD, School of Health Sciences, University of Tampere, Tampere, Finland.

Peter Ryan, Middlesex University, London, UK.

Wendy Simpson, PhD, Dundee, Playfield Institute, NHS Fife, University of Dundee, Dundee, Scotland.

Ian Dawson, Nordland Hospital Trust, Bodo, Norway.

Izabela Tabak, PhD, Department of Child and Adolescent Health, Institute of Mother and Child, Warsaw, Poland.

Norbert Scherbaum, PhD, Department of Addiction Medicine and Addictive Behaviour, LVR-Hospital Essen, Hospital of the University of Duisburg-Essen, Duisburg, Germany.

Journal of Behavioral Health Services & Research, 2017. 1–11. © 2017 National Council for Behavioral Health. DOI 10.1007/s11414-016-9548-1

training self-rating scores. The participants in some countries were mainly drawn from one professional group (i.e. teachers in Finland, social workers in Germany and psychologists in Poland). It was found that stigma was considered an extremely important concern even before the training, whilst country-specific legal issues were not taken into proper account in the training. Some possibilities for further refinement of the training programme are suggested.

Introduction

The children of parents with a mental illness and/or substance misuse (COPMI) are at risk of developing emotional, behavioural or psychological problems themselves. Moreover, parental mental illness is considered one of the most substantial risk factors for the development of a mental disorder in the general population.¹ Even if the problem is acknowledged by the professionals concerned, there are still major challenges in terms of everyday service provision for these families. Services for adults and those for children do not always collaborate, and health and social care organisations often work in isolation from each other, which reduces the possibility of effective multi-agency cooperation. Efforts to increase identification of difficulties experienced by children of patients with mental illness are needed to enable prevention of more severe problems.² Parents with a mental illness and/or substance misuse often avoid mentioning any problems they may be having regarding parenting, as they can suffer stigma related to their parental role.³ Children pay a high price for their invisibility; some children may feel guilty, over-burdened, isolated and take on responsibilities far beyond their years. In many situations, they do not have a voice, nor do they know whom to approach for help. The importance of this topic and the lack of adequate emphasis given to COPMI is confirmed by a prolific stream of formal documentation (e.g. brochures, dedicated websites and educational books) as well as informal initiatives (e.g. Facebook groups and children).

Some interventions to prevent mental illness and psychological symptoms in the children of parents with mental illness have been demonstrated to be effective.⁴ Different types of intervention have been proposed: support groups for children,⁵ online courses for parents with mental illness⁶ and psycho-education interventions.⁷ In a recent study, a focus group with GPs was carried out in which they highlighted many examples of how they could aid children as next of kin, including identifying children at risk, counselling the parents and taking part in collaboration with other health and social care professionals.⁸

Although many prevention programmes have been put into action, some of them can be difficult to export from their original socio-cultural context. Moreover, they can require considerable financial expense. The challenge of a successful training programme is to address the varied needs of different professionals, as well as increasing multi-agency networking, so as to improve collaborative care.

The lack of pan-European guidelines for empowering the children of parents with mental illness and/or substance misuse and the organisational gap between services were the main drivers leading to the EU project CAMILLE—*Empowerment of Children and Adolescents of Mentally Ill Parents through Training of Professionals Working with Families*.

The first task of the project was to analyse the current state of practice, as well as perceptions and needs of the target group by means of a survey questionnaire and focus groups. Each participating country carried out three focus groups: (1) professional staff working with children and families, (2) children (aged over 18) and relatives of patients with mental illness and/or substance misuse, and (3) parents with mental illness and/or substance misuse. These results, in conjunction with the existing evidence base on this topic, were used to develop a 2-day training programme targeted at professionals working with families from a variety of different backgrounds. The first draft of the training package was developed by Nordland Hospital, Bodø (Norway) and

was then tested and evaluated for its acceptability during a pilot phase in two sites (Norway and Scotland) in order to fine-tune it and make it suitable and transferable across Europe. Major suggestions after the pilot phase were to improve the organisational flow of the programme, to balance the informative content with more practical examples and open discussions amongst trainees and trainers, to clarify content by incorporating some modules into others (e.g. an original module on ‘bullying’ was incorporated into ‘stigma’) and to include some materials about personal experiences of COPMI. This feedback was then discussed in a transnational meeting with all CAMILLE researchers (in collaboration with users—both parents and grown-up children). Subsequently, the training package was revised and finalised, and all the materials were translated from the original English language into another four languages: Finnish, German, Italian and Polish. Following this, an experimental 2-day training programme was carried out in all the European countries involved in the project.

This article presents the main results of the outcome evaluation of this experimental phase, considering the main outputs and outcomes achieved as a whole, as well as examining the specific results from each country.

Methods

The CAMILLE training programme was created with the aim to raise awareness, provide knowledge and to develop the skills and competencies of the training audience in each participating country. The training modules consist of PowerPoint presentations and videos of theoretical themes (e.g. YouTube videos made by university institutions on attachment theory), videos and audio recordings of real-life stories (told by both fictitious characters and individuals telling their personal stories), group work and discussion points on these materials. The group work was designed as an exchange of viewpoints amongst participants and trainers, taking into account both personal and professional experiences, and it aims to generate discussions on how effective collaboration can be achieved between different professions. Since COPMI families benefit from health, education and social services working together, the programme, wherever possible, was delivered to multidisciplinary and heterogeneous staff groups. After a short introduction about aims, background and the development of the training, the main content is organised under three main themes with three modules in each theme, as follows:

1. Knowledge base.

- (a) ‘Mental Illness & Substance Misuse’ gives the participants a basic understanding of mental illness and substance misuse by explaining the basic features of the most common psychiatric disorders and misused substances as well as highlighting the potential harm that can be caused to families.
- (b) ‘Child & Adolescent Development’ gives an overview of normal child and adolescent development and explores how parental mental health problems can have an impact on this.
- (c) ‘Attachment’ introduces some of the basic concepts of attachment showing secure, insecure-avoidant and insecure-resistant attachment styles. It highlights how lack of responsiveness from a parent with a mental disorder can affect their child.

2. Experiences and needs of families.

- (a) ‘Living with a Parent’ introduces the trainees to the daily life of children of families with a parent with a mental disorder, describing their experiences, difficulties and feelings.

- (b) 'Being a Parent' challenges trainees to hear the thoughts and experiences of parents with a mental illness, including their views on how their illness can affect their children and also how they manage it.
- (c) 'Stigma' raises the issue of discrimination not only for the person with the mental illness or substance misuse but also their surrounding family. It challenges the trainees to consider how they can reduce stigma.

3. Methods for supporting families.

- (a) 'Talking with Children' gives practical suggestions on how professionals can empower parents to talk to their children about their difficulties and possible solutions.
- (b) 'Resilience' clarifies and encourages discussion on what is meant by this term and what supports it, with a particular focus on what has been shown to build resilience in COPMI families.
- (c) 'Successful Services' focuses on the importance of the joint effort and collaboration of different agencies and professionals to support these families and encourages the trainees to consider how this can be achieved in their area.

The training was delivered in six different countries between June and September 2014. The locations were the Department of Mental Health, Social Work and Integrative Medicine of the University of Middlesex in London, England; the School of Health Sciences of the University of Tampere in Finland; the Department of Addiction Medicine and Addictive Behaviour of the University Hospital of Essen in Germany; the Mental Health Center of the Local Health Authority of Rovigo in Italy; the Academy of Special Education of Warsaw in Poland; and the Playfield Institute for Children and Young People's Wellbeing in Fife, Scotland.

The selection of trainers in each participating country followed guidelines defined by the training model. In general, the programme was delivered by a team of two or three professionals (including psychiatrists, psychologists, mental health nurses, social workers, resident and graduate students and voluntary agency workers) but also in some sites by service users, who received a 1-day specific orientation and preparation for the CAMILLE training. The inclusion of trainers who have personal experience of being children, parents or a partner in families with mental illness was recommended as important and valuable. The other trainers were expected to have first-hand knowledge of the modules' contents and experience working with families with mental illness.

The groups of trainees were heterogeneous in terms of professional and educational backgrounds. This choice was made in order to open a dialogue amongst different professionals and encourage them to share and learn from their different experiences, but also to build working links for the future. Trainees were recruited on each site of the study by local advertising in different workplaces; their participation was on a voluntary basis. Some trainees attended the training during their work time with the possibility of educational credit.

The training programme was set up to be delivered in a 2-day format. A limitation to be acknowledged is that the training modules were delivered over different time frames in different countries. In some countries, two full days were run consecutively, and in others, the training sessions were 3 days to a maximum of 2 weeks apart. Moreover, in some countries, the 2 days of training were divided into shorter sessions to suit local settings, for example, delivering one to two modules per session spread over a longer time frame. The amount of time, the length of training and the time of day could have represented a confounding set of variables affecting the learning and the perceptions of trainers.

The evaluation of training effectiveness has received considerable attention in the research literature.^{9,10} A before-and-after approach was used to evaluate CAMILLE training outcomes,

consisting of measures completed by the training participants before and after the training in order to assess any learning related to the CAMILLE training programme. Even though standardised questionnaires are easier to use, a questionnaire specifically suited to the aims and contents of the CAMILLE training was chosen and designed to be fit for purpose. The different items of the questionnaire have been retrieved from different sources, such as the quantitative study of training needs, the Flourishing Scale,¹¹ the project's conceptual framework and other relevant inputs. The final selection of the most relevant items was decided during a transnational meeting involving the whole partnership. The questionnaire rationale can be divided into two macro-dimensions: knowledge of professionals on several issues related to COPMI; and skills that professionals should have when dealing with such children and their families, including both problem identification and intervention skills. Items are numbered in Table 2.

Pre- and post-questionnaires were identical, except for some additional open-ended questions at the end of the second questionnaire (with the aim of receiving feedback about the implementation of the training and suggestions for possible improvements). Both an online and a paper version of the questionnaires were available; the coordinating partners in each centre were free to use any of the two versions, according to the IT equipment available in the training venue. Those centres that opted for the paper version were asked to upload the data on the online version.

The questionnaire was designed to assess the perceived learning of the participants in terms of any changes in the perceived importance of the topic and in their perceived awareness or competence in the subject area. Evaluating behavioural differences in the practice environment was not attempted. All participants were asked to make a self-assessment of the perceived importance, awareness and competence of each of the knowledge and skill items on a 5-point Likert-type scale.

Statistical analysis was performed using SPSS 21.0.0.1. To test significant differences in importance, awareness and competence between the before and after results, paired-samples *T* tests were performed. To reduce the large set of variables of the evaluation questionnaires, a principal component analysis (PCA) was performed. To analyse differences between group means, a series of one-way analyses of variance (ANOVA) was implemented.

Results

One hundred and thirty-one subjects took part in the study across the six participating European centres. There is a total of 111 respondents: this is because 20 trainees completed only one of the two questionnaires and were therefore excluded from the final sample. Amongst the whole sample, the vast majority is female (88.5% vs. 11.5% male) and the mean age (\pm SD) is 40.4 ± 11.5 .

As already mentioned, the participants came from a mix of different professional backgrounds. In three of the countries, there was a predominance of one particular profession in the group: in Finland, 14 participants out of 16 were kindergarten/pre-school teachers; in Germany, 16 participants out of 17 were social workers; and in Poland, 14 participants out of 25 were psychologists.

Overall, the most common professional group represented in the training are social workers (25.2%), whilst the least represented are GPs (1.5%). Amongst the category 'other', there are students, trainers, office workers and other specialists (for example, substance misuse specialists).

In order to identify significant differences amongst different professionals, four different categories have been distinguished:

- Psychological: psychologists
- Social: social workers, educators and voluntary agency workers
- Medical: nurses, GPs and psychiatrists
- Educational: teachers, including primary/secondary and kindergarten/pre-school staff

The main characteristics of the sample are shown in Table 1.

Table 1
Main characteristics of the sample ($n = 131$)

	England	Finland	Germany	Italy	Poland	Scotland	Total
Profession							
Psychologist	2	1	1	6	14	3	27
Social worker	4	0	16	4	0	9	33
Educator	4	0	0	4	0	1	9
Nurse	5	0	0	6	1	0	12
GP	1	0	0	0	1	0	2
Psychiatrist	0	0	0	4	1	0	5
Teacher	2	1	0	2	1	0	6
Teacher in kindergarten	0	14	0	0	0	0	14
Voluntary agency worker	2	0	0	0	5	0	7
Other	11	0	0	0	2	3	16
Education							
Non-graduated	4	8	1	5	5	5	28
Graduated	27	8	16	21	20	11	103
Workplace							
Hospital	3	0	9	3	3	3	21
Counselling centre	5	0	0	1	8	0	14
Medical centre	2	0	0	13	4	1	20
Social care centre	3	0	8	5	4	8	28
School	6	2	0	3	2	0	13
Nursery	0	14	0	0	1	0	15
Other	11	0	0	1	3	4	19
Recipients of intervention							
Children	12	16	7	6	2	12	55
Adolescents	27	1	7	13	1	9	58
Adults	16	1	13	21	21	7	79
Families	13	12	9	11	7	10	62
Mean (\pmSD) working years							
	5.4 \pm 3.9	15.7 \pm 9.4	14.5 \pm 8.4	15.3 \pm 10.8	6.6 \pm 7.5	6.5 \pm 6.3	10.2 \pm 9.0
Previous learning experience on empowerment programmes							
Yes	11	5	2	12	9	3	42
No	19	11	15	14	16	13	88

Trainees had the chance to add some comments in the post-evaluation questionnaire. The main positive factors about the training were described as the competence of the trainers, the videos shown and the opportunity to work in a group with a multidisciplinary approach. The main negative factors were described as the provision of too much information considering the limited time available (with some feeling a sense of ‘rush’), the lack of pragmatism and the need for more concrete examples. In those groups with a uniform professional profile (Finland, Germany and

Poland), another negative factor was raised about the inappropriateness of certain components of the training contents in relation to that specific professional group.

Pre- and post-evaluation differences

As shown in Table 2, the paired-samples *T* tests performed on the whole sample revealed a significant increase in awareness and competence for all the items of the questionnaire. Considering perceived importance, the analysis on the whole sample showed that 3 out of 8 knowledge-related items and 11 out of 15 skills-related items obtained significantly higher scores on perceived importance after the training.

With the aim of analysing differences between group means, a series of analysis of variance (ANOVA) was performed. No statistically significant differences were found considering different age groups or number of working years. There were some significant differences in educational level. Participants with a graduate degree reported higher mean values in *perceived awareness and competence* for *skills item 2* [$F(1,111)=4.689$, $p < 0.05$ for *awareness*; and $F(1,110)=4.681$, $p < 0.05$ for *competence*]; participants with a graduate degree also reported higher values for some items related to the ability of working with other professionals/institutions, in particular *skills item 12: importance* [$F(1,121)=10.985$, $p < 0.01$], *awareness* [$F(1,112)=5.341$, $p < 0.05$], *competence* [$F(1,110)=4.481$, $p < 0.05$]; *skills item 14: importance* [$F(1,120)=3.993$, $p < 0.05$], *awareness* [$F(1,110)=4.001$, $p < 0.05$]; and *skills item 15: competence* [$F(1,109)=5.106$, $p < 0.05$].

Considering the different countries separately, no decrease between pre- and post-score values was detected. Each country achieved results close to those of the general situation described above, with the exception of Germany which showed only a few significant improvements. In particular, German trainees acknowledged an improvement only in the *competence* dimension and only for *knowledge items 2 and 7* and for *skills items 3 and 6*. The only item in which there was not a significant pre-post difference in any country was the *skill* of keeping a non-judgmental attitude. *Knowledge item 1 (information about legal regulations)* was significant only in the Scottish sample.

Principal components analysis and differences amongst groups of professionals

A principal components analysis (PCA) was performed with the aim of identifying the principal components that account for most of the variance in the original variables.

Five components for *importance* emerged from the analysis:

- Theoretical knowledge: including items related to general information and knowledge of legal regulations, theories, effects of mental illness or substance misuse, coping strategies;
- Child-related skills: including items related to the professional practice with children (support, relationship, communication, etc.);
- Parent-related skills: including items related to the professional practice with parents (identification of risky behaviours, relationships, communication);
- Working with other professionals: including items related to being able to collaborate with other professionals/institutions and work in multidisciplinary teams;
- Non-judgmental attitude: referring to *skills item 10*.

The three components emerging for *awareness* and *competence* were the same:

- Theoretical knowledge;
- Child-related skills;
- Adult-related skills (this one pulled together ‘parent-related skills’ and ‘working with other professionals’).

Table 2

Sample mean scores of the before and after assessments

		Importance		Awareness		Competence	
		Before	After	Before	After	Before	After
Knowledge	Information about legal regulations in case of mental health and or substance misuse problems in the family	4.3	4.4	2.9	3.3*	2.5	3.1*
	Different child attachment styles	4.4	4.6*	3.3	4.1*	2.9	3.7*
	Effects of adult mental illness or substance misuse on child development	4.7	4.8	3.5	4.1*	3.0	3.7*
	Effects of adult mental illness or substance misuse on child behaviour	4.7	4.8	3.5	4.1*	3.0	3.8*
	Effects of adult mental illness or substance misuse on child needs	4.6	4.8*	3.4	4.1*	2.9	3.8*
	Effects of adult mental illness or substance misuse on parental skills	4.6	4.8*	3.3	4.1*	2.9	3.7*
	Coping strategies used by a child to deal with stress	4.5	4.6	3.2	3.9*	2.7	3.7*
	Coping strategies used by families to deal with stress	4.5	4.7	3.1	4.0*	2.7	3.6*
Skills	• Identifying parental behaviours that may put a child at risk	4.7	4.8	3.6	4.0*	3.1	3.8*
	• Identifying a child's behaviours which may suggest risk of mental health problems/developmental problems	4.6	4.7	3.4	4.0*	3.1	3.7*
	• How to support the child to become more resilient	4.5	4.6	3.2	4.0*	2.8	3.7*
	• Developing a trustful relationship with children	4.5	4.7*	3.7	4.2*	3.4	3.9*
	• Having effective communication skills to establish supportive relationship with a child	4.6	4.7*	3.7	4.2*	3.4	3.9*
	• Discussing the implications of a mental illness or substance misuse with a child	4.3	4.6*	3.3	4.0*	2.9	3.6*
	• Developing a trustful relationship with a parent	4.6	4.8*	3.8	4.2*	3.5	3.9*
	• Having effective communication skills to establish a supportive relationship with a parent	4.6	4.9*	3.8	4.2*	3.5	4.0*
	• Discussing the implications of a mental illness or substance misuse with a parent	4.4	4.7*	3.5	4.1*	3.1	3.7*
	• Keeping a non-judgmental attitude	4.9	4.9	4.2	4.4*	3.9	4.1*

Table 2 (continued)

	Importance		Awareness		Competence	
	Before	After	Before	After	Before	After
• Working together with the whole family	4.4	4.7*	3.7	4.2*	3.3	3.8*
• Establish/reinforce collaborations with other institutions	4.6	4.8*	3.7	4.3*	3.5	3.9*
• Sharing knowledge and practices with other co-workers	4.7	4.9*	4.0	4.4*	3.7	4.2*
• Working in multidisciplinary teams	4.7	4.8*	4.0	4.4*	3.7	4.1*
• Knowing where and when to seek other professionals' advice	4.8	4.9*	4	4.4*	3.7	4.1*

Paired-samples *T* tests (* $p < 0.05$)

The principal component analysis (PCA) of each dimension produced different results between the different professional categories. This analysis was carried out only on the pre-training data in order to identify the starting point and the training needs of different professional groups. Considering *importance*, teachers find as more important the two dimensions: child-related skills and non-judgmental attitude [$F(3,92) = 3.871, p < 0.05$ and $F(3,92) = 2.856, p < 0.05$, respectively], whilst psychologists consider parent-related skills more important [$F(3,92) = 3.503, p < 0.05$]. With regards to *awareness*, psychologists are more aware of theoretical knowledge [$F(3,87) = 2.314, p < 0.1$] and teachers are more aware of child-related skills [$F(3,87) = 2.806, p < 0.05$]. On the contrary, teachers are less aware of adult-related skills [$F(3,87) = 2.310, p < 0.1$]. For the dimension *competence*, two components show significant differences between groups: teachers feel more competent than other professionals in child-related skills [$F(3,80) = 3.024, p < 0.05$] but less competent with adult-related skills [$F(3,80) = 3.01, p < 0.05$].

Discussion

To date, the majority of research focuses on prevention programmes for children⁵ and/or parents¹² or on how services both for children/adolescents¹³ and for adults² struggle with this issue. There has been no programme that has brought all the key components from each arena into a coherent framework, being sufficiently flexible to deliver to professionals and organisations with varying requirements. The present study is one of the few examples in the literature about a training programme specifically tailored for different professionals who work with COPMI.

The subjects participating in the training constitute a sample which is sufficiently large and has a good internal heterogeneity in terms of professional background: profile, workplace, recipients of intervention and working years.

In terms of demographic factors, no significant differences emerged for age groups or number of working years, and only a few were detected regarding educational level (those with degree level education rated themselves as being more confident and aware, with some skills).

Overall, the post-training scores either increased or remained the same, with no decreases occurring. The training was generally successful in terms of improving the perceived awareness and competence of participants' knowledge and skills with respect to the knowledge and skills offered in the CAMILLE training, whilst it was effective only for some items in terms of improving the perceived importance of the subject. The major explanation of this could be that the

participants already considered the topic very important before starting the training: as shown in Table 2, pre-score values of *importance* were all above 4.3 in a 1–5-point scale. Another possible contribution to the explanation of these limited differences in pre- and post-average scores of *importance* could be related to the trainees' voluntary, self-selection process for participation.

The training achieved an increase in awareness of the consequences for COPMI in professionals of different backgrounds. This goal is central since, even if the problem is acknowledged by all the professionals, more action is needed in terms of everyday working practice. In addition, a greater emphasis needs to be placed on case identification in terms of emerging problems experienced by the COPMI.²

The item keeping a non-judgmental attitude did not achieve a significant difference in any of the countries involved; however, this item was rated as extremely important on the pre-training questionnaire (with a mean score of 4.9 in a 1–5-point scale). This result is encouraging. Nevertheless, because the trainees in this study were self-selected, they may have had less judgmental attitudes than the general population. One of the main difficulties for the child of growing up in a family with a parent with a mental disorder (and/or with substance misuse) is the experience of being judged or stigmatised. This has been demonstrated in several previous studies. For instance, Somers¹⁴ found that COPMI appeared to experience stigma and, as a result, believed that mental illness should be kept hidden in the family.

The principal components analysis highlights at least three main basic components of the training programme. These are theoretical knowledge (e.g. attachment theory, coping strategies, legal regulations), child-related skills and parent/adult-related skills. The emphasis on these three major themes could be useful for future prevention programmes.

The different professionals had varied opinions regarding the importance of the main components of the overall topic shown by the analysis performed on the pre-questionnaires. Unsurprisingly, teachers judged child-related skills as more important than any other professional group and they felt more competent when working with children, whilst they were the least aware of adult-related skills. The social work group, on the other hand, considered child-related skills less important in their professional practice. Psychologists were the most aware of different theories and general knowledge related to dealing with COPMI. Being aware of such differences could be helpful for trainers to decide which aspects to focus on when dealing with a training class mainly composed of a single professional group. These data raise the question as to whether it is better to carry out the training in a heterogeneous class or not. On the one hand, the heterogeneity of the audience is important since there is considerable evidence that neither adults' nor children's services work together on these issues very effectively.^{13,15} This strategy would encourage thinking in synergy, not in silos, meaning that all professionals can contribute to meeting the complex needs of young people and their families in a timely coordinated fashion.^{16,17} However, the dilemma is that different professionals can find the topics hard to understand or, on the contrary, redundant and simplified for their educational background (e.g. a lesson on attachment theory can be totally new for a teacher whilst it may be boring for a psychologist).

Limitations

The major limitations of the study are that the impact of the training programme cannot be referred to as medium or long term since the assessment was carried out immediately after the training and that the evaluation involves self-assessment of knowledge and skills, not actual behaviour change.

Other limitations regard the control of variables that can minimise effects and make results difficult to interpret; two areas have to be acknowledged as critical. First are the teams of professionals that delivered the training as they varied in knowledge, skills and professional background. The guidelines provided for the trainers' selection generated variability in terms of

professional profiles and number of trainers in the various countries, and this may have affected the quality of training. The second area of concern is the varying time frames in which different countries conducted training (two consecutive days or intermittent training up to 3 weeks apart). Using learning theory as a guide, the amount of time, the length of training and even the time of day can be a confounding set of variables that not only affects the learning but also the trainees' views.

Also for the professional groupings of trainees, it has to be recognised that there was no heterogeneity in the single samples of each country involved in the study. This is particularly true for Finland, Germany and Poland, over-represented respectively by teachers in kindergarten, social workers and psychologists. The results for Germany (which was the only country with only three statistically significant results) may be a consequence of this. German participants were mostly social workers who reported high scores before the training.

Moreover, the CAMILLE training did not explicitly cover legal issues. In effect, there was not a specific module for legal aspects in the training package, and this should be implemented in the refinement of the training, considering that legal concerns are quite common in everyday practice.¹⁸ The legal aspects of clinical work in this area of expertise are also cross-cultural and often require a multi-systemic approach with frequent meetings amongst the services involved.

Implication for Behavioural Health

The present study confirms the need to introduce and implement training programmes, extending the knowledge, the awareness and competences of interdisciplinary teams working with families which have experienced parental mental illness and/or substance misuse. The interdisciplinary approach developed in the CAMILLE training is based on the guidelines of the World Health Organization¹⁹ and its advantages are underlined in the literature, mainly emphasising the importance of the mutual exchange of clinical experiences.²⁰ The CAMILLE project is compatible with WHO guidelines which calls for professional training courses to be prepared in close cooperation between people dealing with education and clinical work. Evidence has been presented in this article which demonstrates significant impact on professional awareness of these issues and enhanced confidence in translating this into routine practice. These benefits varied from country to country and with respect to the pre-existent skill mix of the training groups receiving the training. This training package has been shown to make a difference to professionals' perceived awareness and competence of knowledge and skills across a number of different countries in Europe. It thus shows potential for the successful provision of a pan-European training package which can really help professionals support children whose parents have a mental disorder and/or substance misuse. Further improvements in the CAMILLE training package could include using a less theoretical approach with more clinical case study examples and videos, adapting the package to different professional groups and giving greater emphasis to the legal aspects of the training. Another recommendation would be to organise periodic 'refresher' modules to sustain the awareness of the topic and the skills learned, and to follow this up with operational implementation learning sets, to further facilitate the effective translation of awareness into routine work with families.

Acknowledgements

The authors wish to thank all the investigators of the CAMILLE project for their unique and precious contribution without which this study would not have been possible. They are Dr Martin Smith from Middlesex University, London, England; Dr Katja Joronen from the School of Health Sciences, University of Tampere, Finland; Dr Michael Specka and Dr Christine Auffenberg from the Department of Addiction Medicine and Addictive Behaviour, LVR-Hospital Essen, Hospital of the University of Duisburg-Essen, Germany; Drs Antonello Grossi, Francesca Siviero and

Emanuele Toniolo from the Department of Mental Health of the Local Health Authority of Rovigo, Italy; Dr Simonsen Inger from Nordland Hospital Trust, Bodo, Norway; Drs Czesław Czabał and Lidia Zabłocka-Żytka from the Academy of Special Education, Institute of Applied Psychology, Warsaw, Poland; Drs Alex Baldacchino, Sarah Gray and Catalina Martin from the University of Dundee, Playfield Institute, NHS Fife, Scotland; and Drs Emilio Gregor and Luigi Mauri from Synergia s.r.l., Milan, Italy.

CAMILLE project website: <http://mailtodawson.wix.com/camilleproject>

Compliance with Ethical Standards

Declaration of Conflicting Interests The authors declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Funding The CAMILLE project is funded by the DG Justice of the European Commission under the Daphne III programme (JUST/2012/DAP/AG/3336).

References

1. Reupert A, Maybery D, Kowalenko N. Children whose parents have a mental illness: prevalence, need and treatment. *Medical Journal of Australia Open*. 2012; 1(Suppl 1):7-9.
2. Lauritzen C, Reedtz C, Van Doesum KT, et al. Implementing new routines in adult mental health care to identify and support children of mentally ill parents. *BMC Health Services Research*. 2014; 14:58.
3. Jeffery D, Clement S, Corker E, et al. Discrimination in relation to parenthood reported by community psychiatric service users in the UK: A framework analysis. *BMC Psychiatry*. 2013; 13:120.
4. Siegenthaler E, Munder T, Egger M. Effect of preventive interventions in mentally ill parents on the mental health of the offspring: Systematic review and meta-analysis. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2012; 51(1): 8-17.
5. van Santvoort F, Hosman CM, van Doesum KT, et al. Effectiveness of preventive support groups for children of mentally ill or addicted parents: A randomized controlled trial. *European Child and Adolescent Psychiatry*. 2014; 23(6): 473-484.
6. van der Zanden RA, Speetjens PA, Arntz KS, et al. Online group course for parents with mental illness: Development and pilot study. *Journal of Medical Internet Research*. 2010; 12(5):e50.
7. Lucksted A, McFarlane W, Downing D, et al. Recent developments in family psychoeducation as an evidence-based practice. *Journal of Marital and Family Therapy*. 2012; 38(1): 101-21.
8. Gullbra F, Smith-Sivertsen T, Rortveit G, et al. To give the invisible child priority: Children as next of kin in general practice. *Scandinavian Journal of Primary Health Care*. 2014; 32(1):17-23.
9. Alvarez K, Salas E, and Garofano CM. An integrated model of training evaluation and effectiveness. *Human Resource Development Review*. 2004; 3(4): 385-416.
10. Kraiger K. (Ed). *Creating, Implementing, & Managing Effective Training & Development: State-of-the-Art Lessons for Practice*. San Francisco, CA: Jossey-Bass, 2001.
11. Diener E, Wirtz D, Tov W, et al. New well-being measures: Short scales to assess flourishing and positive and negative feelings. *Social Indicators Research*. 2010; 97(2): 143-156.
12. Solantaus T, Paavonen EJ, Toikka S, et al. Preventive interventions in families with parental depression: children's psychosocial symptoms and prosocial behaviour. *European Child and Adolescent Psychiatry*. 2010; 19(12): 883-892.
13. Katz I, Hetherington R. Co-operating and communicating: A European perspective on integrating services for children. *Child Abuse Review*. 2006; 15(6): 429-439.
14. Somers V. Schizophrenia: The impact of parental illness on children. *The British Journal of Social Work*. 2007; 37(8): 1319-1334.
15. Cooklin, A. 'Living upside down': Being a young carer of a parent with mental illness. *Advances in Psychiatric Treatment*. 2010; 16(2), 141-146.
16. Smith M. Care of adolescents who have mental health and substance misuse problems. *Mental Health Practice*. 2013; 16(5): 32-36.
17. Plsek P, Wilson T. The challenge of complexity in healthcare organisations. *British Medical Journal*. 2001; 323: 746-749.
18. Corwin DL, Keeshin BR. Estimating present and future damages following child maltreatment. *Child and Adolescent Psychiatric Clinics of North America*. 2011; 20(3): 505-518.
19. World Health Organization. *Mental health: facing the challenges. Building solutions. Report from the WHO European Ministerial Conference, 12-15 January, Helsinki*. Geneva: World Health Organization, 2005.
20. Twomey C, Byrne M, Leahy T. Steps towards effective teamworking in community mental health teams. *Irish Journal of Psychological Medicine*. 2014; 31(1): 51-59.