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RESEARCH PAPER

# Digital Psychoeducational Programs for Children and Families Living with Parental Mental Illness: A Scoping Review

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**ABSTRACT**

The present scoping review aims to map digital psychoeducational programs for children and families with parental mental illness to identify significant gaps in the existing literature and inform future programs. We systematically searched studies including digital psychoeducational programs/interventions targeting children and families affected by parental mental illness using platforms, e.g., PubMed, Scopus, PsycINFO, etc. The review was reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR). The information was plotted and synthesized based on population, concept, and context criteria (PCC). This review included sixteen studies based on nine peer-reviewed publications, two research protocols, and five grey literature sources. The studies were reviewed for the type of materials used, modality, content, format, and details of sessions. Digital psychoeducational programs used in these studies have shown improvements in mental health literacy, child and family communication, coping, and a decrease in stigma. This scoping review notes that digital psychoeducational programs could benefit children and families with parental mental illness. Yet, it is essential to conduct large-scale, comparative, and longitudinal studies using effective digital psychoeducational resources and platforms addressing the local needs of affected children and families across the globe.

**Keywords:** Review, Psychoeducation, Parental Mental Illness, Families

## Introduction

Parental mental illness (PMI) affects millions of families across the world and is linked to more psycho-social, and other developmental difficulties in children (Gatsou et al., 2016; Grant et al., 2024). Further, children with PMI frequently experience impairments in academic (Lui, 2015) and social functioning and poor quality of life (Radicke et al., 2021). The adverse impact of PMI is lifelong, and if not intervened upon, may result in psychopathological outcomes during adulthood (Kamis, 2021), increasing the burden on families and mental health systems (Isobel et al.,2021; Perich & Andriessen, 2024). Studies have shown that having a parent or family member diagnosed with mental illness causes social isolation and shame for the rest of the family members, mainly including children and caregivers who face personal and societal stigma (Koschorke et al., 2017; Hine et al.,2023). Stigma around mental illness is greater in the Global South, including Pakistan (Javed et al., 2021; Campbell & Patrick, 2023). Family stigma not only hinders help-seeking but also cause maladaptive coping in children, thus lead to transfer of suffering across generations (Reupert et al., 2021).

Inadequate knowledge about mental illness is among the main reasons for ongoing negative impact, ineffective coping, and risk of transmission in families of PMI (van Houtum et al., 2024). Children of PMI often are unaware of their parents' mental health condition. According to a British survey, nearly 50% of parents in the general community do not

discuss mental health problems or disorders with their children (Reedtz et al., 2019). Inadequate knowledge may lead to misinformation and worries. The adverse outcomes for families and children with PMI can be reduced by protective factors and selective interventions (Van Schoors et al., 2023).

These preventive and supportive programs enhance healthy family communication, positive parent-child relationships, and supportive connections (Wansink et al., 2015; Furlong et al., 2021). Therefore, a variety of interventions are used with families and children with PMI aimed at solving families' communication problems, improving parenting skills, fostering resilience, lowering children's feelings of shame and guilt, and increasing their understanding of their parents' struggles (Van Santvoort et al., 2014; Grové et al., 2015; Gellatly et al., 2019). They also tend to encourage prosocial behavior in children with PMI (Reedtz et al., 2019). Despite the encouraging results presented by the preventive interventions implemented in reducing the risk of psychopathology and enhancing resilience in children of PMI, most of the interventions have been provided in the traditional, face-to-face mode.

Most recently, digital interventions have emerged as an interesting alternative in the field of mental health service delivery (Philippe et al., 2022). As the world transforms to digital mental health, these approaches have become especially significant as society acknowledges the need for reachable and evidence-based support of vulnerable groups (Leah et al., 2024; Maqsood et al., 2024). Therefore, digital psychoeducational programs delivered through digital modes, e.g., web-based, mobile applications, e-learning software, DVDs, or online interactive forums (Bevan et al., 2024), which are associated with geographically and socio-economically public accessibility, enhanced scalability, and a chance of lowering stigma as the children and family members can attend remotely and anonymously (Bond et al., 2023). Furthermore, it also lessens the burden on mental health care systems in low- and middle-income countries by reducing the financial costs of travelling to major cities with families and minimizing interruptions to routine matters (Karyotaki et al., 2023).

Past reviews on interventions with families and children of PMI have emphasized in-person preventive initiatives, excluding the importance of digital psychoeducational programs (Thanhäuser et al., 2017; Lannes et al., 2021; Furlong et al., 2021; Tapias et al., 2021; Stark et al., 2022). Given the increasing rate of children and families of PMI and the probabilities of adverse developmental outcomes posed to them, this scoping review aims to provide a comprehensive overview of the existing data regarding digital psychoeducational programs and interventions designed to support families and children with PMI. The present review charted existing digital psychoeducational programs that are available for children and families lived with PMI to describe the characteristics, features as well as present a narrative synthesis of previous assessments and their conclusions.

## Material and Methods

We adhered to the 5-step approach for scoping review derived from Levac et al., (2010), who modified and expanded the structure of the framework created by Arksey, (2005). Stakeholder consultation as an optional sixth step was not pursued because the emphasis of this review was on the synthesis of the existing literature. In the sections that follow, each process is explained in detail.

### Step 1: The Research Questions

An iterative method based on exploratory literature searches, a scrutiny of specific terms and concepts, and thematic dialogs among the team members resulted in the research questions. This team has been working with youth and families affected by PMI in Punjab, Pakistan, for the last three years in a research project funded by the Higher Education

Commission of Pakistan through the World Bank's Grand Challenge Fund grant in 2021 (Khawar et al., 2024; Khawar et al., 2025).

1. Which digital psychoeducational programs/interventions are developed for families and children suffering from PMI?
2. What are the main characteristics of these programs?
3. What kind of content is covered, and which methodologies are mostly used in these programs?
4. Which assessments were carried out to determine the outcome and efficacy of the programs, and what conclusions did they draw?

**Step 2: Determining Relevant Studies**

The systematic search was performed in May 2025, and updated in July 2025, in six databases (Scopus, PsycINFO, MEDLINE, ASSIA, Embase, ProQuest) and the search engine Google Scholar. The search strategy was planned in teamwork with a skilled research librarian and concentrated on three topics, including PMI, children and family, and digital mental health education. The keywords in these areas were contrasted with Boolean operators (OR, AND), irrelevant searches (e.g., psychotherapy without psychoeducation) were removed, and those studies that were not based on families and children with mental illness were also removed. To identify more relevant papers, grey literature and the reference lists of the included research were also examined. Records that were retrieved were imported into Zotero to be managed and deduplicated. The review was registered on the Open Scientific Frameworks (https://osf.io/kf9bs/).

**Step 3: Selection of Study**

The records retrieved from the database search were uploaded into Rayyan (2016), an online platform intended for numerous reviewers to liaise on reviews. Further, the Population, Concept, and Context (PCC) principle was used to describe the inclusion and exclusion criteria (Tricco et al., 2020).

*Population:* Studies that reviewed or described a program for parents with a diagnosis of mental illness. The programs could be parent-focused, child-focused, or family-focused. For this search, children of PMI, COPMI, offspring of PMI, PMI, families living with PMI, and parents having a psychological disorder were used as key words. The age range of children is between early childhood and young adulthood (3-25 years). These children's parents had to have at least one parent diagnosed with a mental illness.

*Concept:* Psychoeducation is an organized, education-focused intervention that increases knowledge about mental illness (Sarkhel et al., 2020) by offering details about disorders, facilitating communication, problem-solving, and emotional regulation (Colom et al., 2006). According to WHO (2018), mental health policy considers a program as a specific intervention, prevention, or treatment initiative, usually conducted at a smaller scale. The concept of a digital psychoeducational program can be interpreted in the sense of an intervention, providing psychoeducation using digital technologies, for example, web-based, mobile applications, e-learning software, DVDs, or online forums (Torous & Keshavan, 2020; Barry et al., 2019). Therefore, programs that involved psychoeducation with or without therapeutic interventions, and those including elements of clinical guidance or support, were included. In this regard, peer-reviewed published papers, study protocols, and grey literature were taken into consideration. Grey literature in this review refers to information available through online resources such as dedicated websites and platforms for COPMI and families. Psychoeducation, psychoeducational intervention, psychoeducational program, family intervention, and mental health literacy intervention were the key words used to identify the relevant programs. Interventions that only involved face-to-face, print, or broadcast were excluded.

*Context:* This review considered programs that implemented a psychoeducational approach in digital environments. Such digital settings that qualified were online platforms, mobile applications, web resources, online discussion forums, and social media groups, so long as it provided a meaningful interaction or communication among the users. Both structured online programs and clinician-moderated platforms, as well as informal information exchanges such as peer-support forums were considered. Programs that were originally face-to-face but adapted into digital formats (e.g., online workshops conducted during COVID-19) and blended or in-person with an online option were included. Additionally, the mode of delivery was specified using keywords, e.g., digital, web-based, online, e-health, mobile app, internet-based, and virtual. Reviews, abstracts, and posters were not used.

The present review included articles that were published in the English language. We considered manuscripts and literature published in the past fifteen years (January 2010 to July 2025). This duration is marked by rapid technological advancements resulting in a shift from traditional to digital modes of mental health service delivery across the world for a variety of affected populations (Stark et al., 2022).

**Step 4: Charting the Data**

The data were extracted with the help of the structured method that is frequently used to manage scoping reviews (Arksey & O'Malley, 2005; Levac et al., 2010; Tricco et al., 2018). The authors identified essential information and study characteristics to be presented in tables according to the pre-determined criteria. Grey literature materials were also plotted together with peer-reviewed articles to have a complete picture of the available digital psychoeducational programs. The final data charting included three tables (Tables I-III) based on the main characteristics of the studies, description of psychoeducational methods and features, and depiction of assessment methods and outcomes of studies.

**Step 5: Gathering, Compiling, and Presenting the Outcomes**

In accordance with Levac et al., (2010) this phase was separated into three phases. Initially, we conducted a descriptive examination of the studies, presented in the first table showing citation, program name, journal/publisher, country, study design/source type, and population/sample. Second, we described the features and procedures of psychoeducational programs, including the types of material and modalities used, content, format, and session details. Third, we discussed the assessment methods, reported outcomes, efficacy, and limitations of the programs. We did not critically evaluate the included publications' methodological quality because the purpose of this scoping review is to offer a broad picture of the field of research, not to assess the efficacy of the interventions.

**Results and Discussion**

**Screening and Inclusion of the Studies**

A total of 1,230 records were searched on databases and gray literature. After removing 467 duplicate archives, the number of records remained 763. Two reviewers screened these records using the title and the abstract. Out of this, 590 records were filtered out, and only 173 full-text articles were studied in detail. After the full-text screening, 127 articles were removed, leaving 46 articles initially eligible. The subsequent reference screening and snowball searching eliminated 30 other studies because of overlaps, missing protocols, and failure to satisfy the digital psychoeducational criteria, eventually including 16 studies (9 peer-reviewed articles, 2 research protocols, and 5 grey literature reports). This scoping adheres to the PRISMA-ScR (Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews) checklist's reporting requirements (Peters et al., 2020).

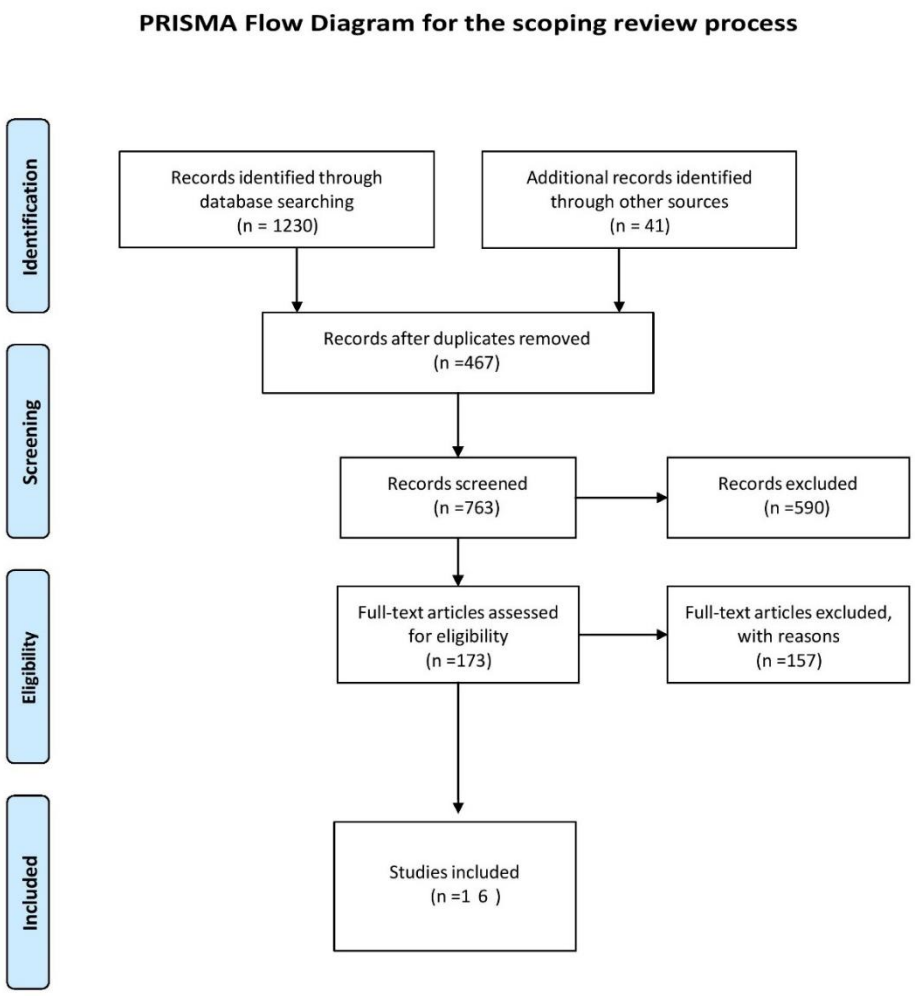


Figure 1 Flow diagram of identification of reports

**Table 1**
**Basic Characteristics of the Studies**

| Study ID | Citation | Program | Country | Study Design/ Source Type | Population/The Sample |
|---|---|---|---|---|---|
| DPP1 | Woolderink et. al., (2010) | KOPSTORING | Netherlands | Randomized Controlled Trial (Two-arm, parallel-group) | Young Adult (16-25) years of PMI n= 214 |
| DPP2 | Zanden et al., (2010) | KopOpOuders Intervention | Netherlands | Pilot Study with Pre–Post Design (Single Group) | PMI n=94 Parents |
| DPP3 | Drost & Schippers, (2013) | Survival Kid | Netherlands | Single-Case Study | Young adults (12–25 years) of PMI |
| DPP4 | Trondsen and Tjora, (2014) | Online Self-Help Group for Adolescents | Norway | Qualitative Descriptive Study | Adolescents (15-18 years) with PMI n=13 |
| DPP5 | Widemalm & Hjärthag, (2015) | The Forum as a Friend | Sweden | Qualitative Content Analysis | Adolescents and young adults (12-25 years) with PMI |
| DPP6 | Grove et al. ,(2013) | Family Focus Intervention | Australia | Mixed-Methods Pre–Post Study (Single Group) | Children (8-12 years) with parents diagnosed with depression or anxiety n=29 children |

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|---|---|---|---|---|---|
| DPP7 | Elgán et al., (2016) | Grubbel | Sweden | Randomized controlled trial study protocol, Multi-center two-arm study. | 15- 25 years old young adults of PMI n=140 Treatment n=90 Control n= 50 |
| DPP8 | Jones et al., (2017) | Web-based Integrated Bipolar Parenting Intervention (IBPI) | UK | Randomized Controlled Pilot Trial (Two-arm) | Parents with bipolar disorder, children between 3 and 10 years old n=97 parents |
| DPP9 | Reupert et al., (2020) | mi.spot | Australia | Single-Group Pre–Post Study | Youth (18-25 years old) of PMI n=31 adolescents |
| DPP10 | Moltrecht et al., (2024) | Kids Time | UK | Qualitative Evaluation | Parents and children (8-18) living with PMI n=22 families |
| DPP11 | Dülsen et al., (2025) | iCHIMPS | Germany | Cluster-Randomized Controlled Trial (cRCT) with two arms, study protocol | Adolescents (12–18 years) living with at least one diagnosed with PMI n = 22 |
| DPP12 | Australian Kookaburra Kids Foundation (AKKF), (n.d.) | Online Kookaburra connect | Australia | Grey Literature | Children and Adolescents (8-18) of PMI |
| DPP3 | Emerging Minds, (n.d.) | Emerging Minds | Australia | Grey Literature | Families, children, and professionals of PMI |
| DPP14 | Helping Minds, (n.d.) | COPMI WA | Australia | Grey literature | Families of PMI |
| DPP15 | Illawarra Shoalhaven Local Health District, (n.d.) | COPMI booklet and web resource hub | Australia | Grey Literature | Families of PMI |
| DPP16 | Health Direct Australia, (n.d.) | COPMI | *Australia* | Grey literature | Families, children, and professionals of PMI |

Note: DPP=Digital Psychoeducational Programs

**Table 2**
**Description of Psychoeducational Methods and Features**

| STUDY ID | Type of Materials and Modalities | Content | Format | Session Details |
|---|---|---|---|---|
| DPP1 | Web-based modules with secured online chat boxes and downloadable materials | Themes about mental health issues, understanding home environment, recognizing various cognition & social networks and focusing on self-growth | Structured & individualized | 8 group sessions, 90 min/week, with 4-5 people in each group, with one booster session. Sessions based on peer-talk, self-reflection and homework task |
| DPP2 | Online modules with secured group chat forums, manual, and homework tasks | Understanding different parenting skills, emergency plans, and protecting your gains | Structured | 8 weekly 90-minute online meetings and sections to post facilitator material, e.g. videos and agendas, outlines |
| DPP3 | Web-based text module with asynchronous chat forums, interactive and visual materials | Understanding mental illness, problem solving and social interaction | Unstructured | Self-paced sessions, Activities included quizzes, self-reflection and interactive tasks |

| | | | | |
|---|---|---|---|---|
| DPP4 | Internet based asynchronous discussion forum | Understanding PMI, regularizing distress, and peer-talk | Unstructured | Online self-help group of peer discussion |
| DPP5 | Asynchronous peer-to-peer chat led in publicly 5 online discussion forums | Understanding PMI, stress management, and discussing open assess healthcare system | Unstructured | Based five Swedish forums with 35 thread and 301 comments on it, where participants post their personal stories |
| DPP6 | A DVD was giving for home or personal multimedia use | Situations of various families and the impact of PMI on children and on family relationships | Unstructured | The participants could view the DVDs at their own free time, at the convenience of multimedia devices |
| DPP7 | Web-based modules delivered in an online chat meeting and providing interactive exercises | Understanding mental health issues, personal issues and family roles. And managing personal life in relation to social media | Structured | 8 online chat sessions, lasting 90 minutes and a follow-up. Activities including peer discussions, creative activities, including role-play, storytelling, journaling |
| DPP8 | Web-based module that is self-paced, includes audio, videos, and downloadable tasks | Eight-module including: psychoeducation about bipolar disorder, self-awareness and mood monitoring | Structure | 1week module on 16 weeks. The activities will involve self-reflection exercises, mood monitoring, and exercises to improve emotions regulation |
| DPP9 | Online material presented in live discussion forms and activity sheets | Mental illness literacy, understanding family relationships and stress management | Structured | 6 sessions for 1 hour, with exercises between sessions that incorporate a self-assessment and progress tools provided online, and peer discussion |
| DPP10 | Online and blended workshops on activity-based modules | Mental illness literacy, traumatic childhood experience and role-playing of familial roles | Structured, Age-appropriate groups sessions through ZOOM | 6-month program for 12 families included psychoeducation, shared meals and creative activities, with second parent support groups. Cohort 1 was fully online, while cohorts 2–3 joint select face-to-face & online sessions |
| DPP11 | Online modules with asynchronous mode providing videos, animations, and interactive activities | Understanding personal circumstances and strengths, psychoeducation, enhancing social and familial bonds and managing stress | Structured | 8-week course, with 1 module per week, utilizing multimedia tools, videos, animations, reflective tasks, and homework |
| DPP12 | Hybrid model of in-person camps/workshops and online | Enhance belonging, mental health literacy, promote safe help-seeking | Structured | Online twice in a week. Interactive sessions provide a safe online space to connect, share experiences, and engage in planned activities |
| DPP13 | Training modules, and toolkits, are available on the website that is downloadable | Online resources and programs increase mental health literacy, and early prevention for children and families | Unstructured | Self-paced learning involved readings, videos family discussions, and facilitator support |

| | | | | |
|---|---|---|---|---|
| DPP14 | Workshops and conducted in a hybrid format (face-to-face and online) | Mental health literacy, coping skills, and resilience building | Structured | Online workshops are delivered by professionals, featuring planned activities, peer discussions, and skill training |
| DPP15 | Website-based materials and downloadable booklets | Mental health literacy, coping strategies, and available support services for families affected by PMI | Unstructured | Self-paced, downloadable textbooks and Visual materials |
| DPP16 | Web-based information and suggests helpline to referral services. | Promoting children's mental health, reducing stigma and teaching coping skills | Unstructured | Self-paced, where participants select and use resources |

Note: Type of Materials and Modalities = delivery resources (manuals, modules, booklets, online/blended or hybrid); Content = key themes (e.g., mental illness literacy, coping, parenting); Format = delivery style (group, individual, self-guided); Session Details = number, duration, frequency, and main activities.

**Table 3**
**Assessment, Outcome, and Barriers of the Studies**

| STUDY ID | Assessment Tools | Reported Outcomes | Barriers |
|---|---|---|---|
| DPP1 | Youth Self-Report (YSR), EuroQol (EQ-5D), Credibility/Expectancy Questionnaire (CEQ). Assessment was taken at Baseline, 3, and 9 months | Reduction in internalizing and externalizing problems | Internet issues, lack of emotional connectedness and the requirement for training |
| DPP2 | Study-created questionnaires, Self-Perception Profile for Children (SPPC), The Dutch Parent Child Interaction Questionnaire, Strengths and Difficulties Questionnaire (SDQ): administered at baseline, 3 months, post-test, and after 5-6 months | Improvement in parenting competence. But no significant improvement was noted in the children's behavior | Short timeframe study, based on single informants (parent or child), and mostly included children |
| DPP3 | Qualitative analysis of the participants' interviews conducted at the end of the study | Increased mental illness literacy, improved coping skills, developed emotional regulation | Lack of proper remarks from the facilitator, and no quantitative inquiry |
| DPP4 | Qualitative thematic analysis of the forum post | Emotional distress is decreased and reduces the feelings of loneliness | Participants were not personally linked and inadequate guidance |
| DPP5 | Qualitative content analysis to interpret the forum discussion | Increased emotionally supportive and information on PMI, reducing stigma and caregiver burden | Lack of emotional attachment due to anonymity and reluctance to discuss personal experiences |
| DPP6 | Children's knowledge scale of mental illness, Help-seeking behavior, and semi-structured interview | Increased mental illness literacy, reduced stigma, and improved feelings of empowerment | The functionality of DVDs is not long-lasting |
| DPP7 | The Center for Epidemiological Studies Depression Scale for Children (CES-DC), the Brief COPE, the World Health Organization's Quality of Life Questionnaire (WHOQOL-BREF), the Alcohol Use Disorders Identification Test (AUDIT-C), the Ladder of Life, and the Youth Self-Report (YSR) questionnaire Baseline was done after 3 months, 6 and 12 months of follow-up after | Will improvement in mental health literacy, coping skills, and building resilience | Recruitment via Facebook ads may have introduced selection bias |

| | | | |
|---|---|---|---|
| DPP8 | Strengths and Difficulties Questionnaire (SDQ), Parenting skills, and confidence. Assessment is done at baseline, 16, 24, 36, and 48 weeks of follow-up | Child behavior, parental stress, and parenting sense of competence improved | Small sample and logistical issues |
| DPP9 | The Mental Health Continuum short form (MHC-SF) and the depression, anxiety, and stress scale (DASS-21). Per and post assessments are taken | Significant gains in coping, social connection and well-being. However, no improvement in general help-seeking behavior | Lack of generalizability due to female sample |
| DPP10 | Semi-structured interview and focus group data were analyzed through thematic and content analysis | Increased social relationships and family relationships | Logistic problems, parents hesitate for their children involvement. |
| DPP11 | Youth Self-Report (YSR 11–18R), World Health Organization (WHO-5), Oslo Social Support Scale (OSSQ-3), Brief Coping Orientation (Brief COPE), and Rosenberg Self-Esteem Scale (SES). The measurements were done at baseline, 1st , 2nd, and 6 months | Expected outcomes are better health, coping, and family communication | Low recruitment and family engagement may reported |

Note: Assessment tools = instruments used (e.g., questionnaires, interviews); Reported outcome/status = main findings (e.g., improved knowledge, reduced distress); Barriers = challenges (e.g., stigma, low attendance, technical issues).

## Basic Characteristics of the Studies

The number of identified studies and program descriptions was sixteen, including peer-reviewed as well as grey sources. A majority of the empirical researches were conducted in high-income nations, especially the Netherlands (Woolderink et al., 2010; Zanden et al., 2010; Drost and Schippers, 2013), Australia (Grove et al., 2013; Reupert et al., 2020), the United Kingdom (Jones et al., 2017; Moltrecht et al., 2024), and other European settings such as Sweden (Widemalm & Hjarthag, 2015; Elgan et al., 2016). The studies included represented a variety of research designs, such as randomized controlled trials (Woolderink et al., 2010; Elgan et al., 2016; Dulsen et al., 2025), mixed-method or pre-post studies (Zanden et al., 2010; Grove et al., 2013; Reupert et al., 2020) and qualitative study design (Trondsen and Tjora, 2014; Moltrecht et al., 2024). The population was mainly the children; the adolescents and young adults aged between 8-25 years who were living with a parent with a mental illness. Fewer of the interventions were oriented towards parents themselves, and usually had a preventive/psychoeducational theme (Zanden et al., 2010; Jones et al., 2017). Further, digital/web-based formats including KOPSTORING, KopOpOuders, and mi.spot were used in several studies, which points to the increased adoption of web-based mental-health-delivery platforms (Woolderink et al., 2010; Zanden et al., 2010; Reupert et al., 2020). Besides peer-reviewed articles, grey literature such as the ones published by HelpingMinds, Healthdirect Australia, and the Australian Kookaburra Kids Foundation mentioned programs and resources hubs provided by the community in supporting families of parents with mental illness (Helping Minds, n.d.; Healthdirect Australia, n.d.; Australian Kookaburra Kids Foundation, n.d.). All these findings together are indicative of a biased representation of evidence in the Western settings and the prevalence of digitally-based, family-oriented psychoeducational models.

## Description of Psychoeducational Methods and Features

In the reviewed literature, digital psychoeducational initiatives took different formats, content, and delivery. The majority of them were web-based courses with interactive lessons and online discussions and downloadable resources, whereas other include supplementary multimedia elements, including videos and audio materials, to improve user engagement (Woolderink et al., 2010; van der Zanden et al., 2010; Elgan et al., 2016). Peer communication and support was encouraged in asynchronous forums, and

multiple grey-literature sites provided open toolkits and self-help resources with no empirical validation (Emerging Minds, n.d.; HelpingMinds, n.d.). Some of them were hybrid models that incorporated online course content with minimal in-person training (Moltrecht et al., 2024).

Mental health literacy, stigma management, and coping abilities were mostly covered in the program content, and some of the programs expanded to parenting competence and family communication (Jones et al., 2018; Reupert et al., 2020). Children and families were approached through creative and experience methods like storytelling, role-play, and journaling (Drost & Schippers, 2015). The duration of structured interventions was usually 6-8 sessions per week of 60-90 minutes, and the self-paced design had flexibility of access but fewer instructions

**Assessment and Evaluation of Digital Programs**

Different standardized and qualitative instruments were employed to evaluate digital psychoeducational programs in studies. The most common measures were YSR, SDQ, and DASS-21 of child and youth outcomes, and the WHOQOL-BREF and EQ-5D of well-being (Woolderink et al., 2010; Elgan et al., 2016; Dulsen et al., 2025). Parental relationships and parental functioning were assessed in terms of Parenting sense of competence (van der Zanden et al., 2010; Jones et al., 2018). in qualitative studies interviews and analysis of forums was used to investigate experiences and grey literature depended on descriptive feedback. In general, the results showed a better quality of coping, emotional regulation, and family communication, low levels of stress and stigma (Reupert et al., 2020; Trondsen and Tjora, 2014). Stigma, however, revealed that not all of the programs had significant change in emotional outcomes (van der Zanden et al., 2010).

Nevertheless, studies had positive effects, but noted technical barriers, low levels of engagement, small samples, and brief follow-ups (Elgan et al., 2016; Dulsen et al., 2025). The lack of facilitator support and fear of being stigmatized also limited the participation. Grey literature sources were not empirically validated and thus one could not make firm conclusions that they are good.

**Discussion**

This scoping review represents a synthesis of digital psychoeducational programs and interventions that are created purposefully to help children and families exposed to vulnerable conditions as a result of parental mental illness. Generally, digital platforms have emerged as supporting platforms for enhancing access, minimizing stigma, and providing support that might not have been achievable with traditional resources (Rodríguez-Rivas et al., 2022).

The majority of the interventions have been designed in the Western countries (Woolderink et al., 2010; Trondsen and Tjora, 2014; Elgan et al., 2016; Jones et al., 2018; Moltrecht et al., 2024; Dulsen et al., 2025), where the mental health systems are well-established. This localized concentration signifies an imbalance in equity because families residing in low- and middle-income environments, with typically greater demands, are not part of this awareness. The range of methods used in the studies was mixed-methods designs, pilot trials, and RCTs, which offered data on efficacy and contextual insight (Drost and Schippers, 2015; Reupert et al., 2020). Nevertheless, limited samples, short-term follow-ups and methodological dissimilarities restrict the generalizability and long-term conclusions. Better evaluation systems are required in order to detect effective program components and populations.

Programs using interactive strategies (storytelling, art-based activities, and journaling) promoted interaction and increased the meaning of psychoeducation in children

(Grové et al., 2013; Moltrecht et al., 2024). Likewise, group discussion enabled closeness and emotional encouragement, but discussion quality was diminished by a lack of facilitators and the unwillingness to disclose personal experiences (van der Zanden et al., 2010; Trondsen and Tjora, 2014). This highlights the importance of the necessity to counterbalance digital flexibility with human facilitation.

Altogether, digital psychoeducation enhanced the knowledge of mental illness, coping strategies, and resilience in children and families (Woolderink et al., 2010; Jones et al., 2018). Nevertheless, the magnitude of effects was relatively small and they were not necessarily maintained in time (Widemalm et al., 2015; Dulsen et al., 2025), which implies that longitudinal follow-ups are necessary. The fact that there is high attrition and low access to digital show that self-directed formats might not be adequate. Ongoing assistance, enhanced online literacy and political interventions to guarantee fair access is necessary. In addition, psychoeducation organizations could be integrated into trusted community or healthcare developing systems, which would decrease stigma and increase participation.

## Implications

Such results have implications to policy and practice. Digital psychoeducational programs are not supposed to act as a single solution to families with mentally ill parents, but they are expected to be integrated into a larger family support system. Usability and impact can be enhanced by their administration in schools, medical care, and local community settings. The barriers which need to be addressed to achieve equity and participation include the poor internet access, low digital literacy and stigma. The success of such interventions is associated with the ability to adapt to the culture, frequent assessment, and compatibility with the existing care systems. Such digital programs provide low-priced and culturally suitability means to increase family resilience and support the enduring well-being, particularly in Pakistan, where patients are stigmatized and mental health-care is inadequate.

## Limitations

This review summarizes the evidence on digital psychoeducational interventions to help families of parents with mental illness, including both peer-reviewed and grey literature in several countries. However, the literature was restricted to English publications, and the majority of evidence was based in Western countries, thus limiting external generalization. There was no formal quality evaluation of the included studies, and due to the variations in the study design, it was not easy to compare the outcomes. Thus, results should be interpreted with carefully.

## Conclusions

Digital psychoeducational programs are a valuable resource for enhancing knowledge, reducing stigma, and supporting coping strategies for children and families affected by parental mental illness. However, existing data are limited, mostly short-term, and focused on Western populations. This gap could be addressed by developing flexible, culturally appropriate, and broadly accessible digital tools and resources for the relevant population, supported by policies that integrate them into routine mental health care.

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