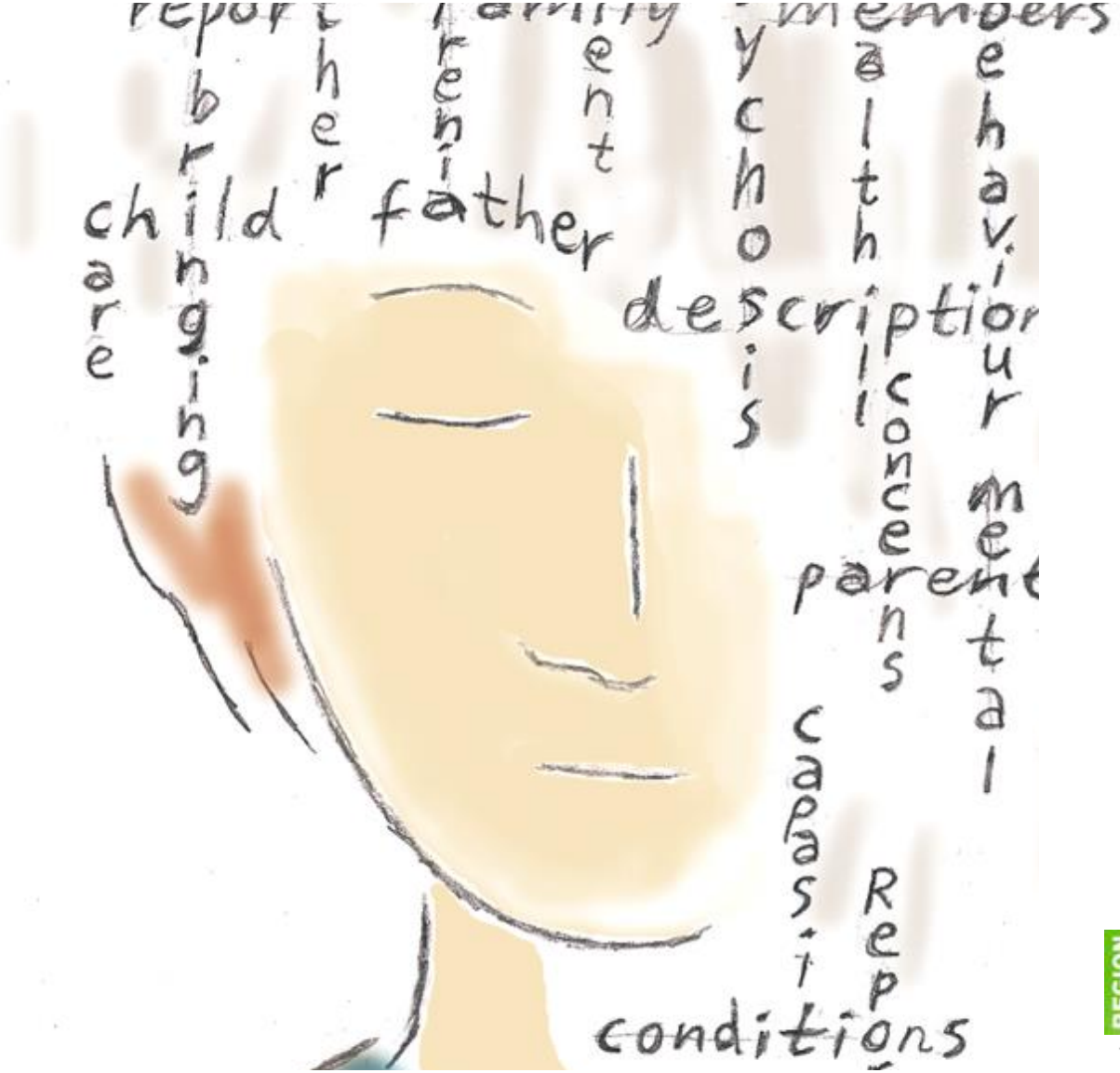


Børn af forældre med psykisk sygdom

Opvækstvilkår og perspektiver på forebyggelse

Anne Ranning, assistant professor and clinical psychologist
University of Copenhagen/Mental Health Centre Copenhagen

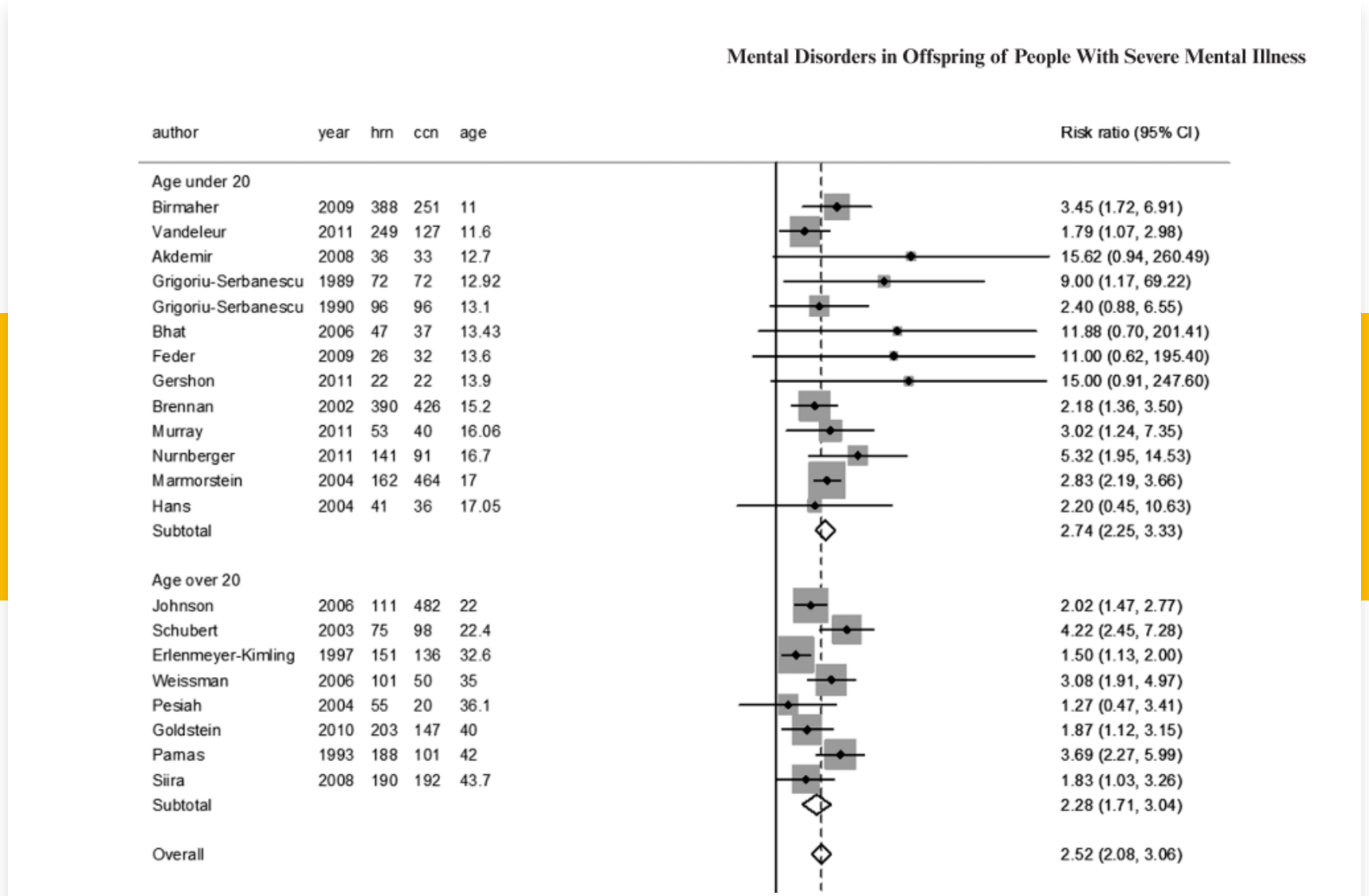
REGION H Psykiatri

UNIVERSITY OF COPENHAGEN

Disposition

- BAGGRUND
  - En population i øget risiko
  - Opvækstvilkår belyst af registerstudier
  - Underretninger om børn af patienter i psykiatrien

- SAFIR PROJEKTET
- Baggrund for family talk
- SAFIR Family Talk



Før 30-årsalderen får
55%: any diagnosis
33%: SMI

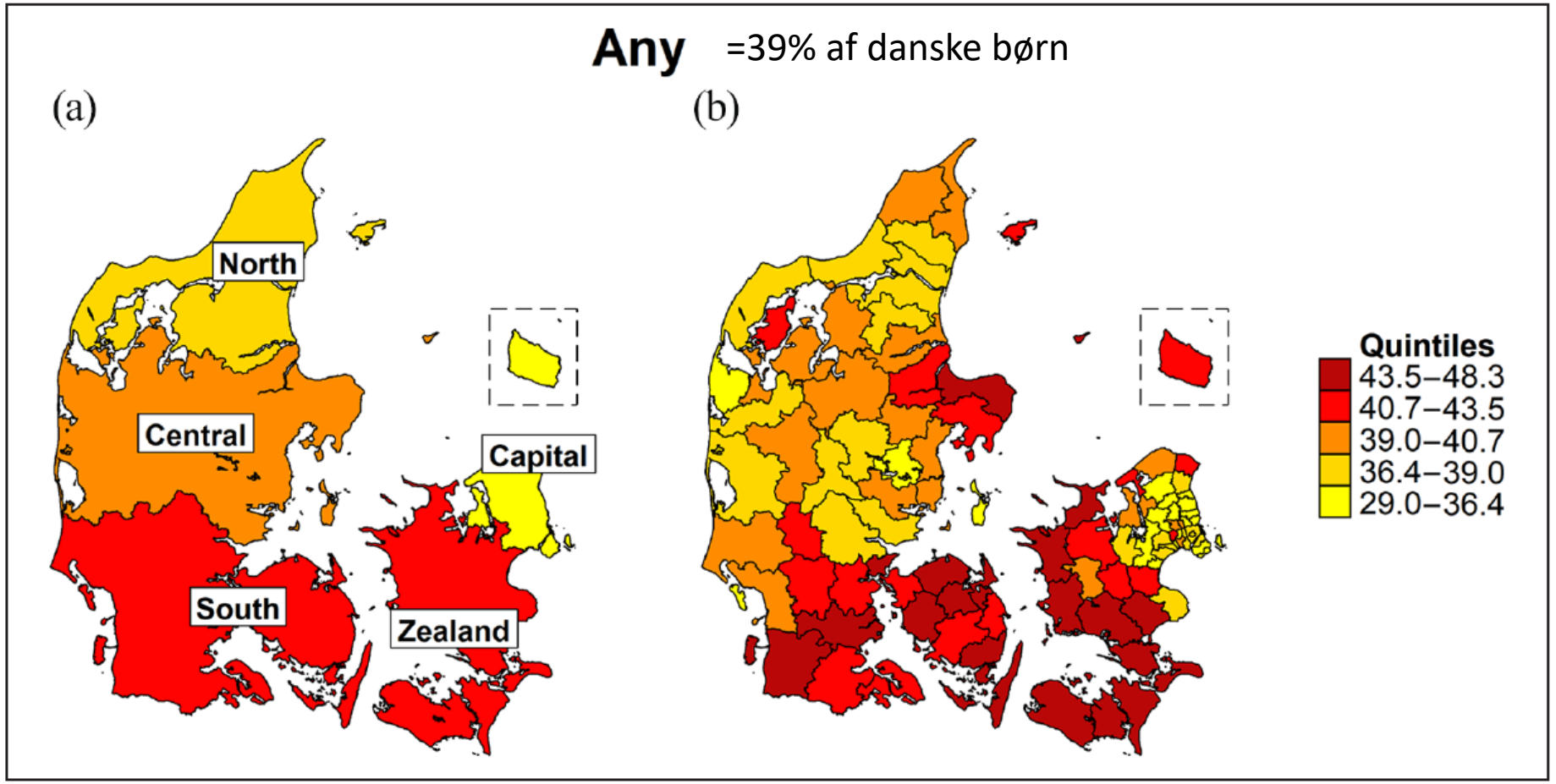


Figure 1. Prevalence of children with any parental mental health conditions in the Danish regions (a) and municipalities (b). Both regions and municipalities are coloured according to quintiles of the municipalities.

Minor parental mental health conditions (23.5%) were more common than moderate (13.5%) and severe parental mental health conditions (2.2%). Hospital-diagnosed parental mental health conditions were prevalent in 12.8% of the children.

Christesen 2021

Diskussion med sidemakker

- Hvad er dit kendskab til emnet?
- Har du berøring med børn af forældre med psykisk sygdom i dit arbejde?
- Hvad har du erfaret?

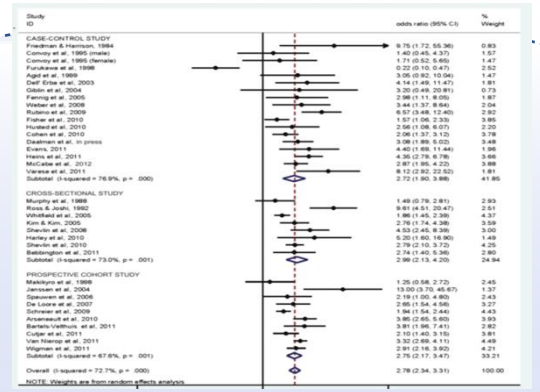
Opvækstvilkår for børn af forældre med psykisk sygdom

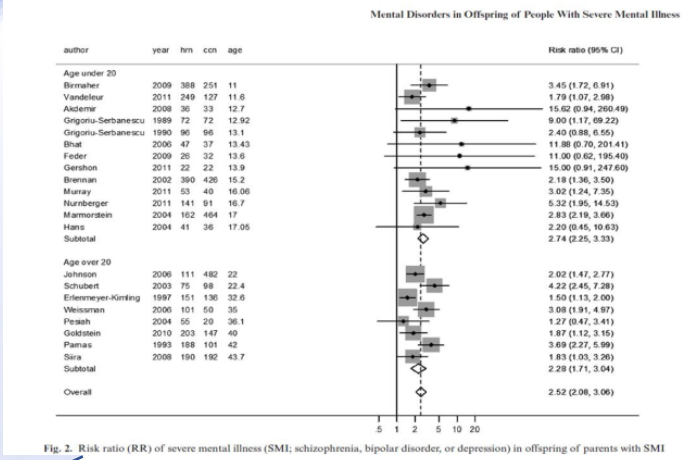
Svære opvækstvilkår

Risiko for psykisk sygdom

?

Børn af forældre med psykisk sygdom

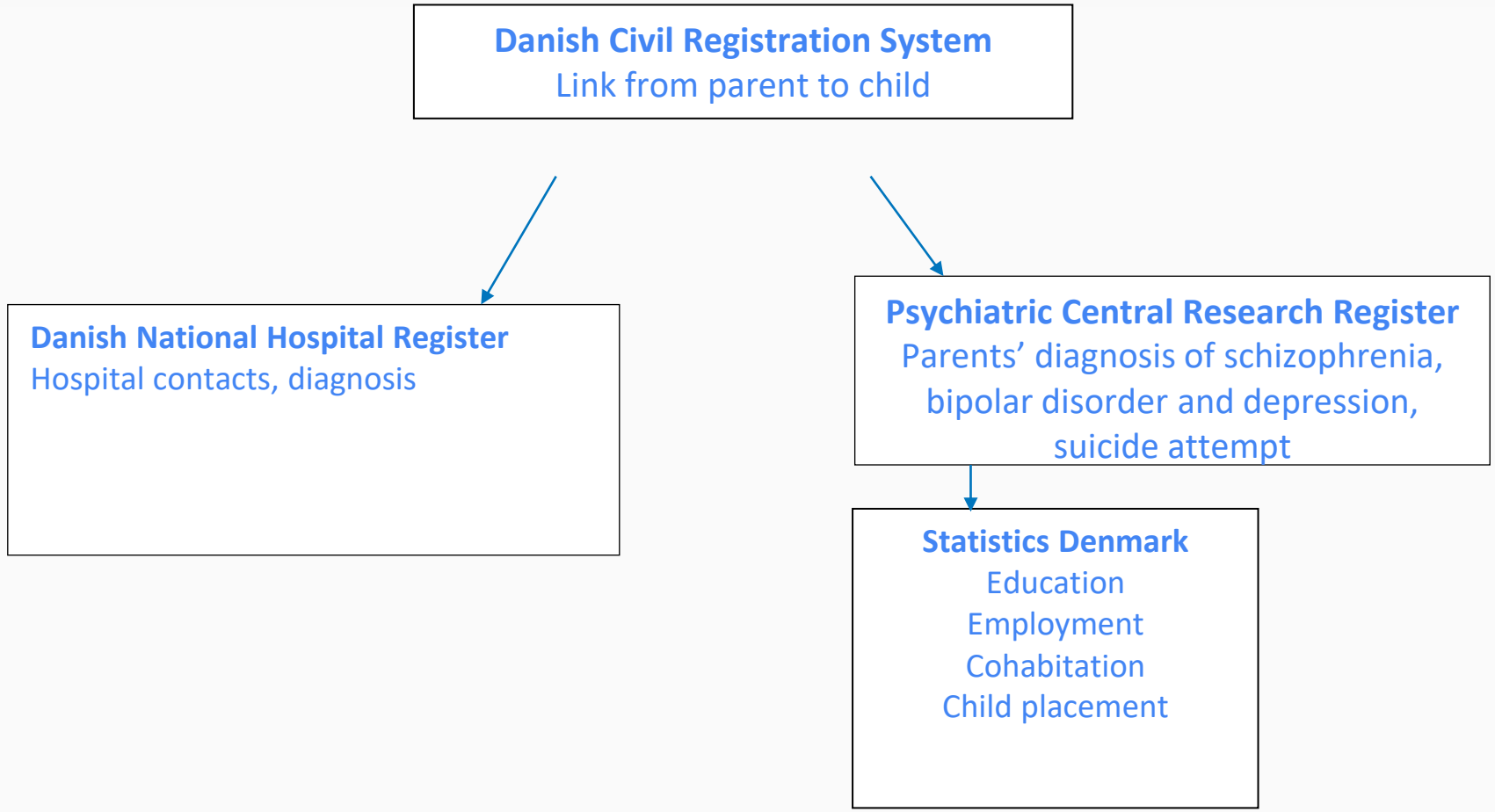




Methods register-based studies

- Design: Prospective, registerbaseret kohorte studie
- Alle børn født I Danmark 1980 – 2010/2016
- Forældre med følgende diagnoser inden barns fødsel:

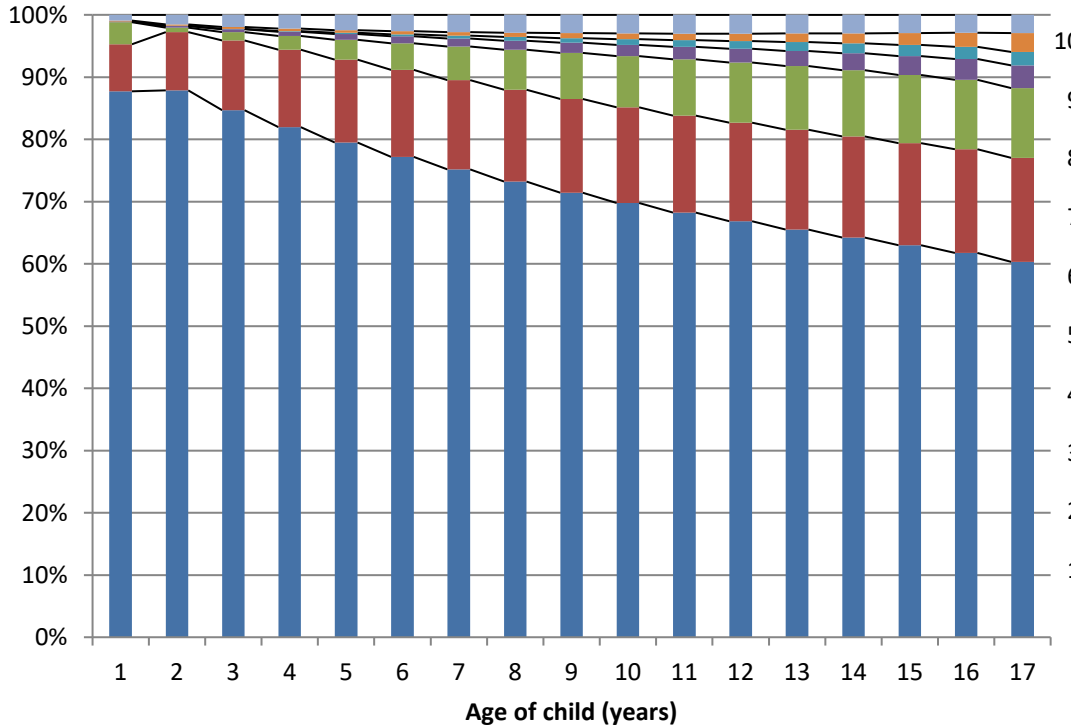
- skizofreni n=4163
- bipolær lidelse n=2515
- depression n=19794



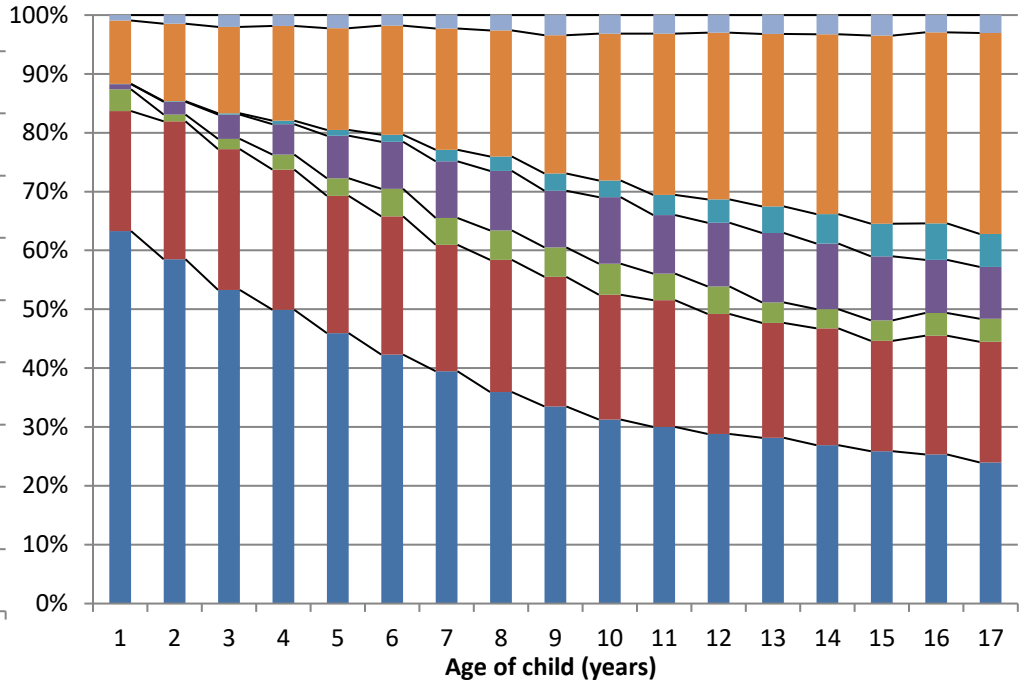
Children of Parents With Serious Mental Illness: With Whom Do They Grow Up? A Prospective, Population-Based Study

Anne Ranning, PhD, Thomas Munk Laursen, PhD, Anne Thorup, PhD, Carsten Hjorthøj, PhD, Merete Nordentoft, PhD, DMSc

Børn af baggrundsbefolkningen



Børn af mødre med skizofreni



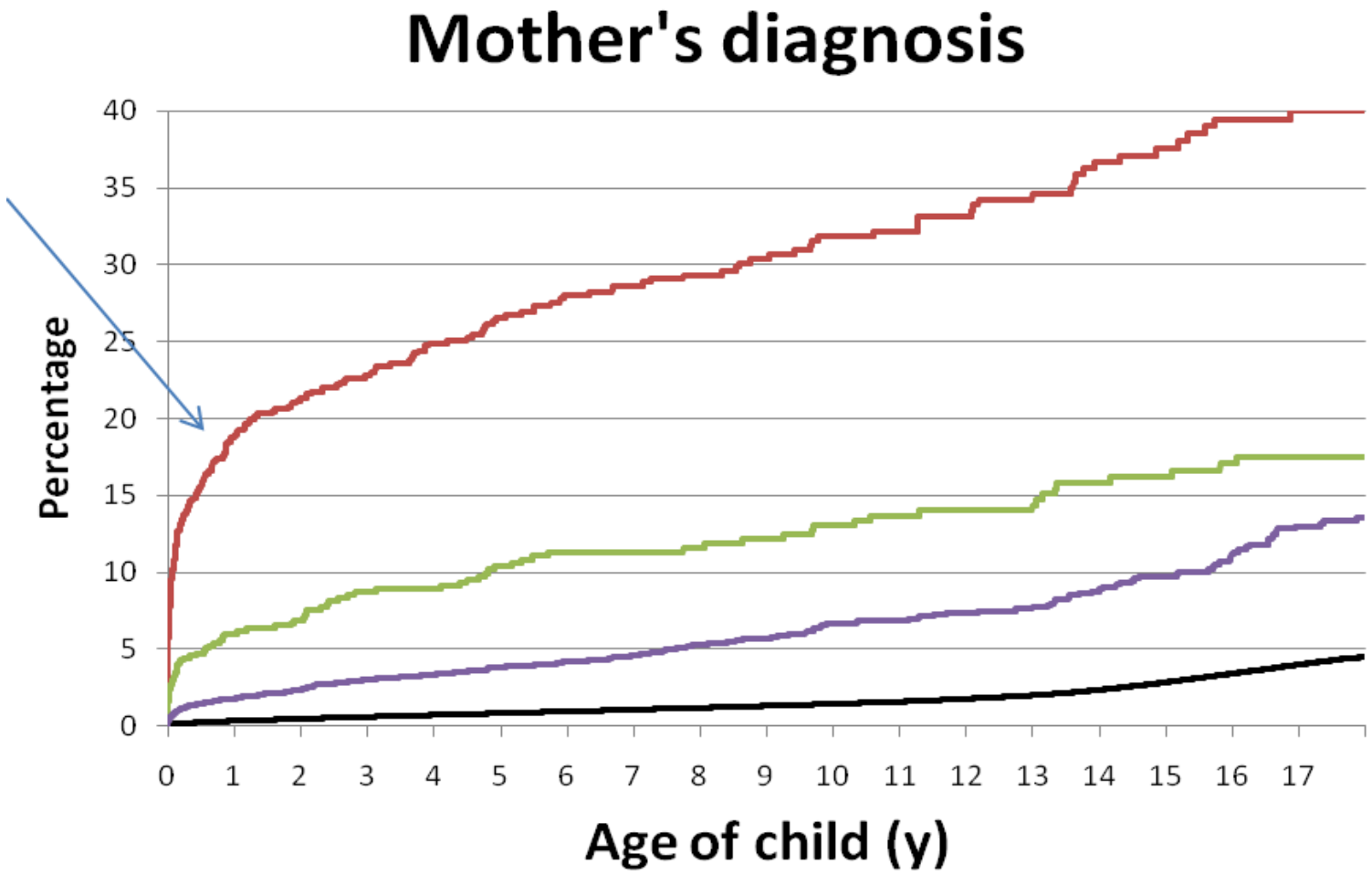
Mother and Father Mother alone Mother, new partner

Father, alone Father, new partner Not with parents

Original Research

Serious Mental Illness and Disrupted Caregiving for Children:
A Nationwide, Register-Based Cohort Study

Anne Ranning, MScPsych; Thomas Munk Laursen, PhD; Anne Thorup, PhD; Carsten Hjorthøj, PhD; and Merete Nordentoft, PhD, DMSc



Schizophrenia 40%

Bipolar disorder 17%

Depression 14%

General population 5%

Psychological Medicine

cambridge.org/psm

School performance from primary education in the adolescent offspring of parents with schizophrenia and bipolar disorder– a national, register-based study

Original Article

Cite this article: Ranning A, Laursen T, Agerbo E, Thorup A, Hjorthøj C, Jepsen JRM, Nordentoft M (2018). School performance from primary education in the adolescent offspring of parents with schizophrenia and bipolar

Anne Ranning[1,2], Thomas Laursen[2,3], Esben Agerbo[2,3], Anne Thorup[1,2,4], Carsten Hjorthøj[1,2], Jens Richardt Møllegaard Jepsen[4,5,6] and Merete Nordentoft[1,2]

Table 5. Grade point average (GPA) and completion of elementary school according to parent's diagnosis, adjusted for highest ranking educational attainment among two parents

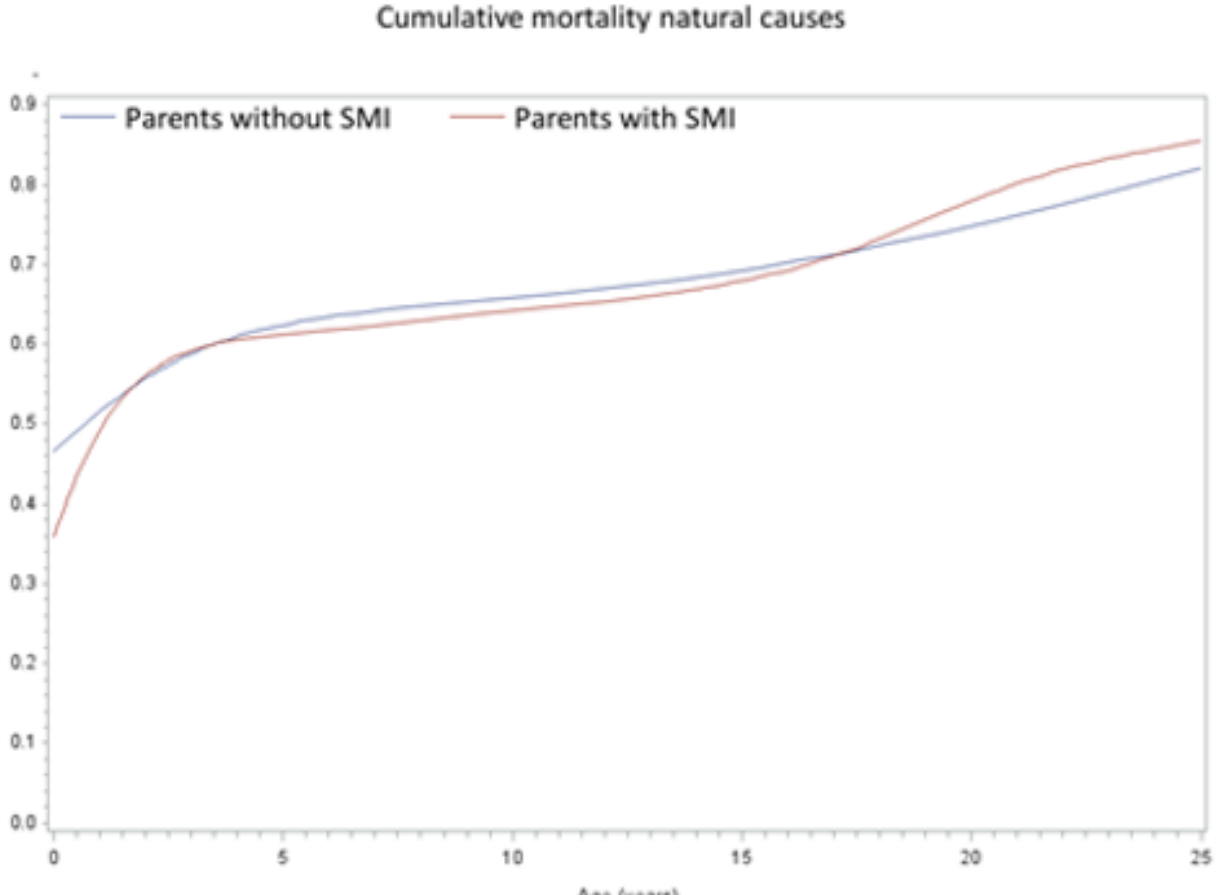
	Schizophrenia Univariate adjusted	Schizophrenia Adjusted for parents' education[a]	Bipolar disorder Univariate adjusted	Bipolar disorder Adjusted for parents' education[a]
High GPA ⩾8	**OR 0.70 (0.63–0.77)**	**OR 0.81 (0.74–0.89)**	1.03 (0.95–1.11)	0.99 (0.91–1.07)
Medium GPA 4⩽ *X* <8	1 (reference)	1 (reference)	1 (reference)	1 (reference)
Low GPA <4	**OR 1.63 (1.50–1.76)**	**OR 1.32 (1.21–1.42)**	1.06 (0.97–1.15)	1.06 (0.97–1.16)
No graduation	**OR 2.62 (2.4–2.86)**	**OR 1.95 (1.78–2.15)**	**1.43 (1.28–1.59)**	**1.39 (1.24–1.56)**

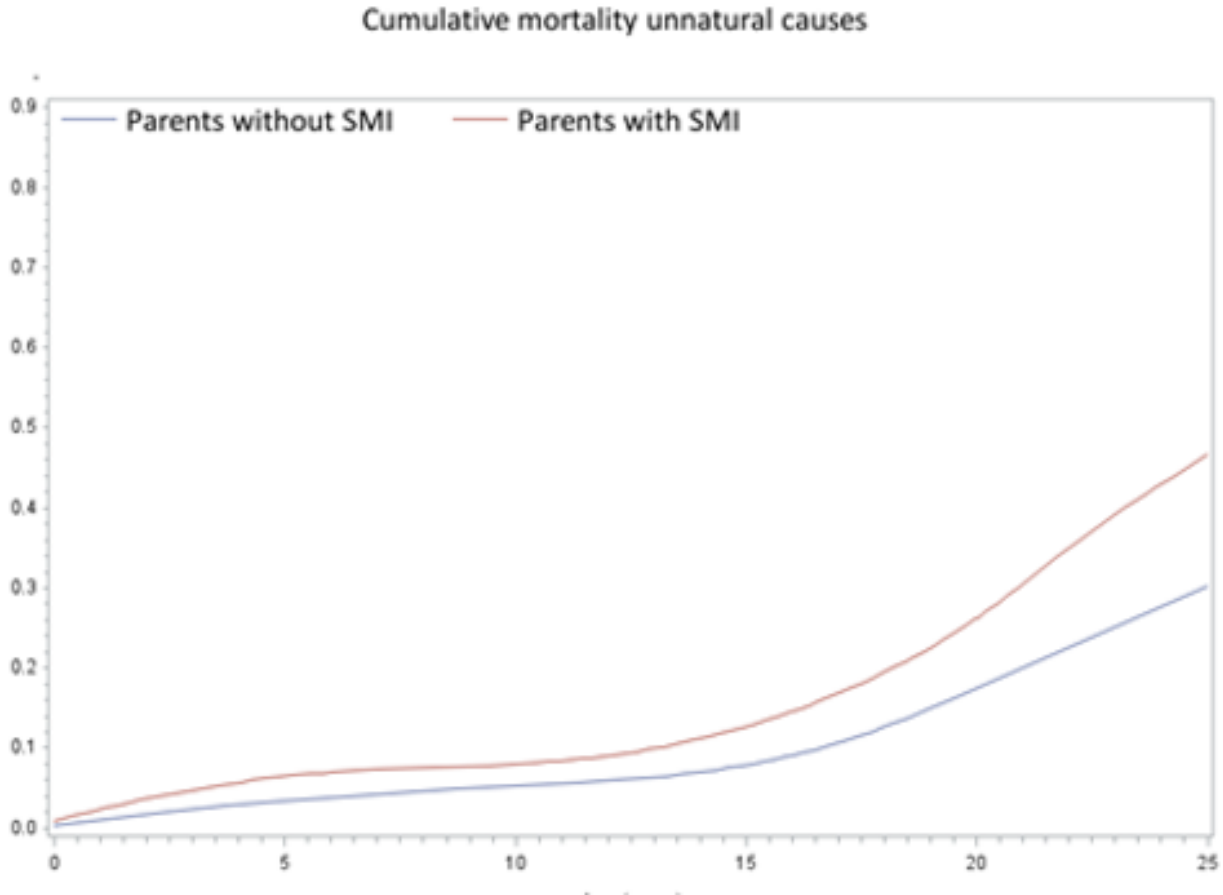
OR, odds ratio with 95% confidence intervals.
Bold numbers indicate significant differences on a 5% level.
[a]Adjusted for highest ranking educational level among child's parents.

Schizophrenia Bulletin
doi:10.1093/schbul/sbz040

Morbidity and Mortality in the Children and Young Adult Offspring of Parents With Schizophrenia or Affective Disorders—A Nationwide Register-Based Cohort Study in 2 Million Individuals

Anne Ranning*[,1,2], Michael E. Benros[1,2], Anne A. E. Thorup[3,4], Kirstine Agnete Davidsen[5,6], Carsten Hjorthøj[1,7], Merete Nordentoft[1,2], Thomas Munk Laursen[2,8,9], and Holger Sørensen[1,2,9]





Cumulative incidence:
Accidents, 83%
ill-defined conditions , 35%
Respiratory system, 32%

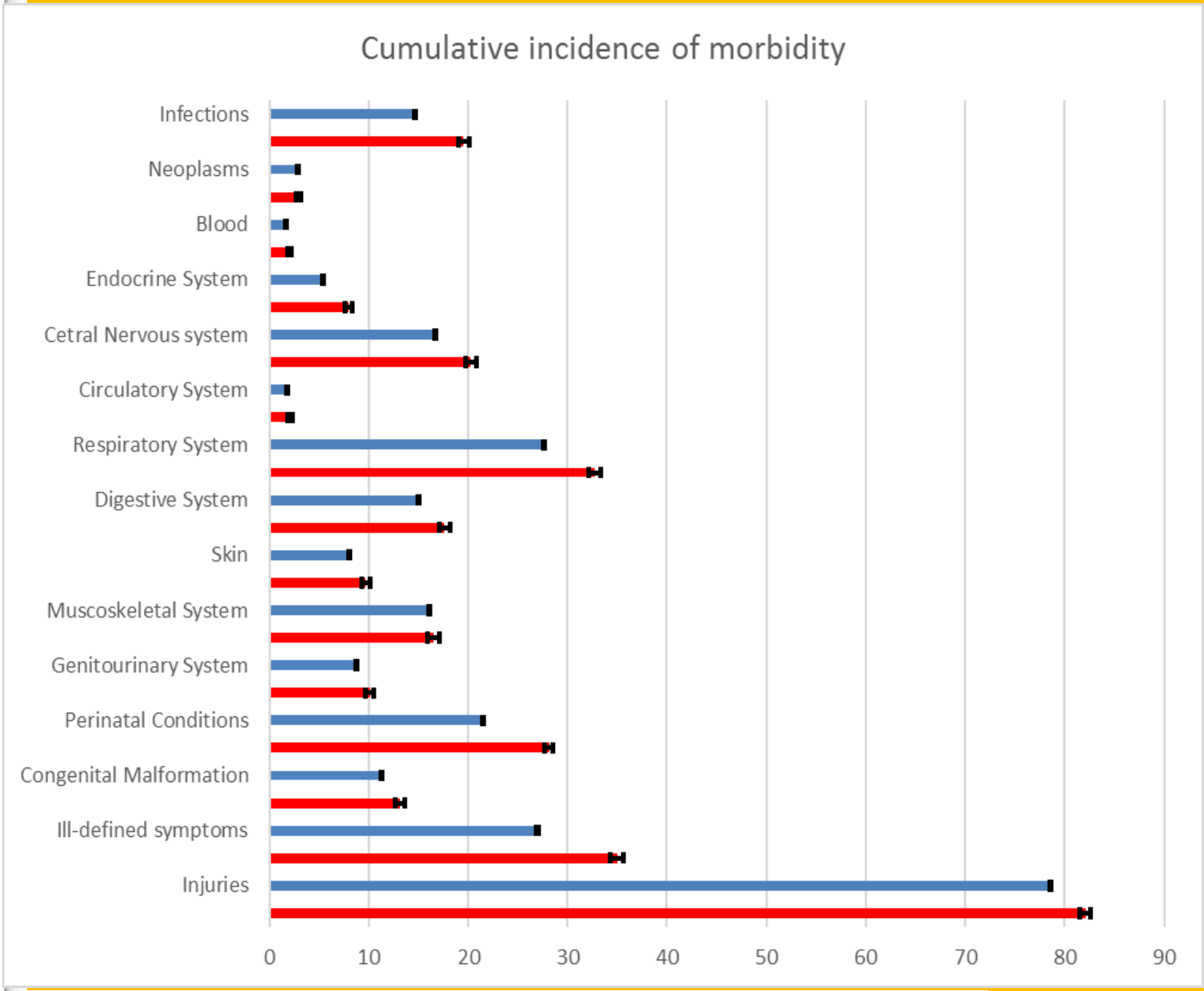


Figure 1: Cumulative incidence percent of 15 somatic diagnostic categories in the offspring by age 18 years,

Psychological Medicine

cambridge.org/psm

Intergenerational transmission of suicide attempt in a cohort of 4.4 million children

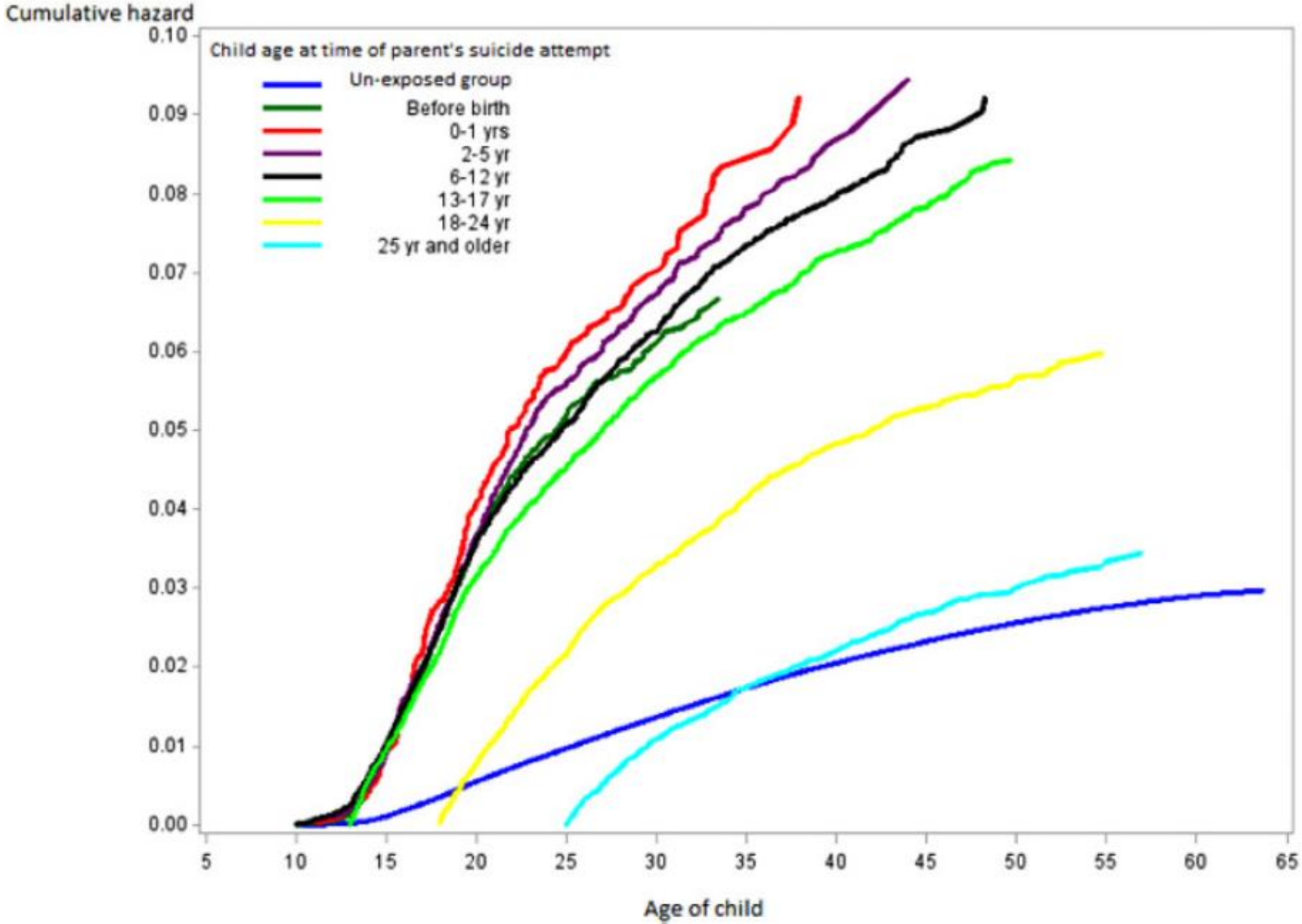
Anne Ranning[1,2,3], Md Jamal Uddin[1,4,5], Holger J. Sørensen[1], Thomas Munk Laursen[6], Anne A. E. Thorup[7], Trine Madsen[1], Merete Nordentoft[1,2,8] and Annette Erlangsen[2,9,10]

Original Article

Table 2. IRRs of children's SA in relation to factors of parental SA

	Number of cases	Person-years	IR per 100 000 person-years	IRR (95% CI)	IRR (95% CI)
Child age at parents' SA				Model 1[a]	Model 2[b]
No parental SA	69 609	91 762 383	75.9 (75.3–76.4)	1 (ref)	1 (ref)
Before birth of child	949	317 929	298.5 (279.5–317.5)	4.2 (4.0–4.5)	2.9 (2.7–3.1)
Age 0–1	225	65 389	344.1 (299.1–389.1)	4.7 (4.2–5.4)	2.8 (2.5–3.2)
Age 2–5	659	219 120	300.7 (277.8–323.7)	4.1 (3.8–4.4)	2.4 (2.2–2.6)
Age 6–12	1522	557 296	273.1 (259.4–286.8)	3.6 (3.4–3.8)	2.1 (2.0–2.2)
Age 13–17	1242	463 891	267.7 (252.8–282.6)	3.5 (3.3–3.7)	2.1 (2.0–2.2)
Age 18–24	1052	534 106	197.0 (185.1–208.9)	2.6 (2.5–2.8)	1.6 (1.5–1.7)
Age ⩾25	1296	773 812	167.5 (158.4–176.6)	1.8 (1.6–1.9)	1.2 (1.1–1.4)

Cumulative hazard of attempted suicide according to child's age of exposure to parental suicide attempt



frontiers in Psychiatry

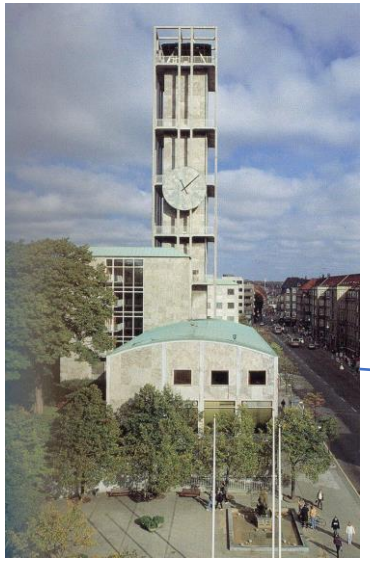
ORIGINAL RESEARCH
published: 19 June 2020
doi: 10.3389/fpsyt.2020.00527

Children of Patients Undergoing Psychiatric Treatment: An Investigation of Statutory Support Services After Referrals to Child Protection Services

Anne Ranning[1], Carsten Hjorthøj[1,2], Kamilla B. Jensen[1], Frank Cloyd Ebsen[3], Idamarie Leth Svendsen[3], Anne Amalie Elgaard Thorup[1,4] and Merete Nordentoft[1]*

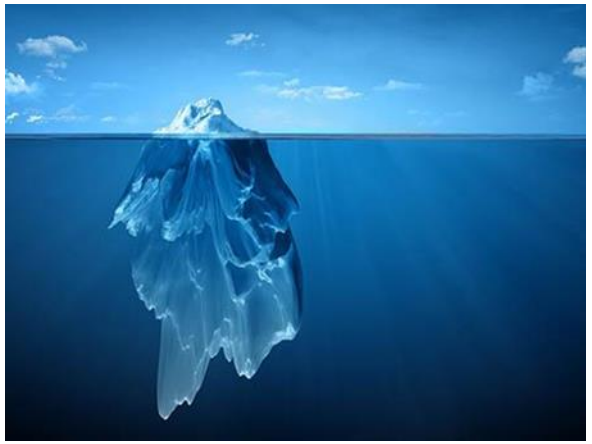
REGION Mental Health Services

Datakilde:
Underretninger
N=272
(373 børn)



Outcome: Iværksatte foranstaltninger efter underetningsdato

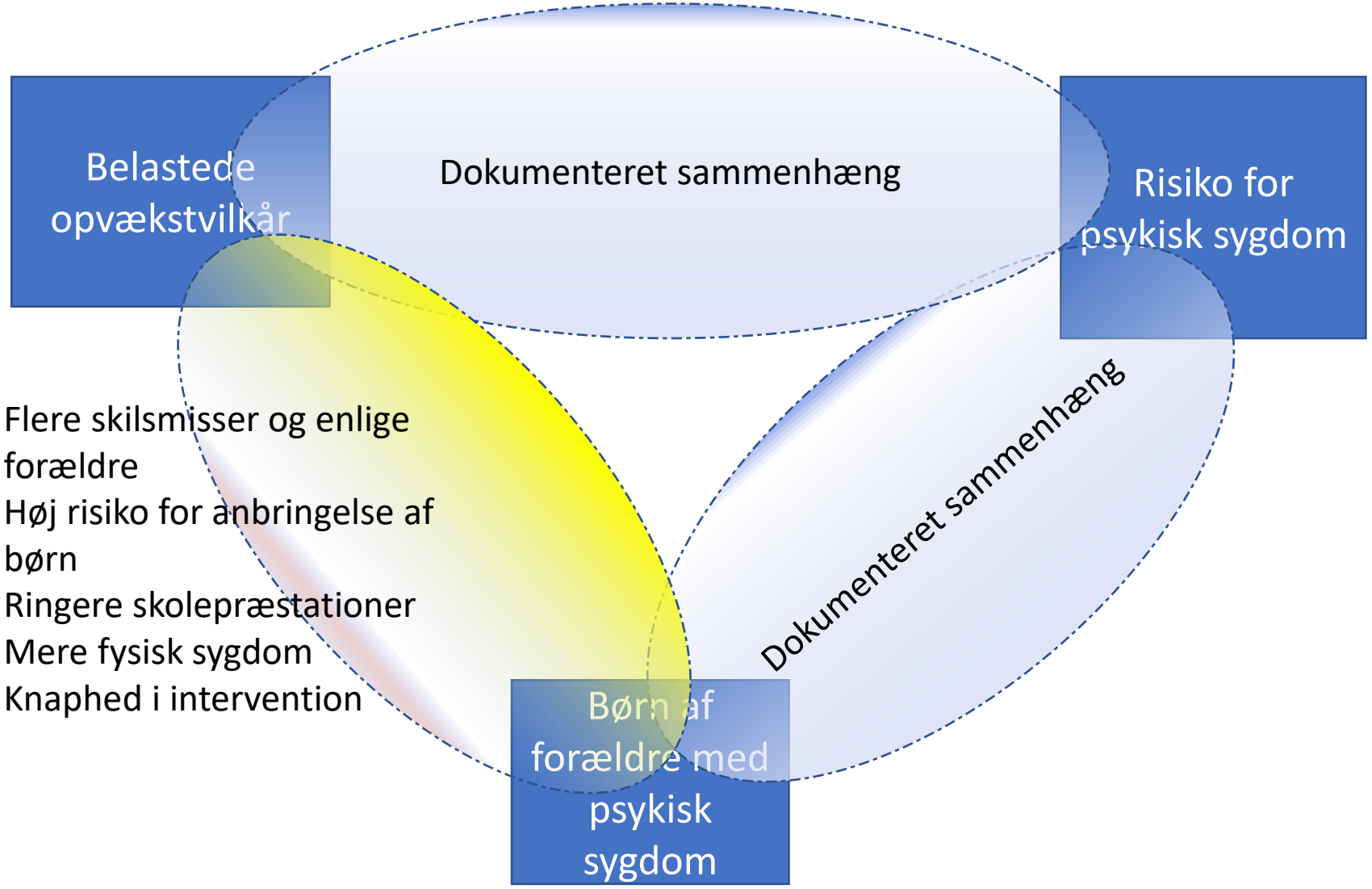
Datakilder:
Barnets kommune Danmarks Statistik
Det Psykiatriske Centralregister



Classification of referral	
Vague concern	132 (40.5%)
Specific concern	129 (39.6%)
Acute concern	26 (8.0%)
Vague concern and acute concern	6 (1.8%)
Specific concern and acute concern	33 (10.1%)

FOREBYGGELSE AF PSYKISK SYGDOM I EN HØJRISIKOPOPULATION

Børnenes opvækst er mere belastet



1. Flere skilsmisser og enlige forældre
2. Høj risiko for anbringelse af børn
3. Ringere skolepræstationer
4. Mere fysisk sygdom
5. Knaphed i intervention

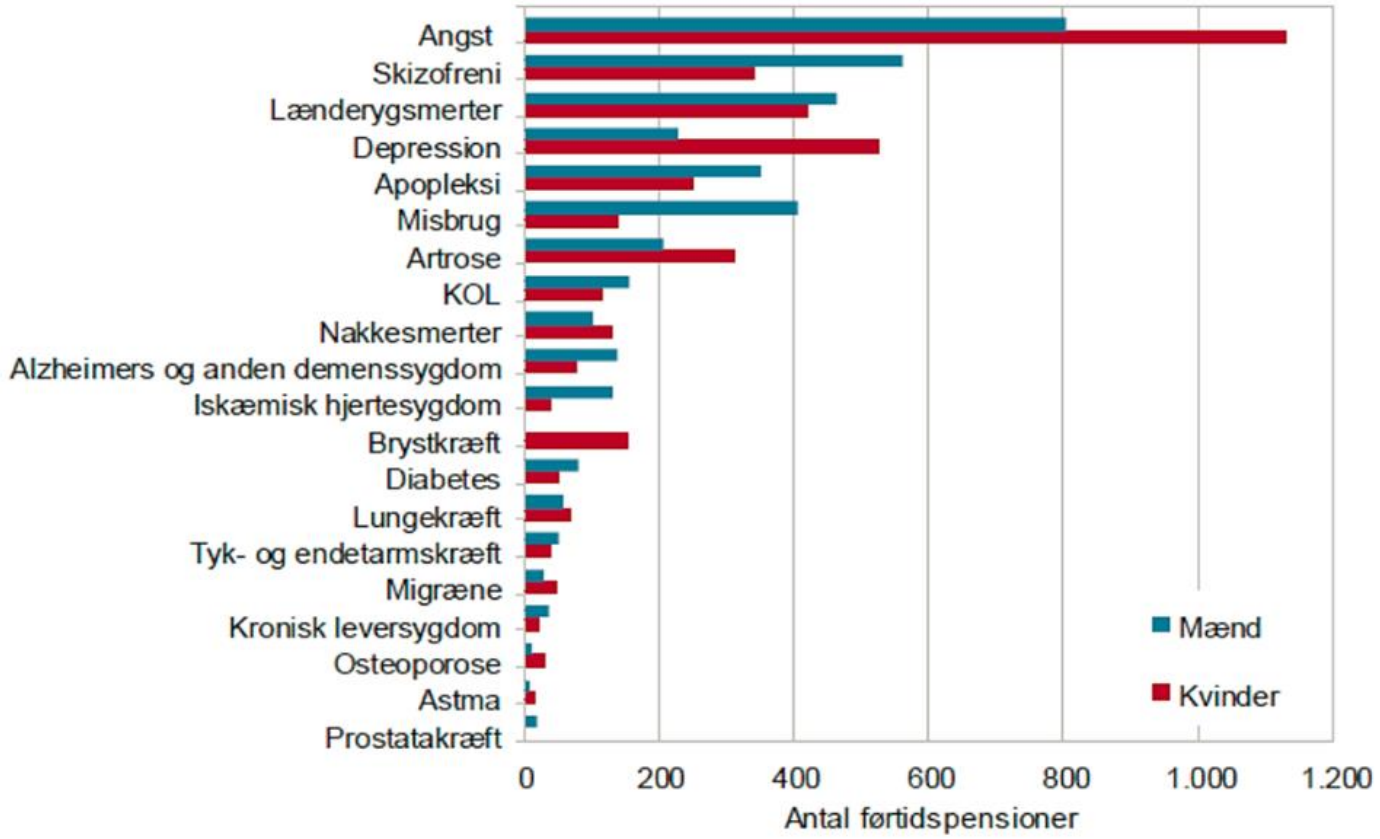
Refleksion med sidemakker

- Hvordan forestiller I jer mulige forklaringsmekanismer for den øgede risiko for psykisk sygdom, hos børn af forældre med psykisk sygdom?
- Hvordan løser vi problemet?

Hvorfor forebyggelse

- 2,5 x øget risiko (55%)
- Personlige og samfundsmæssige omkostninger
- Generelt sundhedsfagligt princip

- Burden of disease



We need to stop just pulling people out of the river.

We need to go upstream and *find out why they're falling in.*

-Desmond Tutu

Preventive strategies for mental health

Celso Arango, Covadonga M Díaz-Caneja, Patrick D McGorry, Judith Rapoport, Iris E Sommer, Jacob A Vorstman, David McDaid, Oscar Marín, Elena Serrano-Drozdowskyj, Robert Freedman, William Carpenter

Available treatment methods have shown little effect on the burden associated with mental health disorders. We review promising universal, selective, and indicated preventive mental health strategies that might reduce the incidence of mental health disorders, or shift expected trajectories to less debilitating outcomes. Some of these interventions also seem to be cost-effective. In the transition to mental illness, the cumulative lifetime effect of multiple small effect size risk factors progressively increases vulnerability to mental health disorders. This process might inform different levels and stages of tailored interventions to lessen risk, or increase protective factors and resilience, especially during sensitive developmental periods. Gaps between knowledge, policy, and practice need to be bridged. Future steps should emphasise mental health promotion, and improvement of early detection and interventions in clinical settings, schools, and the community, with essential support from

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Published Online May 14, 2018
http://dx.doi.org/10.1016/S2215-0366(18)30057-9

Department of Child and Adolescent Psychiatry, Hospital General Universitario Gregorio

Introduction

Although interest in early detection to prevent progression to severe mental health disorders such as schizophrenia and recurrent major depression is increasing, knowledge of risk factors and developmental trajectories has not yet been widely applied to clinical practice and public health.[1] Psychiatry has traditionally been based on treatment and prevention of progression and disability in individuals with established illness (ie, tertiary prevention). Although many medical specialties have joined forces with public education and health associations to reduce risk factors for diseases such as myocardial infarction,[2] preventive initiatives for mental health have received far less attention. Scientific evidence gathered from other areas of medicine, along with increasing knowledge of developmental risk factors preceding psychiatric illness, and preliminary findings supporting preventive inter-ventions, indicate that our field could move toward the more ambitious goals of universal prevention of vulnerability, selective prevention in high-risk subgroups, and indicated prevention of full or more severe expression of illness in individuals already showing early manifestations.[3] The reality is that less than 5% of mental health research funding goes on prevention research, even in countries that invest in prevention.[4]

In this Review, we will first summarise the various possibilities for mental health prevention throughout development, and the evidence supporting them. We will then review the potential limitations associated with these approaches, and potential ways to overcome them.

Prevention in mental health

Preventive interventions

Prevention in mental health aims to reduce the incidence, prevalence, and recurrence of mental health disorders and their associated disability. Preventive interventions are based on modifying risk exposure and strengthening the coping mechanisms of the individual.[5] Effective interventions require the identification of causal risk factors[6] and can target both generic risk factors, which are likely to be shared by different disorders, and disease-specific factors. Most involve a combination of stra to risk factors, enhancing pro putative mediating causal me schemas or neurotransmi preventive interventions in factors and promote mental h clinically diagnosable mental could target a whole popula risk (universal prevention), a at increased risk for m prevention), or individuals al clinical manifestations (indi provides an overview of the interventions in mental hea This Review will focus mo interventions.

Risk factors increasing vulne

Mental disorders have diffe with pathogenic genetic

Key messages

- Increasing evidence support selective preventive interve wellbeing and prevent ment development
- Indicated prevention in indi manifestations of vulnerabi trajectories towards less deb the onset of severe mental
- Ethical and safety considera implementation of preventi health, especially in young
- Mental health professionals prevention into their daily p cooperation with other spec obstetrics, and paediatrics) a social services) to increase a for preventive interventions

	Population	Aims	Examples
Mental health promotion interventions	General public or whole population	Promote psychological wellbeing and increase the ability to achieve developmental milestones. Strengthen abilities to adapt to adversity and build resilience and competence	School-based programmes to foster healthy eating or positive coping skills
Universal primary preventive interventions	General public or whole population, regardless of individual risk factors	Target risk factors in the whole population to prevent the development of one or more conditions. Interventions should be effective, safe, and associated with low costs	School-based programmes to prevent bullying
Selective primary preventive interventions	Individuals or subpopulations with a higher than average risk of developing mental disorders; identification of at-risk groups might be on the basis of biological, psychological, or social risk factors	Target risk factors and strengthen abilities in these individuals or subpopulations to prevent the development of one or more conditions. Interventions should be effective and associated with low risk of adverse events and moderate costs	Interventions in the offspring of patients with severe mental disorders
Indicated primary preventive interventions	Individuals at high risk with early minimal but detectable clinical manifestations, but currently not meeting diagnostic criteria	Treat subclinical manifestations to prevent transition to the full-blown disorder. Target risk factors and strengthen abilities in these individuals to promote resilience. Interventions might be associated with higher costs and some risks can be accepted	Interventions in people at clinical high risk for psychosis (ie, showing attenuated psychotic symptoms and a recent decline in functioning)
Secondary preventive interventions	Individuals meeting diagnostic criteria in the early stages of illness	Early detection and intervention in patients already meeting diagnostic criteria for a specific mental disorder. Provide adequate treatment, improve satisfaction with treatment, reduce substance use, and prevent relapses	Interventions to improve early detection and access to services in patients with depression to reduce the duration of untreated depression
Tertiary preventive interventions	Individuals with established illness	Treat established disease to prevent deterioration, disability, and secondary conditions	Interventions for smoking cessation or cognitive remediation in patients with schizophrenia. Prevention of suicide with lithium in patients with bipolar disorder

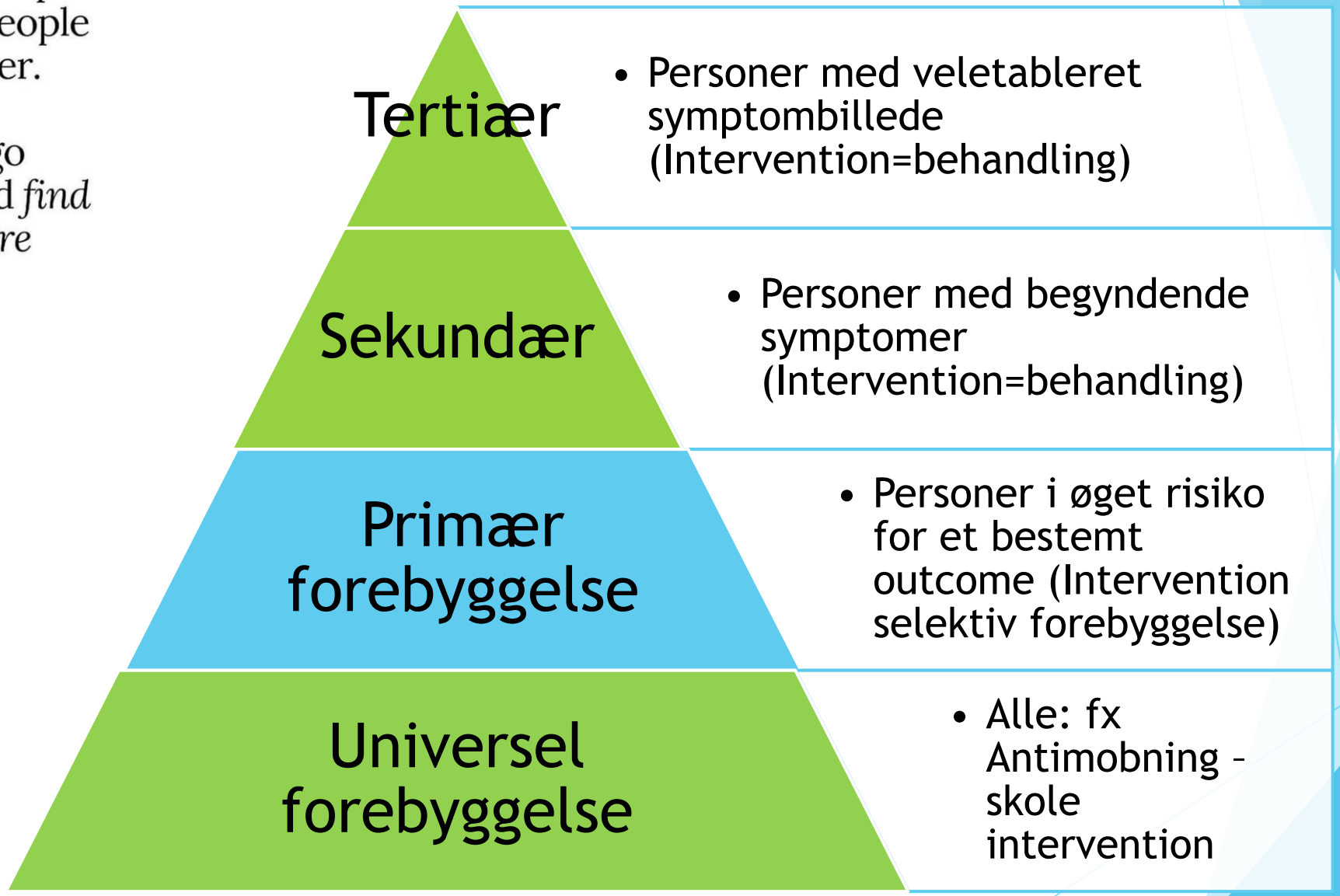
Some overlap exists between indicated primary preventive interventions and secondary preventive interventions. Universal primary preventive interventions will frequently use mental health promotion strategies.

Table 1: **Preventive interventions in mental health**

We need to stop just pulling people out of the river.

We need to go upstream and *find out why they're falling in.*

-Desmond Tutu

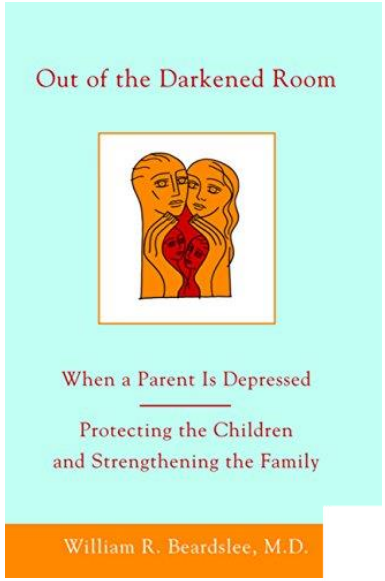


SAFIR

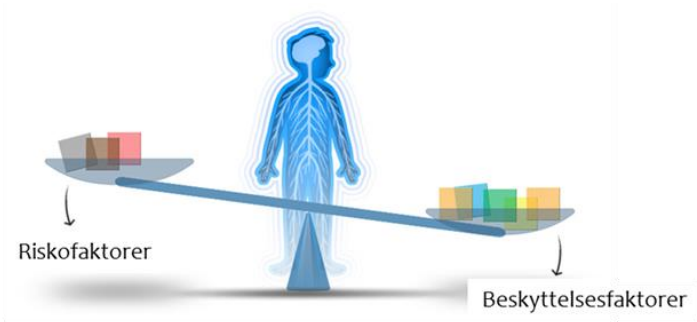
Family Talk

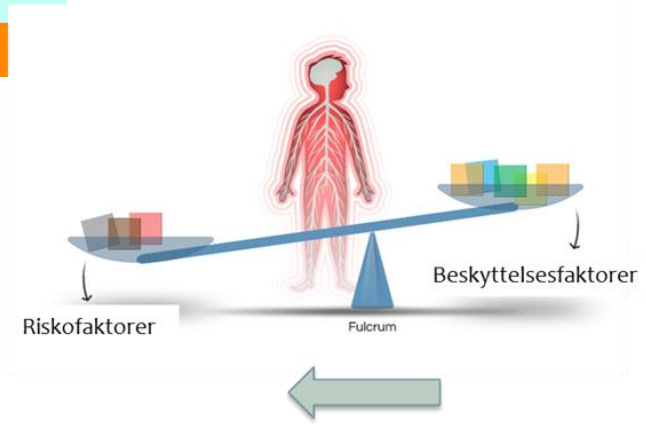
Et randomiseret klinisk studie af effekten af samtaleforløb for familier, hvor en forældre har psykiatrisk sygdom

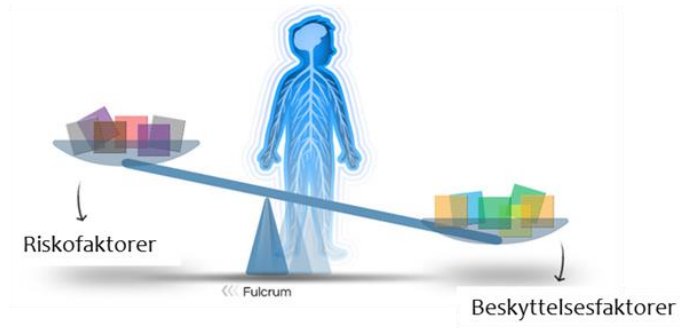
Grundlæggeren af Family Talk



William R. Beardslee, M.D.
Harvard Medical School







The National Scientific Council on the Developing Child, 2015

Inklusionskriterier: Patienter med børn 8-17 år. Alle diagnoser.

SAFIR TRIAL

TrygFonden

Family Talk Preventive Intervention

William R. Beardslee

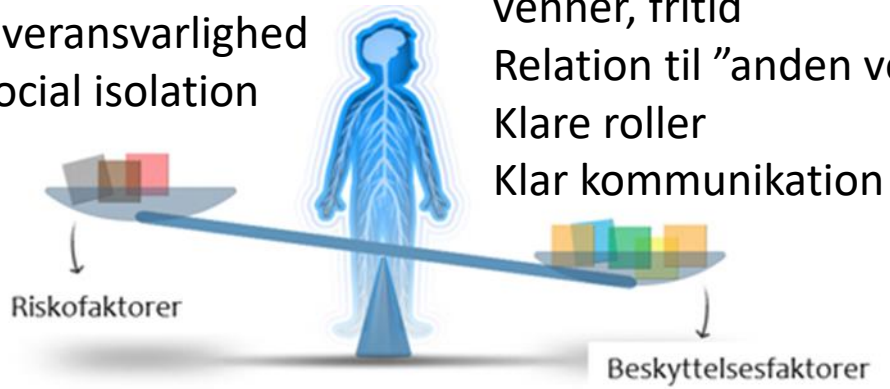
MÅL

AT REDUCERE

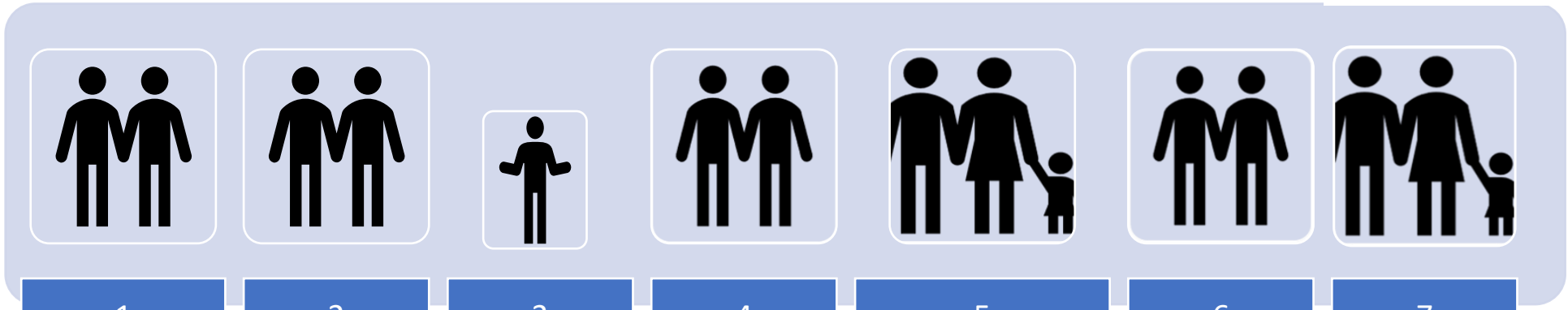
Konflikter i familien
Utryghed
Skyldfølelse
Overansvarlighed
Social isolation

AT STYRKE

Familiens funktion
Forældrekompetencer
Fokus på barnets behov
Barnets funktion/trivsel: skole, venner, fritid
Relation til ”anden voksen”
Klare roller
Klar kommunikation



Family Talk sessioner

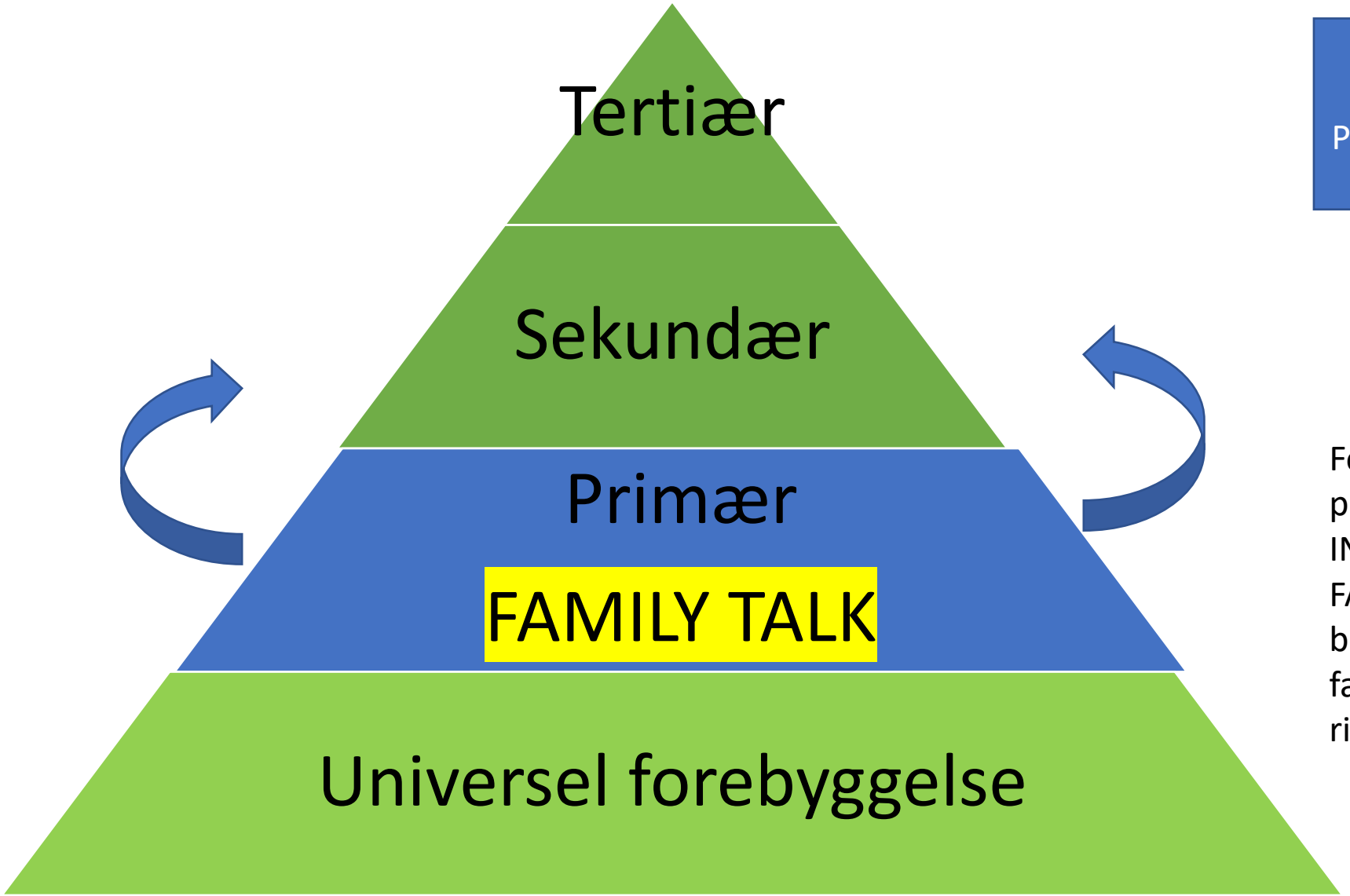


1	2	3	4	5	6	7
Forældre Psykisk sygdom og familie	Forældre Barnets situation	Barnet Barnets oplevelse	Forældre Plan for Familie-møde	Børn og forældre Familiemøde	Follow-up 1 måned	Follow-up 4 måneder

Patienter med børn 7-17 år. Alle diagnoser.

Evidens for Family Talk

- Beardslee, 2007. N=100. Lecture group vs Family Talk. 4,5 years follow-up. FT. effect on: Parents' child-related behaviors (e.g., increased talking with children about depression) and attitudes (e.g., increased awareness about risk and resiliency in children). Effect size = 0.84 Children's understanding of mental illness. Effect size=0.33
- Solantaus, 2010. N=106. Two conversations about child vs FT. Effect on SDQ, internalization at 4 months follow-up.
- Pihkala, 2010 Qualitative studies: "The children perceived more openness in the family. Because of more knowledge, understanding and talking within the families, sense of closeness to each other increased."



Intervention:
Søger at styrke beskyttende faktorer og minimere risikofaktorer

ENDPOINT=
Psykisk sygdom

Forskning: Måler på INTERMEDIERE FAKTORER beskyttende faktorer og risikofaktorer

SAFIR TRIAL

Families where a parent is treated at Mental Health Center in Capital Region of Copenhagen

Inclusion criteria: Patient's child aged 8-17 years. All parental psychiatric diagnoses are included

Excluded

- Not meeting inclusion criteria
- Meeting exclusion criteria

Inclusion in SAFIR-trial , baseline assessment and randomization(n=286)

Randomized to treatment as usual (TAU) N≈143)

Intervention

Randomized to Family Talk (N≈143)

4 months post treatment assessment

Follow-up

4 months post treatment assessment

12 moths follow-up assessment

12 months follow-up assessment

The hypothesis

SAFIR-Family Talk (S-FT)= Family Talk for all parental diagnoses

The hypothesisis that S-FT is superior to TAU with regard to

- Improving the child's functioning and emotional wellbeing
- Improving family functioning and wellbeing in the family
- Improving communication in the family
- Improving parents' feeling of parental competence and recovery in the role of parenting
- Reducing prevalence of mental illness among the children in the long-term
- Identifying children who need additional services (Child psychiatrist Prof Anne Thorup as consultant)

Visioner for fremtidige studier og behandlinger

- Børn i **ALLE** aldre (0-17 år)
- Børn af forældre med **ALLE** diagnoser (kontakt med sekundær sektor indenfor de sidste tre år)
- 2-årig tilknytning til ***tværfagligt, specialiseret team***

grundpakke

GRUNDPAKKE

Kontaktperson til koordinering af al kontakt (tværfagligt team)

Psykoedukationsforløb (Family Talk)

Forældretræningsprogram (Triple P)

Parterapi/partnerstøtte

Tidlig børne-unge psykiatrisk indsats

Peer-support elementer (tbd)

Altid KUN de elementer der passer familiens aktuelle behov og motivation, børnenes alder og mindste middels princip

Instrumenter I SAFIR

Samlet tid ca 1,5 time

Barnet

Instrument	Metode	Emne
C-GAS	Interview	Funktionsniveau
Beck's Youth Inventory	Spørgeskema	Screening psykopatologi
CYRM	Spørgeskema	Resiliens
GSQ-AMPI	Spørgeskema	Skyld og skam ifht. forældre
Forældre-barn kommunikation	Spørgeskema	Kommunikation mellem forældre og barn
KIDSSCREEN	Spørgeskema	Livskvalitet
SDQ	Spørgeskema	Styrker og vanskeligheder
Family assessment device	Spørgeskema	Familiefunktion
COPMI spørgsmål	Spørgeskema	Børnenes bekymring for forældre og tanker om psykisk sygdom
Reaktion på forældres humør	Spørgeskema	Barnets reaktion på forældres humør
Evaluering før/efter	Spørgeskema	Positive og negative effekter af indsats

Forælder

Instrument	Metode	Emne
C-GAS	Interview	Barnets funktionsniveau
PSP	Interview	Forælders egen funktionsniveau
GAF -S	Interview	Forældres eget symptomniveau
SDQ	Spørgeskema	Barnets styrker og vanskeligheder
Forældre-barn kommunikation	Spørgeskema	Kommunikation mellem forældre og barn
PSOC	Spørgeskema	Kompetence omkring forældrerollen
SDQ	Spørgeskema	Styrke og vanskeligheder
FAD	Spørgeskema	Familiefunktion
Evaluering før/efter	Spørgeskema	Evaluering udviklet af Family Talks forskere
Negative effects questionnaire	Spørgeskema	Negative effekter af indsats

Andre mål

Datakilde	Oplysninger
Styrelsen for IT og læring	Fravær fra skole
Styrelsen for IT og læring	Trivsel i skolen
Forældre	Modtaget RHPs familiesamtale
Forældre	Modtaget andre tilbud
Forældre	Diagnose hos barn