



UiT The Arctic University of Norway

Faculty of Health Science

Regional Centre for Child and Youth Mental Health and Child Welfare

Family focus in mental health and social services for adults

Supporting minor children of parents in challenging life situations

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Cover image by Olav

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Abbreviations

BAP – barn av psykisk syke [children of parents with a mental illness]

COPMI – children of parents with mental illness

DMHSD – Division for Mental Health and Substance Use Disorders

HRP – Health research projects

NAV – Arbeids- og velferdsforvaltningen [The Norwegian Labor and Welfare Administration]

QAP – quality assurance projects

RKBU – the Regional Center for Child and Youth Mental Health and Child Welfare

SMI – severe mental illness

UN CRC – the United Nations Convention on the Rights of the Child

UNN – the University Hospital of Northern Norway

List of papers

- I. Kristensen, K. B., Lauritzen, C., Handegård, B. H., & Reedtz, C. (2023). Parents with mental illness and their sense of parenting competence. *Advances in Mental Health*.
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- II. Kristensen, K. B., Lauritzen, C., & Reedtz, C. (2022). Support for children of parents with mental illness: an analysis of patients' health records. *Frontiers in Psychiatry*, 13, 276-286. <https://doi.org/10.3389/fpsy.2022.778236>
- III. Kristensen, K. B., Lauritzen, C., & Reedtz, C. (2021). Child-focused practice in social services for adults in Norway. *Journal of Social Work*, 22, 931-951.
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Summary

Parental mental illness, parents' loss of ability to work and family poverty affect children and put them at risk for adverse life outcomes. Support for and attendance to minor children and parenting in adult mental health and social services should therefore be an incorporated practice. The main aim of this thesis was to investigate the extent and quality of a family focus in these adult services.

Paper 1 investigates self-reported levels of parenting sense of competence among parents with a mental illness. The findings were that parents with a mental illness did not report lower on their parenting sense of competence scores compared to samples from the general population. The paper discusses whether parents felt sufficiently safe to convey any difficulties in parenting they might experience.

Paper 2 evaluates the performance of the Child Talks intervention in mental health services using both qualitative and quantitative methods. Results were that few patients, and even fewer children of patients, participated in Child Talks. The quality of the support and follow-up that professionals provided to children and families was inadequate.

Paper 3 explores the level of child focus in practices and the level of knowledge and use of the UN CRC among counselors in social services for adults. The main result of the paper was that thematizing children's situation was not a part of common practice in social services for adults.

In conclusion, findings from the three papers suggest that children and parenting is not an incorporated focus among professionals in mental health and social services for adults. The extent and the quality of the family focus in these adult services is insufficient to enable prevention of adverse life outcomes for children and to enable direction of further support of families.

Norsk sammendrag

Foreldre som mottar behandling i psykiske helsetjenester eller rådgivning i NAV er i livssituasjoner som påvirker barna deres. Denne avhandlingen handler om ivaretagelse og støtte av mindreårige barn av foreldre som mottar hjelp fra helse og sosialtjenestene for voksne. Artikkel 1 handler om pasientenes rapporterte opplevelse av tilfredshet og mestring av foreldrerollen. Artikkel 2 handler om helsepersonells informasjon og støtte til barn av pasienter i psykisk helsevern for voksne med bruk av tiltaket Barneperspektivsamtalet. Artikkel 3 handler om veiledere i NAV sitt fokus på klientenes mindreårige barn.

Hovedresultatet i denne avhandlingen er at barn og foreldrerollen adresseres i for liten grad i tjenester for voksne hvor foreldre er i utfordrende livssituasjoner. Få barn inkluderes i samtaler, barnas situasjon tas i for liten grad hensyn til, barn og foreldrerollen er i for liten grad et tema, og kvaliteten på oppfølgingen barna og familien får av profesjonelle i tjenestene er for lav. Et familiefokus er ikke en integrert del av praksisen i sosial- og psykisk helsetjenester for voksne. Et avgrenset fokus på brukeren eller pasienten i utdanning, praksis, organiseringen av tjenestene, overordnede retningslinjer og systemer, i politikken og i bevilgninger diskuteres som faktorer som bidrar til å opprettholde et manglet barneperspektiv.

1 Introduction

1.1 Children in families in challenging life situations

The World Health Organization (1978) defines a family as *a household or a group that lives together as a social and biological unit within a cultural setting*. The conception of family has evolved over the years, and in modern societies, families can be arranged in multiple ways. Biological, socioemotional and legal relationships are all elements relevant to the consideration of what a family is (Raundalen, 2012). Statistics Norway (2022) defines a family as *individuals living together, related to one another as a married couple or partners, and/or as parents and children*. By this definition, there are minor children living in every fourth Norwegian household, and 84% of the children live with two parents. The majority (80%) of the children who live with just one parent live with their mother (Statistics Norway, 2022).

Since children grow up in a family context, it is reasonable to assume that the parent's situation affects the child's situation. More specifically, parents' physical and mental health, economic resources and social resources affect children's physical and mental health, development, life possibilities and outcomes (Hosman et al., 2009; Norwegian Institute of Public Health, 2022; Pillas et al., 2014). Adults receiving psychiatric treatment and/or counseling from social services are in life circumstances where they need support due to financial, physical and/or mental health problems. Ensuring that these adults' minor children are supported by the social and mental health services seems obvious when considering how children are dependent on and affected by their parents' situation. Yet little is known about the extent of family focus in adult social services. There is also a lack of knowledge about how and to what extent mental health services support children and parenting. The main objective of this thesis is to investigate the extent and the quality of the family focus in adult mental health and social services.

In this thesis, “children” are defined as individuals below the age of 18 years, and “parents” are defined as the mother/stepmother, father/stepfather or any adult fulfilling the parenting role of a child below the age of 18 years. For readability reasons, *adult services* refers in this thesis to both adult mental health services and adult social services, *professionals* includes both mental healthcare professionals and social service counselors with user contact, and *users* refers to both patients and social service receivers. *Family focus* is chosen as the term referring to practices to support and attend to the parenting role and to minor children of the users. In Paper 3, the term “child-focused practice” was used. In this thesis, child-focused practice is a part of family focus and referred to as such.

1.1.1 Prevalence of parental mental illness

The prevalence of parental mental illness is estimated in various ways. There are, however, three main types of prevalence studies of parental mental illness. In the first type of study, the proportion of parents of minor children who has a mental illness is estimated. In the second type, the proportion of adults with a mental illness who are parents is estimated. In the third type, the proportion of children who has a parent with a mental illness is estimated.

Not only are there different types of prevalence studies; there are also a range of different factors causing variations in the estimated numbers. Mental health can range on a spectrum from psychological wellbeing to mental illbeing (Huppert, 2014), and prevalence estimations differ in terms of how severe the mental illness has to be to be included. Some studies only include individuals with severe mental illness (SMI), while others also include individuals with any diagnosable illnesses or mental health problem. Studies also differ in terms of time period covered: calculations may be based e.g, on a single year or on the entire childhood. Some studies include one parent, others both parents, and the fact that families can consist of a variety of parents, step-parents and children complicate the estimations further

(Statistics Norway, 2022). Moreover, individuals tend to find partners like themselves, which makes it more likely to have a second parent with a mental illness if one parent has a mental illness, compared to if one parent is healthy (Tambs & Moum, 1992). Whether the studies are register studies or self-reported studies also has implications for how the numbers are estimated and for corresponding shortcomings. Register studies often do not consider family composition besides registered parents and children, whereas self-reported studies may suffer from various types of reporting bias.

The first type of study estimates the share of parents who have a mental illness. In Norway, 76% of men and 87% of women are parents by the age of 45 (Hart & Kravdal, 2020). According to Statistics Norway (2022), 32% of the adult population in Norway are parents of minor children at that given point of time. Based on estimates from longitudinal studies with repeated mental health assessments, around 61–85% of the population will experience a mental disorder during their lifetime (Schaefer et al., 2017). Around 20% of the adult population will fulfill the diagnostic criteria for a mental disorder over the course of a year (Tesli et al., 2023). Torvik and Rognmo (2011) estimated that over the course of a year, 28.9% of mothers and 14.1% of fathers of minor children in Norway experienced a mental disorder. When doing these estimations, the authors also considered the fact that having children is less prevalent among individuals with a mental illness compared to healthy individuals, but by contrast, more common during the years that the incidence of mental illness is the highest. Similar results regarding the prevalence of parental mental illness are found in other studies. Within a year, 18.2% of parents in the U.S.A. had a mental illness, and 3.8% of parents had an SMI (Stambaugh et al., 2017). Another study found that 25% of American mothers and 14.5% of American fathers had a mental illness within one year, and 7% of mothers and 2.6% of fathers had an SMI (Luciano et al., 2014). During the 18 years of parenting minor children, the prevalence of parental mental illness will be even higher.

The second type of study estimates the share of adults with a mental illness who are parents. Estimates of adults in treatment for a mental illness who parent minor children range from around one in five (Maybery et al., 2009) to at least a quarter (Göpfert et al., 2004) and is most likely around one third (Maybery & Reupert, 2018; Reedtz et al., 2015; Ruud et al., 2019).

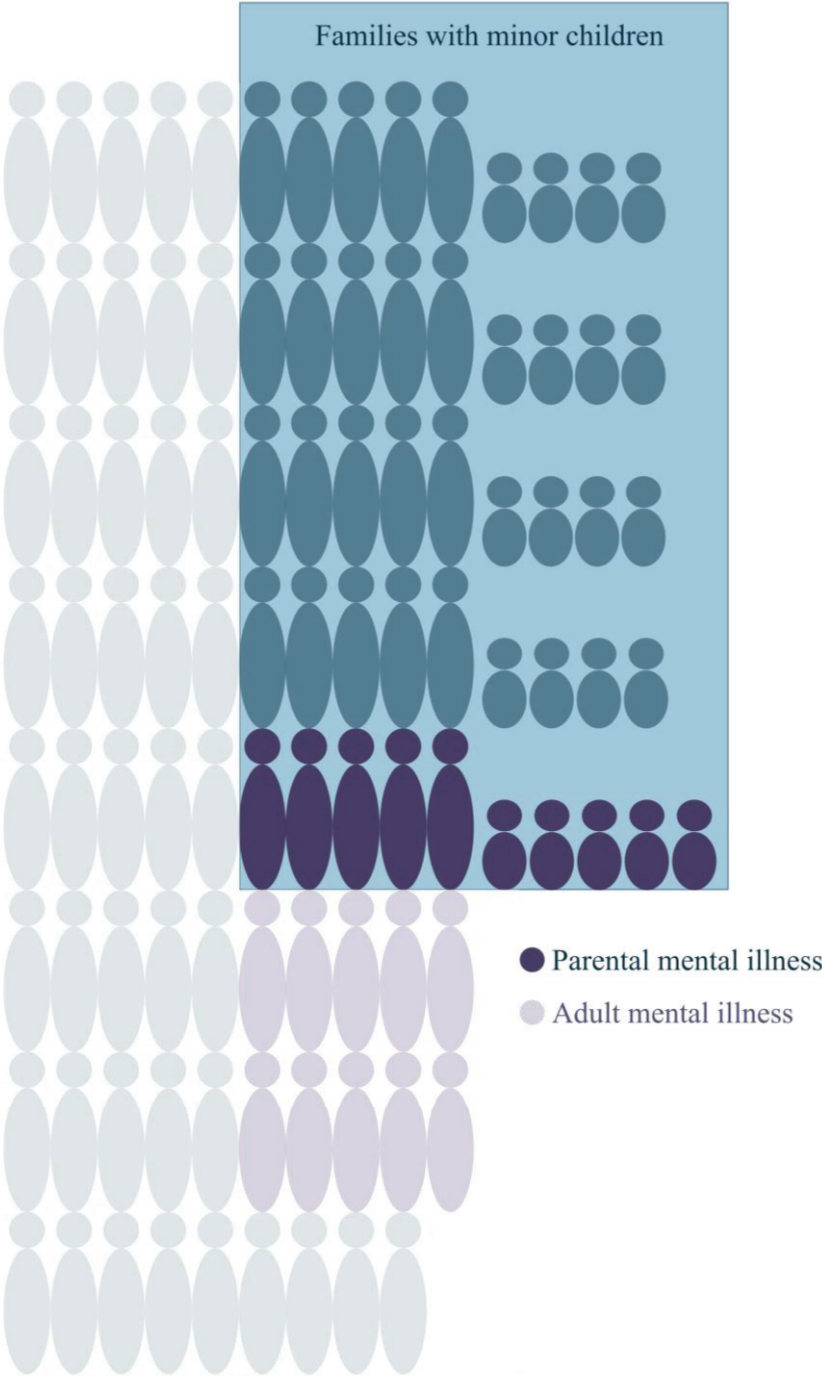
The third type of study estimates the share of children who have a parent with a mental illness. It is estimated that within a one-year period, 37.3% of Norwegian children have at least one parent with a diagnosable mental disorder, 23.1% have a parent with a moderate to severe mental illness, and 10.4% have a parent with an SMI (Torvik & Rognmo, 2011). The international estimates are similar to the Norwegian estimates. At any given time, 23.3% of Australian children have a parent with a mental illness (Maybery et al., 2009), and 11% of Swedish children have a parent with a mental illness that is being treated in secondary care (Pierce et al., 2020). For Canadian children under the age of 12, it has been estimated that within a year, 12.1% live in households where a parent has a mental illness fulfilling the criteria for an anxiety, mood or substance use disorder (Bassani et al., 2009). A study from the U.K. by Abel et al. (2019) used a national primary care database for estimating the prevalence of children of mothers with mental illnesses. Of the children, 23.2% had a mother with an existing mental illness, and by the time the children reached 16 years old, the cumulative risk of maternal mental illness was 53.1% (Abel et al., 2019).

Figure 1 is an overview of the research and the three types of studies estimating prevalence of parental mental illness in the population. The figure gives a combined picture and can be read in different ways based on whether it is the share of parents with minor children who has a mental illness, the share of adults with a mental illness who are parents, or the share of children affected by parental mental illness that is of interest. The figure also

illustrates the large proportion of the entire population that is affected by parental mental illness.

Figure 1

Proportion of the Population Affected by Parental Mental Illness



The numbers in the illustration (Figure 1) are based on the Norwegian adult and child population distribution: 79% of the population are adults, and 32% of adults are parents of minor children (Statistics Norway, 2022). For the illustration of parental mental illness, international estimations are used according to which 20% of the adult population have a mental illness (Tesli et al., 2023), 18% of parents of minor children have a mental illness (Stambaugh et al., 2017), one in three adults with a mental illness have minor children (Maybery & Reupert, 2018; Ruud et al., 2019), and 23% of the child population have a parent with a mental illness (Maybery et al., 2009; Torvik & Rognmo, 2011)

1.1.2 Frequency of parents in adult social services

The sample of Paper 3 consists of social service counselors with user contact; that is, counselors who provided services for adults receiving assessment allowance, disability benefits or social help benefits. Based on the database of NAV (NAV, 2019a, 2019b; Skjøstad, 2019), 596 924 adults received work assessment allowance, disability benefits or social help benefits in Norway in 2022, which amount to 14% of the adult population. Work assessment allowance, disability benefits and social help benefits are social benefits given to adults who are not working because of long-term health issues, or who are receiving benefits because of low income. These social benefits require contact with a social service counselor. In the following, users receiving assessment allowance, disability benefits or social help benefits will be referred to as “social services users”.

Of adult receivers of work assessment allowance, 35% lived with persistent low income (Furuberg et al., 2022), defined as an income below 60% of the median income in the population over a three-year period (Normann & Epland, 2023). Of receivers of disability benefits and receivers of social benefits, 24% and 67%, respectively, lived with persistent low income (Furuberg et al., 2022). Of the 11.3% of children in Norway living in families with

persistent low income in 2021, six of ten were children with immigrant backgrounds (Normann & Epland, 2023). In the child immigrant population, 47% of child immigrants, and 31% of children of immigrant parents, lived in families with persistent low income (Normann & Epland, 2023). Hence, the immigrant population in Norway is overrepresented as users of social services. Since the fertility rate among females in the immigrant population is higher than in the general female population (Andersen, 2019), there are reasons to believe that the share of social service users who have minor children is larger than the share of adults with minor children in the general population. In addition; 45% of receivers of work assessment allowance are in the age group (31–49 years) in which it is also most common to have minor children (Hattrem, 2022; Normann & Epland, 2023). The share of children who live in families with persistent low incomes (11.3%) is also larger than the share of individuals who live with persistent low income in the general population (10.7%) (Hattrem, 2022; Normann & Epland, 2023).

1.1.3 The overlap between parental mental illness and low socioeconomic status

Parents receiving mental health care and parents receiving counseling from social services are overlapping groups, meaning that parents with a mental illness are overrepresented in social services and vice versa. Of those who received work assessment allowance in social services for adults by the first three months of 2023, 43% had a mental health diagnosis (NAV, 2019b). In the age group 31–49, when it is most common to have minor children, 45% of the work assessment allowance receivers had a mental health disorder (NAV, 2019b). The most common mental diagnoses among those receiving work assessment allowance were depressive disorder (30%), post-traumatic stress disorder (10%) and anxiety disorder (8%) (NAV, 2019b). Of receivers of disability benefits 37% had a mental health disorder (NAV, 2019a).

A study in Norway by Ruud et al. (2015) compared parents with physical, mental and substance use disorders in terms of employment, housing, income and educational level. Parents with a mental or substance use disorder had lower employment rates, moved more often, were less likely to own their housing, and had significantly lower income and educational level than parents with a somatic illness (Ruud et al., 2015). Of the parents with a mental illness, 52% received work assessment allowance, disability benefits or social benefits (Ruud et al., 2015).

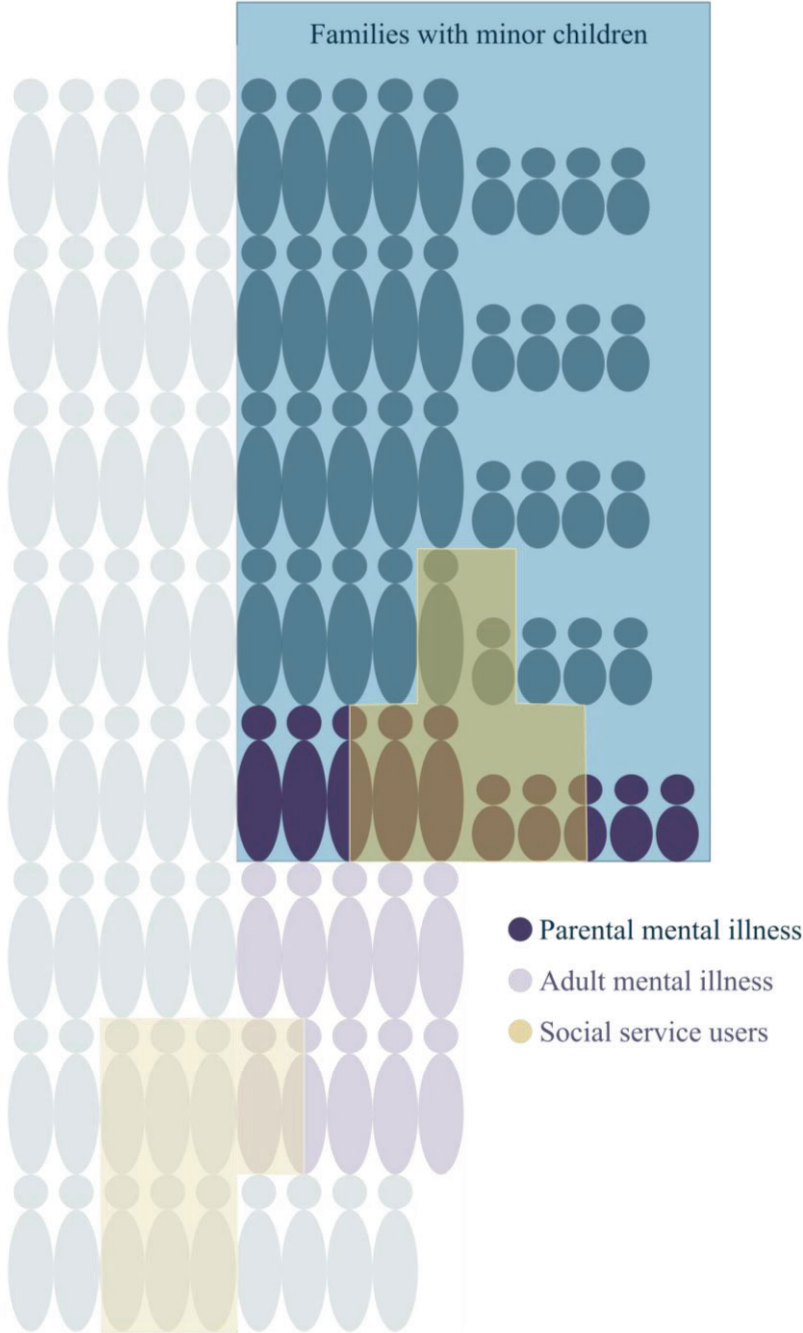
In the U.S.A., employment rates were lower for parents with an SMI than for parents without an SMI. Only 38% of mothers and 60% of fathers with an SMI had a full-time job, compared to 50% of mothers and 85% of fathers without a mental illness (Luciano et al., 2014). Parents with serious mental illnesses were also twice as likely to live in poverty compared to the general population of parents (Luciano et al., 2014). In England, the prevalence of children of mothers with a mental illness was 28.3% in areas with the highest levels of deprivation, compared to 18.0% in areas with the lowest levels of deprivation (Abel et al., 2019). Similarly, a significant association between area deprivation and mental health outcomes has been found in Norway (Piro et al., 2007). Children of parents with mental illnesses had a higher risk of socioeconomic adversity, like poverty or living separated from their parents (Pierce et al., 2020). The link between parental mental illness and socioeconomic adversity is strong and probably bidirectional, indicating that low socioeconomic status can cause parental mental illness and that parental mental illness can cause low socioeconomic status (Pierce et al., 2020).

Figure 2 illustrates the overlap between parental mental illness and receivers of work assessment allowance, disability benefits or social help benefits. Moreover, the figure

illustrates the target population of all papers in this thesis: families with minor children using social services and/or having parental mental illness.

Figure 2

Illustration of the Overlap between Parental Mental Illness and Social Service Users.



This illustration (Figure 2) is based on the Norwegian adult and child population distribution and the population affected by parental mental illness as illustrated in Figure 1. “Social service users” refers to users receiving long-term benefits from adult social services, including work assessment allowance, disability benefits or social help benefits. Based on numbers from the statistical database of NAV (NAV, 2019a, 2019b; Skjøstad, 2019), 14% of the adult population receive work assessment allowance, disability benefits or social help benefits. Due to a lack of more specific numbers of parents of minor children among social service users, the general 32% share of adults who parent minor children is used (Statistics Norway, 2022). Of adults receiving work assessment allowance and disability benefits, 39% had a mental diagnoses (NAV, 2019a, 2019b). Among parents with a mental illness, 52% received work assessment allowance, disability benefits or social benefits (Ruud et al., 2015). For children, the same parent–child ratio is used for children of parents with a mental illness as for children of parents without a mental illness.

The number of children calculated for social benefit receivers is modest, and it is likely higher than this illustration suggests. Though the illustration aims to show the overlap between parental mental illness and social service users, it is important to acknowledge that all children of parents receiving long-term benefits from social services are in life situations where their parent has a long-term illness preventing them from working full time. The 11.3% of children living in a household with persistent low income will represent 2.4 of the 21 children in this illustration. The numbers used to illustrate the share of NAV users in Figure 2 are based on fewer studies and are therefore less certain than the numbers used to illustrate parental mental illness in the population (Figure 1).

1.1.4 Risks of growing up in families in challenging life situations

Compared to children of healthy parents, children of parents with a mental illness are at risk for mental health illnesses, internalizing and externalizing problems, attachment problems, abuse and neglect, social problems, cognitive problems, academic problems, substance use problems and physical problems (Beardslee et al., 2011; Hosman et al., 2009; Reupert & Maybery, 2016; Stein & Harold, 2015; Weissman et al., 2006). Almost half the children with maltreatment allegations had a mother who was in contact with mental health services, and all mental health diagnoses were associated with an increased risk of such allegations (O'Donnell et al., 2015).

In a large register-based study of almost 1.5 million children born in Denmark in the years 1994–2016, children aged 0–6 who were exposed to parental SMI had an increased risk of mental and pediatric disorders (Davidsen et al., 2022). In general, the risk was highest if both parents of the child had an SMI, and higher if the mother was ill compared to if the father was ill (Davidsen et al., 2022). The incidence of any psychiatric disorder were 2 to 5 times higher for children of a parent with a severe mental illness, compared to children of parents without a mental illness, where parental schizophrenia elevated the rate of children having any psychiatric disorder at a factor of 5.23 (Davidsen et al., 2022). The incidence of child anxiety / OCD was 8–17 times higher for children of parents with a mental illness, and the incidence of attachment disorders among children of parents with an SMI was 6–15 times higher compared to children of parents without an SMI (Davidsen et al., 2022). For pediatric disorders in children, the incidence was elevated by a factor of 1.01–1.28 for children with parental mental illness (Davidsen et al., 2022). Other studies have also found risk of adverse outcomes for the youngest children of parents with mental illnesses. In a study by Murray et al. (1996), postpartum depression was found to be associated with adverse consequences for mother–infant interactions and outcomes for the infants. Compared to healthy mothers,

mothers with depression were less sensitively attuned to their infants, and the children had poorer cognitive outcomes measured at 18 months (Murray et al., 1996). Moreover, a systematic review based on 122 studies by Slomian et al. (2019) found that infant cognitive development, language development, infant behavior, quality of sleep and infant health concerns, poor maternal care, bonding difficulties and insecure attachments are significantly associated with maternal depressive symptoms.

A systematic review based on 76 studies by van Santvoort et al. (2015) concluded that children of parents with anxiety disorders mainly had a risk restricted to developing anxiety disorders, while children of parents with depression and bipolar disorders were at risk for both the same disorders as their parent and also a broad spectrum of other problems. These findings resonate with the results of a narrative review by Leijdesdorff et al. (2017).

Children of parents with mental illness are not only affected by their parents' illness when they are infants and children. A meta-analysis by Rasic et al. (2014) concluded that children of parents with severe mental illness had a twice as high risk of mental disorders in adulthood compared to the general population.

A model by Hosman et al. (2009) illustrates how child outcomes are influenced by an interplay of different factors in a child's environment. It is not only the parents' mental health that affects the children's outcomes. In addition, parental mental illness can itself be a risk factor for other risk factors that influence the outcomes for children. For instance, as mentioned above, parental mental illness and socioeconomic adversity are risk factors that are strongly linked (Pierce et al., 2020).

A child's genetics cannot be changed by preventive interventions. In a large study by The Brainstorm Consortium et al. (2018), the researchers examined more than 200 000

patients for brain-associated disorders. Results from the study showed that for many psychiatric disorders, there are high degrees of genetic correlation. There were common genetic risks for attention deficit hyperactivity disorder, bipolar disorder, major depressive disorder and schizophrenia (The Brainstorm Consortium et al., 2018). Psychiatric diagnoses such as schizophrenia and bipolar disorder have a strong genetic factor, with over 80% heritability, leaving only 20% to environmental factors (Bienvenu et al., 2011). For disorders with high heritability, preventive efforts might have less effect on preventing mental illness on a group level, but it is not any less important, since it can contribute to better family function, make it easier to seek help and, of course, still can prevent mental illnesses. In the future, interventions can perhaps be targeted more specifically in terms of genetic risk factors.

Socioeconomic status can be transferred from one generation to the next, where health in early childhood and later in life depends both on parents' socioeconomic status and on parents' health (Norwegian Institute of Public Health, 2022; Pillas et al., 2014). Low socioeconomic status affects physical and psychosocial health both long-term and short-term, and health problems occurring in a child's life can have negative consequences for their later socioeconomic status (Fløtten & Nielsen, 2020; Poulain et al., 2020). Children from families with lower socioeconomic status have poorer health outcomes when compared to children from families with a higher socioeconomic status (Chen et al., 2006). A systematic review and meta-analysis by Balaj et al. (2021) found that children born of mothers with twelve years of education had a reduction of mortality by 31% compared to children born of mothers with no education. Children from families with lower socioeconomic status are more likely to have asthma (Chen, 2014), poorer bedtime routines (Hale et al., 2009), delayed cognitive development (Khanam & Nghiem, 2016), obesity and lower physical activity (Bürge et al., 2010). Children living in social housing had poorer health and educational outcomes compared to children living in normal housing; however, living in social housing in wealthier

areas was associated with better outcomes (Martens et al., 2014). Growing up in families with persistent low income negatively affects children's rate of school completion, earnings as adults, overall health and well-being (Brooks-Gunn & Duncan, 1997; Duncan et al., 2012). By adulthood, children who grew up in poverty early in life (before the age of five), worked less hours, earned half as much, and were three times more likely to report poor overall health compared to children growing up in families with normal incomes (Duncan et al., 2012). Additionally, males were more than twice as likely to be arrested and females were five times more likely to have non-marital births. In Norway, individuals with the highest education live 5–6 years longer, and also have better health, than those with lower education (Syse et al., 2016).

The relationship between family socioeconomic status and child mental health is complex, with different factors moderating and mediating the relationship. There is evidence that there is an association between socioeconomic status and child mental health (Reiss, 2013); however, the causality of the relationship is unclear but most likely bi-directional with multiple factors interplaying (Maaik van der et al., 2014). A systematic review by Devenish et al. (2017) investigated factors influencing the association between family socioeconomic status and poor outcomes for adolescents. Parental depression was associated with poor adolescent outcomes via economic stress, conflicts between parents and reduced quality of parenting (Devenish et al., 2017). One study found support for a model where parental emotional well-being and parenting practices are variables affecting the association of low socioeconomic status and child mental health problems (Bøe et al., 2014). Child externalizing mental health problems were associated with family economy through parents' emotional well-being and parenting practices. Child externalizing mental health problems were associated with the mothers' educational level through negative parenting disciplines. A direct association between parents' educational level and child externalizing problems was also

found that was not mediated by parenting practices. A direct association between child internalizing problems and family economy was found, but also an indirect association through parental emotional well-being and parenting practice (Bøe et al., 2014). Similar results were found in a study by Lugo-Gil and Tamis-LeMonda (2008), where the association between family resources, such as mothers' educational level and family income level, and children's cognitive performance was mediated by parenting quality. Measurement points were at 14, 24 and 36 months. Resilience and adolescents' ability to cope with stressors related to low socioeconomic status and neighborhood safety appeared to be a significant mediating factor for the association between low socioeconomic status and poor adolescent outcomes (Devenish et al., 2017).

Parenting quality is important for the child's development (Smith, 2010). Positive parenting is associated with better health and well-being in children (Davids et al., 2017; Yap et al., 2014). Positive parenting is characterized as supportive and encouraging parenting, parent warmth and responsiveness, parenting involvement and nurturance, and autonomy granting (Davids et al., 2017). Negative parenting behavior, on the other hand, is characterized by parental over-protection, over-involvement and neglectful parenting. Parental mental illness is a risk factor for negative parenting behavior (Oyserman et al., 2005; Seeger et al., 2022). Two different meta-analyses have found associations between negative parenting behavior and depression in mothers and fathers, respectively (Lovejoy et al., 2000; Wilson & Durbin, 2010).

As this chapter describes, children in families in challenging life situations are at risk for a range of problems themselves. Fortunately, there are efforts that can prevent the development of problems.

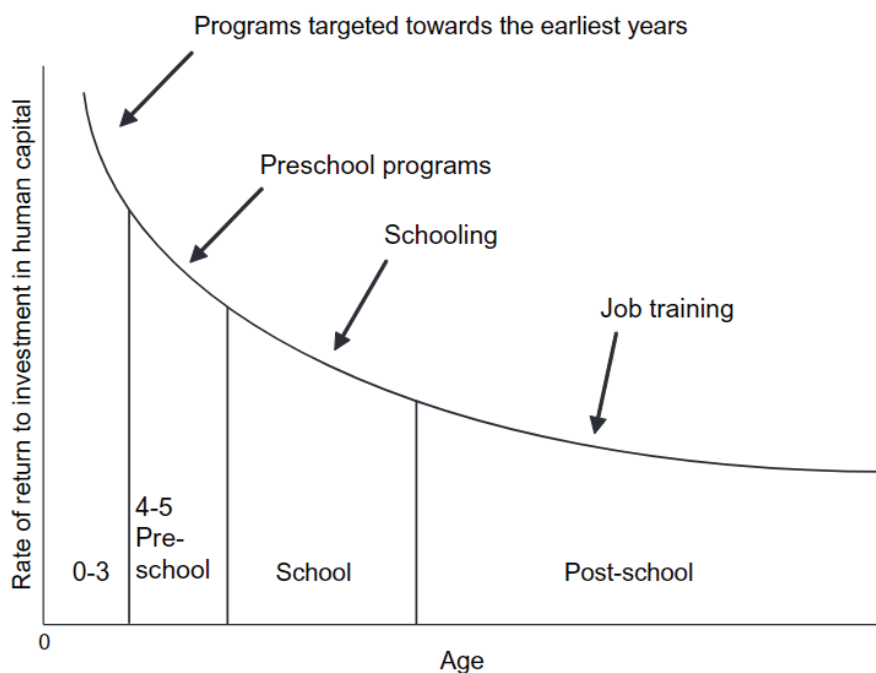
1.2 Prevention and a family focus in services for adults

Based on the previously presented research, it is evident that parents receiving mental health treatment and/or long-term social benefits are in life situations that are affecting their children. These children are at risk for adverse life outcomes. A family-focused practice in these services can facilitate better child outcomes by providing help and prevention efforts.

In addition to improving child outcomes by preventive intervention and an integrated family focus because it will improve the lives for these children, there are also economic arguments for prevention. Perinatal mental health illness costs society a lot, and the majority of the cost is related to adverse impacts on the child later in life (Bauer et al., 2016). The Heckman Curve by (Heckman, 2008) is a model of the economic return of the investment in early childhood programs. The earlier children are provided with preventive programs, the greater the return in terms of human capital (Heckman, 2008).

Figure 3

The Heckman Curve



Note. This figure is produced by Heckman in 2008. From “Schools, skills and synapses”, by J. J. Heckman, 2008, *Economic Inquiry*, 46(3), p. 311 (<https://doi.org/10.1111/j.1465-7295.2008.00163.x>). Copyright by John Wiley & Sons, Inc. Reused with premission.

1.2.1 Interventions for children of parents with a mental illness

Depending on the target group for interventions, preventive interventions can either be universal, selective or indicated (Institute of Medicine Committee on Prevention of Mental Disorders et al., 1994). Universal preventive interventions target the general population, selective preventive interventions target groups with an increased risk, while indicated preventive interventions target high-risk groups with detectable signs indicating predisposition for disorders or other problems (Institute of Medicine Committee on Prevention of Mental Disorders et al., 1994). For families with parental mental illness, there are selective preventive interventions including the children, the parents or the whole family. Some interventions focus on the parenting role, some on the parent–child interaction, while others focus on building resilience and coping strategies in children. In general, preventive interventions aim to reduce the risk and strengthen protective factors.

Several systematic reviews have evaluated effects of interventions for families with parental mental illness. Schrank et al. (2015) reviewed the effects of interventions focusing on improving the parenting quality and providing support for parents with severe mental illness. The systematic review was based on 18 publications from 15 uncontrolled and controlled studies. Parenting interventions included in this review were home visiting programs, residential treatments and online interventions aiming to improve parenting skills and parents’ understanding of the impact the mental illness has on parenting. These parenting interventions were found to be evaluated mainly by low-quality studies without long-term effects measurements (Schrank et al., 2015). Parent- and child-related outcomes were found to

improve, but long-term outcomes were unknown (Schrank et al., 2015). Improving the mental health of the parent will improve the health of the child and the parenting practice. A meta-analysis by Cuijpers et al. (2015) based on nine studies of randomized controlled trials found that psychotherapy for mothers with depression had small positive effects on the mental health of the child and the interaction between the mother and the child, and a medium-size effect on parenting/marital distress. Another meta-analysis by Thanhäuser et al. (2017), including results from 50 randomized controlled trials, found that interventions for mothers with a mental illness that focused on improving mother–infant interactions had small significant effects for the mother’s sensitivity and the children’s and mothers’ behavior during interaction.

A systematic review and meta-analysis of preventive interventions for offspring of depressed parents by Loechner et al. (2018) included seven randomized controlled trials and 14 high-quality publications. The results showed that the effect of the interventions on depressive and internalizing symptoms, and on the incidence of depression in children, was significantly reduced by a small effect. In the follow-ups five to 72 months after interventions, effects were not found (Loechner et al., 2018). The effects that psychosocial interventions had on preventing mental health illness and symptoms in children of parents with a mental illness were evaluated by yet another systematic review and meta-analysis including 20 randomized controlled trials (Lannes et al., 2021). The included interventions were mainly using cognitive-behavioral therapy and psychoeducation. These interventions were found to significantly reduce the incidence of mental disorders in children by 50%. A small significant effect on internalizing symptoms in children was still present a year after intervention; for externalizing symptoms, however, significant effects were not found at post-test (Lannes et al., 2021). Havinga et al. (2021) included 22 articles in their systematic review of preventive interventions for children of parents with a mood or anxiety disorder. Included

interventions had psychoeducation and skill training and/or cognitive-behavioral therapy elements. Small significant effects of these preventive interventions were found for the risk among offspring for developing depressive or anxiety disorder and symptoms. Havinga et al. (2021) called for the need for studies examining how these intervention programs work and for whom. In general, interventions addressing both parents and children produced larger effects, compared to interventions focusing only on the children (Reupert, Bee, et al., 2021; Thanhäuser et al., 2017; Vostanis et al., 2006).

Children's experiences participating in groups-based learning and coping interventions for children of parents or siblings with an illness are summarized in a scoping review by Stenberg et al. (2022). Included interventions aimed to increase children's quality of life, self-efficacy and health literacy. Children reported the following benefits from participating in the interventions: mutual understanding and acceptance, improved knowledge and understanding, improved coping strategies, reduced levels of depression and anxiety, reduced levels of guilt and improved insight (Stenberg et al., 2022).

In sum, there are many preventive interventions available for children affected by parental mental illness, and overall, they reduce mental illness as well as internalizing and externalizing symptoms in children significantly short-term by small effect sizes (Havinga et al., 2021; Lannes et al., 2021; Thanhäuser et al., 2017).

1.2.2 Prevention for children with low income

As shown in the previous sections, many parents who are users of adult social services have a mental illness. Preventive interventions developed for families with parental mental illness can accordingly be useful for these families by improving outcomes for children. However, there are also efforts aiming to improve outcomes for children in families with low income. Small financial grants have been found to have no or little effect on child mental health or emotional

state (Lucas et al., 2008). Moreover, there are interventions in healthcare settings aiming to improve social determinants of health such as educational status, housing, employment, food supply and poverty for patients. These interventions typically involve assessment of patients' social and economic needs and linking them with and helping them navigate social service resources (Gottlieb et al., 2017). In a review of these interventions, Gottlieb et al. (2017) concluded that the research area focuses on the process and social outcomes, rather than health outcomes. Moreover, evaluations were limited by poor study quality, and the included studies reported mixed results (Gottlieb et al., 2017).

1.2.3 Psychoeducation and inclusion of children

Preventive interventions with psychoeducational components are found to reduce the risk of psychopathology and internalizing and externalizing symptoms in children (Lannes et al., 2021; Thanhäuser et al., 2017). Well-functioning communication within the family and mental health literacy are found to be protective factors for reducing the prevalence or severity of problems for children of parents with a mental illness (Reupert & Maybery, 2010; Riebschleger et al., 2019). "Mental health literacy" refers to one's attitudes toward mental health disorders and conditions, and one's ability to prevent, recognize and cope with mental illness.

Having knowledge about mental health provides resilience by strengthening the child's ability to cope with the situation (Riebschleger et al., 2017). Knowledge and openness about mental illness reduces stigma and lowers the threshold for seeking professional help (Riebschleger et al., 2017). Children who receive accurate, non-stigmatizing information about their parents' mental illness, treatment and recovery are better equipped to understand their parents' behavior, talk to others about their situation and feel less lonely (Grové et al., 2015). Children who are not receiving information can blame their parents' behavior on

themselves, and they may misunderstand the illness or the treatment, thereby generating concern, stress and confusion (Riebschleger et al., 2017). Children themselves report that they prefer to learn about their parents' mental illness from healthcare professionals, value opportunities to ask questions and consider it necessary and helpful get information and support from healthcare professionals (Grové et al., 2016). Better insight into mental illness is associated with more sensitive parenting behavior and lower risk of child maltreatment (Mullick et al., 2001).

1.3 Facilitators for and barriers to a family-focused practice

Barriers to a family-focused practice in adult mental health services have been detected in several studies (Korhonen et al., 2008; Lauritzen et al., 2015; Maybery & Reupert, 2009). In a systematic review by Eassom et al. (2014) of facilitating and hindering factors of family involvement in mental health care, the authors concluded that involvement of families requires cultural and organizational change. All members, including leaders of the organization, have to have the same goal. Strong leadership and establishment of working routines are also required (Eassom et al., 2014). Another, more recent review by Gregg et al. (2021) found hindering factors for a family-focused practice relating both to the healthcare professionals and to the workplace. The healthcare professionals who perceived a family focus as inappropriate or damaging for the patient, or who perceived it as a task outside of their area of responsibility, were less likely to have a family-focused practice (Gregg et al., 2021). For healthcare professionals with positive attitudes towards a family-focused practice, a lack of confidence and training in providing family support and a lack of support and resources in the service were barriers (Gregg et al., 2021). Similar barriers were found in a systematic review of qualitative studies of healthcare professionals' experience with a family focus in mental health services by Tuck et al. (2023). Healthcare professionals' approach to a

family-focused practice was found to be influenced by their beliefs in a family focus and their perceived role, responsibility and competence.

A range of barriers are detected when services are implementing new approaches or integrating a holistic family focus. In a systematic review of barriers and factors for implementing perinatal mental health care in health and social care settings such as assessment, care, referral and treatment, a range of factors were detected at different levels. The factors were related to the individual level, the healthcare professionals level, the interpersonal level, the organizational level and political and society levels (Webb et al., 2021). Barriers to the assessment at the user level were the presence of a partner or other family members; a lack of awareness or knowledge about perinatal mental health problems; personal difficulties; and inability to attend assessment due to lack of time, childcare or transport. Barriers to access and perception of treatment were lack of family support, psychological readiness, and personal and psychological difficulties (Webb et al., 2021). At healthcare professionals' level, barriers for assessment and referral were the lack of or poor training, heavy workloads or lack of time, and lack of collaborative work; facilitators for the provision of optimal care were open, non-judgmental, listening and motivating healthcare professionals (Webb et al., 2021). Language barriers, lack of open and honest communication, and lack of privacy and confidentiality were barriers at the interpersonal level during assessment, and trusting relationships were a common facilitator (Webb et al., 2021). Technology issues, wording of screening tool, unclear workflow, unclear or complicated referral pathways, and lack of timely and appropriate services to refer to were barriers for assessment and referrals at the organizational level (Webb et al., 2021).

1.3.1 Collaboration between services

Collaboration between different services or agencies is found to be advantage in terms of earlier recognition of problems, improved access to services, and quicker and more appropriate referrals (Atkinson et al., 2007). However, collaboration demands more of the services, including time and management (Cooper et al., 2016). A review by Maybery and Reupert (2009) identified *collaboration* as one of the main barriers to a family-focused practice in adult mental health services. Barriers to interagency collaboration were lack of adequate structures, policies and procedures, high staff turnover and inadequate resources such as lack of time and high workloads (Maybery & Reupert, 2009). In a review by Cooper et al. (2016), the most common identified facilitating factor for collaboration between agencies was good communication across professionals or services. Good communication was described as frequent, regular, willing, clear, transparent and streamlined communication. Other facilitating factors found were joint training, joint meetings, joint case conferences, joint assessments, co-location, good understanding across professionals and services, mutual valuing, respect and trust, and a named link person (Cooper et al., 2016). Inhibiting factors for collaboration between agencies were inadequate resources, including time pressure, lack of funding and lack of training. Other inhibiting factors were poor communication and poor understanding across professionals and services; lack of valuing, respect and trust; differing perspectives; confidentiality issues; no-one assuming responsibility; low priority, and lack of protocols with regard to interagency collaboration (Cooper et al., 2016).

1.3.2 Communication skills

There are some basic principles for good communication strategies for professionals in mental health care and social services (Silverman et al., 2016). It is, for example, important to acknowledge what is said, to give children time to think before they speak, to explain to children why they are there and to ask open and non-leading questions (Langballe, 2011).

When talking to children, professionals must adjust to the child's cognitive development, be self-aware of conditions influencing the ability to speak with the child, be aware of the conflict of being a professional for the adult user and take what the child is saying seriously (Øvreeide, 2009). There are few studies about children's experiences participating in interventions for children of parents with a mental illness. However, one study found that children participating in interventions for children of parents with a mental illness did not always feel like the group leader cared about their situation or that what they were saying was acknowledged (Nordtug & Grimsgaard, 2021). Communication skill training in education is shown to improve communication skills (Gutiérrez-Puertas et al., 2020; Kerr et al., 2020; Reith-Hall & Montgomery, 2022).

1.3.3 Implementation and sustainability

An integrated family focus in adult services calls for a successful implementation of new practices, efforts or interventions by professionals. Successful implementation, where interventions are used as intended and sustained over time, is dependent on how well elements of the implementation process are accomplished. In the area of implementation science, there are different implementation framework approaches and models for how to accomplish a successful implementation of evidence-based practice. One of the models, by Aarons et al. (2011), describes the different implementation phases and the factors affecting implementation in public service sectors. The success of implementation is affected by a large range of factors both from the outer and from the inner contexts throughout the phases of exploration, adoption decision/preparation, active implementation and sustainment of a intervention (Aarons et al., 2011). In Fixsen (2005), the implementation stages are similar but divided into exploration and adoption, program installation, initial implementation, full operation, innovation and sustainability. The implementation determinators most often

addressed are organizational support, financial resources, social relations, and support and leadership (Nilsen & Bernhardsson, 2019).

An organization's readiness is important for a successful implementation (Fixsen, 2005; Aarons et al., 2011). "Readiness" is a term used in implementation science for the readiness for change among practitioners and organizations. Practitioners/organizations need to be aware of the problem and recognize the need to change something; they need to prepare and plan concerning resources, and leaders need to be actively involved. Everyone involved needs to be enthusiastic and motivated, and sustainability needs to be ensured by support from leaders and administrators. A well-trained and experienced staff is required (Fixsen, 2005).

Intervention fidelity is the degree of adherence to the intervention manual and degree to which the intervention was delivered as intended (Carroll et al., 2007). Potential moderators for the adherence to interventions are: the interventions' complexity – it is easier to achieve high fidelity in simple interventions; facilitation strategies, such as equal training and support, monitoring and providing feedback to intervention deliverers; the quality of the delivery; and participant responsiveness, the degree to which participants are engaged and perceive the intervention to be relevant for them (Carroll et al., 2007).

"Sustainability" is commonly used to refer to what happens after the initial implementation of evidence-based programs and practices in healthcare settings (Wiltsey Stirman et al., 2012). Sustainability concerns the degree to which an intervention or a practice can be continued to be delivered. Key elements for sustaining a family-focused practice intervention in adult mental health services have been identified by Allchin et al. (2022), and are summarized in a model. The components of the model are based on elements found to influence the sustainability of the intervention Let's Talk about the Children found in five different studies and are related to the organization and the broader context. The six action

points of the model are related to how the adult mental health service engages with its service users and professionals, how internal organizational activities can contribute to the implementation and sustainability, and lastly, action points of the model that are related to important actions in the wider context. The authors point out that attention needs to be paid to the complexity and importance of sustainability in the field, and they highlight the inadequacy of an isolated view of actions or elements if the aim is to build sustainability.

1.4 Children's rights

1.4.1 The Norwegian health personnel act

The aim of The Health Personnel Act (2010) is to ensure the quality of health services. § 10 a. assigns healthcare professionals obligations concerning minor children of patients. The regulation states that healthcare professionals shall contribute to meeting the need for information and necessary support that minor children might have because of parents' mental illness, substance use disorder or severe somatic illness or injury. The second section of § 10 a. states that healthcare professionals shall seek to clarify whether the patient has any minor children or minor sibling and the needs these may have for information or support. More specifically, in accordance with section three in § 10 a., healthcare professional shall, when necessary to meet the needs of minor children of patients, according to letter a.) talk with the patient about the child's need for information or support and offer information and guidance regarding support options and interventions; healthcare professionals shall also offer the child and the child's caregiver the opportunity to participate in such conversations, within the limits of confidentiality. Healthcare professionals shall, according to letter b., acquire consent to enable the support of and attendance to children that they regard as appropriate. Additionally, in accordance with letter c., healthcare professionals shall contribute to ensuring that the child and the child's caregiver are given adequate information about the patients' illness, treatment and opportunities to meet.

1.4.2 The United Nations Convention on the Rights of the Child

The United Nations Convention on the Rights of the Child (UN CRC) (The United Nations Human Rights office of the high commissioner, 1989) is incorporated into Norwegian law.

According to article 12, parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in matters affecting the child. The views of the child shall be given due weight in accordance with the age and the maturity of the child.

The child shall be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, directly or through a representative or appropriate body, in a manner consistent with the procedural rules of national law (The United Nations Human Rights office of the high commissioner, 1989). The first section of Article 3 states that in all actions concerning children, the best interest of the child shall be a primary consideration.

Article 6, section 2, states that states parties shall ensure, to the maximum extent possible, the survival and development of the child.

1.5 Theoretical perspectives

1.5.1 Models for success in health promotion efforts

In the review by Maybery and Reupert (2009), barriers to a family focus were detected, and a hierarchical model of how to affect workforce change was proposed, akin to Maslow's hierarchy of needs. The four levels in this model include a basis of organizational support, which includes management support and organizational policies and procedures. Secondly, professionals' attitudes, knowledge and skills can be built on this organizational support, including training and supervision strategies. Once these two levels are established, the third level, client engagement, can be accomplished. Finally, at the very top of the model, children, and family can be supported. In a review by Kokorelias et al. (2019), similar components were detected in family-centered care models. These components were: collaboration between family members and professionals to define care plans that considered the family context; a

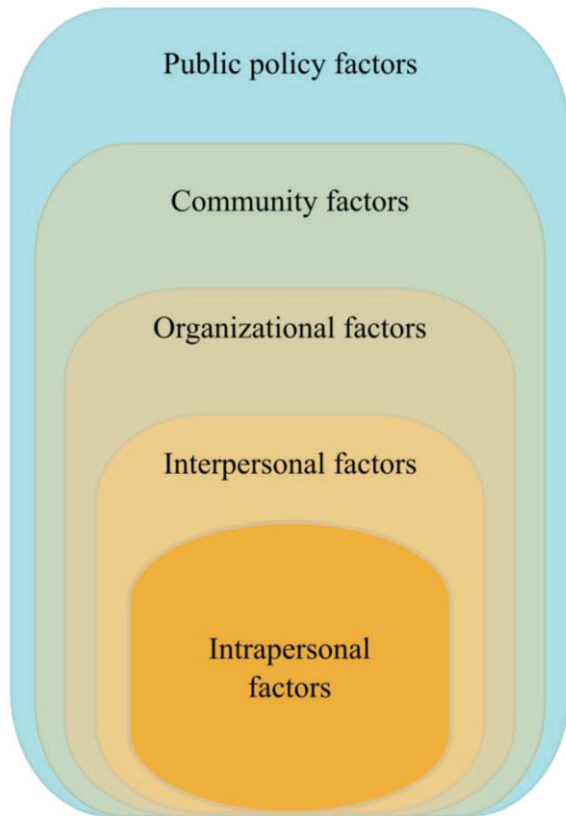
need for flexible policies and procedures; and a need for education for patients, the family and professionals as well as illness-specific education for families.

There are many ecological models that illustrate how an individual is affected by multiple factors and their interplay. The child outcome is a result of the interplay of factors at different levels around the child, as originally proposed by (Bronfenbrenner, 1979). Ecological models are also used as a framework for health prevention and behavioral change. In the ecological model for health promotion by McLeroy et al. (1988), both individual and social environmental factors are targets for the success of health promotion intervention. The model addresses the importance of interventions directed at changing interpersonal, organizational, community and public policy factors to succeed with the intended strategies. The five levels of factors described in this model for health promotion are:

1. intrapersonal factors such as knowledge, attitudes, behavior, skills of the individual;
2. interpersonal process and primary groups, such as social networks, social support systems, family and friends;
3. institutional factors such as organizational characteristics and formal and informal rules and regulations;
4. community factors such as relationships among organizations and institutions;
5. public policy, such as local, state and national laws and politics.

Figure 4

Illustration of the Levels for Health Promotion Described by McLeroy et al. (1988)



In the thesis discussion, I will use the model by McLeroy et al. (1988) to discuss factors that are necessary to succeed with an integrated family focus in adults services, and how these factors relate to the thesis papers. This model is chosen because it takes a holistic view of the interplay and how different factors and levels affect each other.

1.5.2 Sociopsychological concepts influencing professionals' behavior

Two decision-making concepts will be presented and later used to discuss professionals' support of and attendance to minor children: *diffusion of responsibility* and *omission bias*.

Diffusion of responsibility is a sociopsychological phenomenon where individuals feel less responsibility if they believe that there are other people who can take, should take or have taken actions (Darley & Latane, 1968). When a responsibility is distributed among several

individuals, everyone is less likely to take responsibility. Individuals might believe that the situation is already taken care of by other more responsible or skilled individuals or agencies. Whether an individual feels that they have the necessary skills to help, influences whether they feel obligated to take the responsibility. Personal morals can be affected negatively by diffusion of responsibility. When the responsibility of an organization and their obligations are divided among the members, it has been found that people feel less accountable for their work. Individuals tend to focus on their individual work and forget about any broader moral aspects. Individuals feel less obligated to work hard to accomplish a task or a goal if the responsibility is shared within a group rather than if it is an individual responsibility (Darley & Latane, 1968). Individuals can displace the responsibility to others, and in that way not feel morally responsible.

Omission bias is the other concept influencing decision. When faced with a decision of interfering or not, humans judge the harm as a result of commission more negatively than the result of omission (Feldman et al., 2020). Humans prefer the negative consequences caused by no action over negative consequences caused by actions, as humans feel more responsible for the outcomes of active actions, than for the outcomes of choosing to do nothing (Feldman et al., 2020). This is demonstrated by numerous experiments, including the well-known experiment of giving participants the hypothetical choice of pushing a fat man in front of a train in order to save the lives of five people, or doing nothing and consequently killing five people (Edmonds, 2014). Another example is the reluctance to vaccinate a child when the vaccination can cause death, even though the overall likelihood of death from the disease prevented by vaccination is significantly higher than the likelihood of death as a side effect of the vaccine (Ritov & Baron, 1990).

1.5.3 Reluctance to change practice

Changing practice faces aversion both at the individual level and at the institutional level (Godkin & Allcorn, 2008). At an individual level, humans tend to want to maintain status quo, known as psychological inertia, is a phenomenon that explains individuals' tendency to maintain status quo and be reluctant to change, and on an organizational level, the institutional structure of incorporated practice limits the chance for new practice to be established (Godkin & Allcorn, 2008). According to the structuration theory of Anthony Giddens, the institutional structure and the individuals in it affect each other (Hardcastle et al., 2005). The social structure is constructed by the individuals but is also the arena where the individuals are shaped. The individuals are limited by the structure, but at the same time the structure provides the individual with possibilities for actions (Hardcastle et al., 2005).

The theory of self-efficacy by Bandura (1997) applies to work performance, where there is a relationship between self-efficacy and work-related performance (Stajkovic & Luthans, 1998). Accurate descriptions, clear and concise instructions, support elements, and training of employees in developing their self-efficacy in addition to task-related skills will have a positive effect on the work performance (Stajkovic & Luthans, 1998).

1.6 Thesis aims

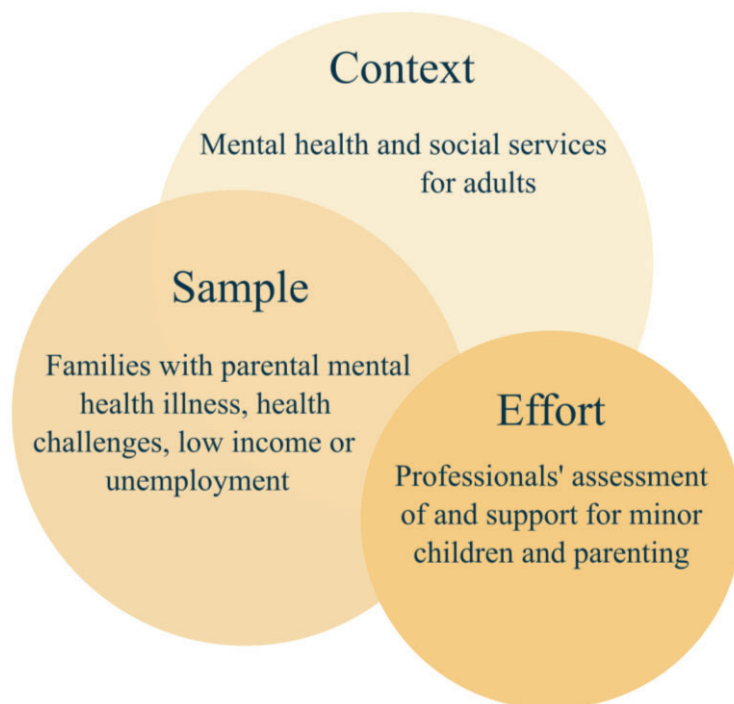
The implementation of new routines and practices in the participating hospital has been evaluated in previous studies from the BAP project. However, there is a lack of knowledge regarding patients' reports about parenting self-efficacy, the performance of the Child Talks intervention and the content of Child Talks conversations. In social services for adults, there is a knowledge gap regarding the level of family focus among counselors.

The overarching theme of the present thesis is *family-focused practice in adult mental health and social services*, or more specifically: *professionals' support for and attendance to*

parenting and minor children of users in adult services. The three papers included in this thesis investigate different aspects of family-focused practice in services that treat and counsel adult users in challenging life situations.

Figure 5

Overarching Themes of the Included Papers in this Thesis.



The overall aim of this thesis was to investigate the extent and the quality of a family focus in adult mental health and social services. In this thesis, I will also discuss what is necessary in order to strengthen the family focus in these services.

1.6.1 Paper 1

The aim of the first paper was to investigate the self-reported level of parenting sense of competence among parents with a mental illness. Next, we aimed to investigate how parents' diagnosis, comorbidity and child age influenced parenting sense of competence scores. Lastly,

we examined whether parenting sense of competence scores were associated with participation in the Child Talks intervention.

1.6.2 Paper 2

The aim of the second paper was to evaluate the performance of Child Talk sessions, particularly focusing on sessions with participating children. We aimed to investigate the participation rate of parents and children in Child Talks, characteristics of participating patients and children, and the thematic content in sessions with children.

1.6.3 Paper 3

The aim of the third paper was to explore the level of child focus practice and the level of knowledge and use of the UN CRC among counselors in social services for adults.

Furthermore, we wanted to gain insight into how knowledge and use of the UN CRC, perceived usefulness of collaboration, and perceived quality of the office's system, routines and guidelines were associated with a child focus among the counselors. We also investigated whether there were any differences between counselors who did ask users about their children compared to counselors who did not.

1.7 Thesis sub-project 1: Children of parents with a mental illness

This thesis is based on two different research projects. Project 1 is a part of the longitudinal research project of the child-focused practice in mental health care for adults called the BAP project. "BAP" stands for "Barn av psykisk syke", which translates to *children of parents with a mental illness*. The BAP project was established in 2010, the same year as it became mandatory by law for healthcare professionals to contribute to meeting children of patients' need for information and support. The project was developed by the Regional Center for Child and Adolescent Mental Health and Child Welfare – North (RKBU North) in collaboration with The University hospital of Northern Norway (UNN) and the non-

governmental organization Adults for Children (VfB). The overall aim of the project was to monitor and support the process of changing clinical practice in the Division for Mental Health and Substance Use Disorders (DMHSD) at UNN, and to ensure identification and support of patients' children. Two interventions were implemented: The Family Assessment Form (FAF) and Child Talks (CT).

1.7.1 Family Assessment Form

The Family Assessment Form (FAF) is an assessment tool to identify minor children of patients. The form consists of 14 questions asking for general information about the patient's children, how the children are taken care of and whether the children are informed about their parents' condition and treatment. The FAF also includes five questions regarding concerns for the children and a 16-item measurement of parental self-efficacy using The Parental Sense of Competence Scale (PSOC),

1.7.2 Child Talks

The Child Talks intervention is a brief health-promoting, psycho-educative, preventive intervention. The intervention provides healthcare professionals with a structure for three conversations regarding the children's situation and needs (Reedtz et al., 2010; Van Doesum & Koster, 2008). The intervention consists of three meetings.

The first meeting is with the patient and, optionally, the other parent of the child. Healthcare professionals explain the intention behind the Child Talks intervention. The parents are invited to talk about their family situation and consequences their illness might have for their children and family. Healthcare professionals should supervise parents with regard to possible effects that parental mental illness might have on children and what might benefit and work as protective factors for the child. In this initial conversation, the next conversation involving the children is planned together with the parents.

The second meeting is with the children. The child is invited to talk about their daily life, express their feelings and ask questions. Information about parental mental illness and the treatment the parent is receiving is given. If the parent is admitted to hospital, information about the duration of the admission and visiting options should also be provided to the child.

In the third and last meeting with the parent(s) and the child(ren), healthcare professionals summarize and discuss the previous conversations together with the family. The family members are given the opportunity to ask questions. Follow-up options to get help and support are discussed with the family.

1.7.3 Implementation results from the BAP study

The clinical change regarding identification of and support for COPMI in the participating clinic has been evaluated in several studies in the BAP project. Before the interventions were implemented in the division for mental health and substance use, information about the current child-focused practice in the clinic was collected. These baseline conditions were assessed in 2010, and outcomes of the initial implementation in terms of identification and support to the children of patients were examined in 2013 (Lauritzen et al., 2014). Measures of the clinical practice were also performed after implementation, at one-year follow up, at five-year follow-up and at eleven-year follow up. In 2015, a five-year follow-up study of the implementation process was conducted aiming to investigate whether the workforce perceived their clinical practice as having changed as a result of the legal change and the implemented interventions (Lauritzen et al., 2018).

Lauritzen et al. (2015) investigated to what extent healthcare professionals in the adult mental healthcare clinic identified minor children of patients. Before implementation, only 44% of professionals with patient contact registered patients' children. Healthcare professionals had in general positive attitudes toward a child perspective in mental healthcare

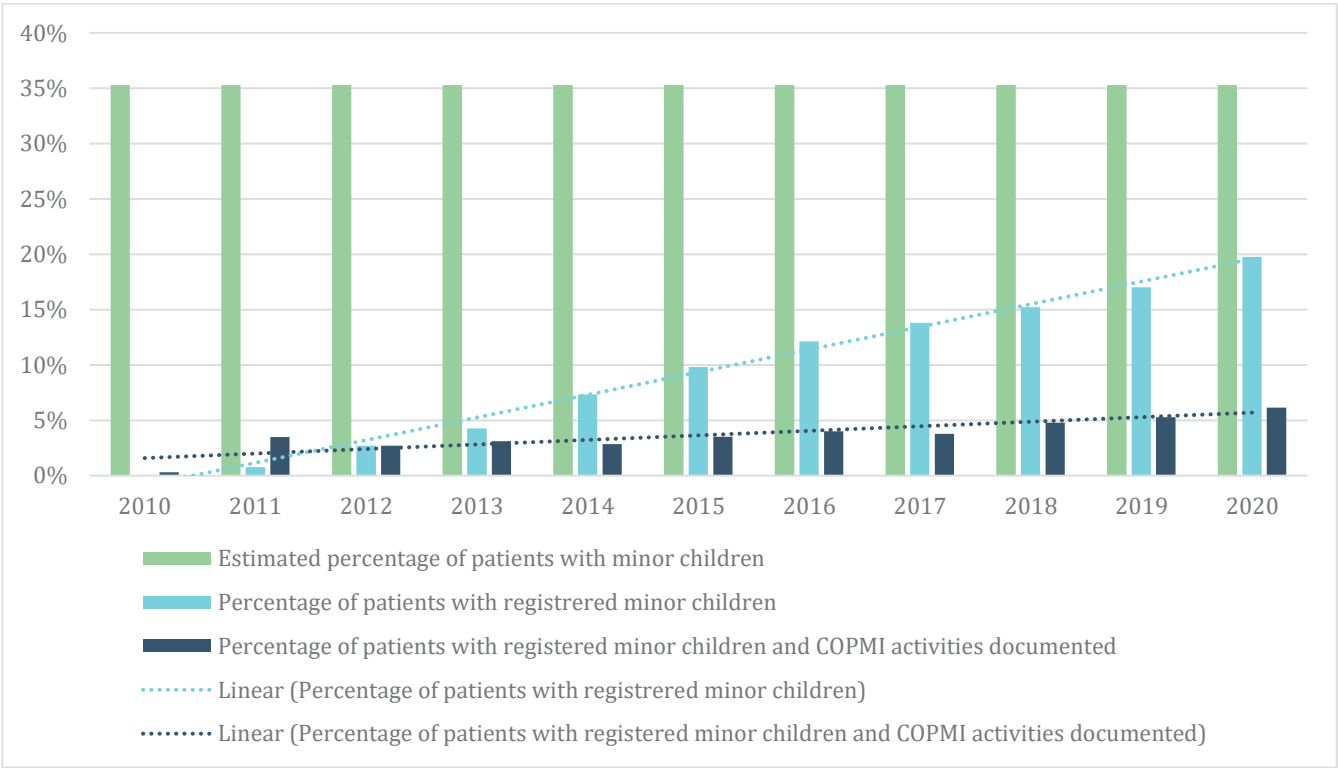
for adults. On a 5-point scale, where 5 was the most positive, the mean score was 4.43 (SD = 0.57, n = 212) (Lauritzen et al., 2015). Implementation challenges for incorporating a family-focused practice at the adult mental health clinic were investigated by Lauritzen and Reedt (2013). The main self-reported barriers were related to organization issues and the lack of time, resources, training, management support, economic support and tools. Identified staff-related challenges were lack of interest and commitment, and knowledge and experience (Lauritzen & Reedt, 2013).

Lauritzen et al. (2014) evaluated the implementation process with regard to these new routines at the participating clinic. There were no significant changes in terms of experiences of having family conversations pre-legislation and three years post-legislation (Lauritzen et al., 2014). Of the healthcare professionals, 25% reported having delivered the intervention Child Talks at post-test (Lauritzen et al., 2014). In terms of registering children of patients, a significant increase was found, from 44% registering children of patient pre-implementation to 65% reporting registering children post-implementation (Lauritzen et al., 2014).

In the 11-year follow-up study conducted by Reedt et al. (2022), data from 2010–2020 on actual registrations of minor children and family-focused activities in the clinic were used, in contrast to the self-reported data previously used. In 2020, almost 19.7% of patients were registered with minor children. The estimated percentage of patients with children is 35.3%, meaning that 55.8% of patients with children had their minor children registered in their journal (Reedt et al., 2022). In this study, we also investigated how many patients had COPMI activities documented in their journal. In 2020, 6.2% of patients had COPMI activities registered in their journal. Of the number of estimated patients with children, only 17.5% of potential children had such activities registered. Figure 6 gives an overview of the development of registration in patients journal over 11 years.

Figure 6

The Trend of COPMI Support from 2010 to 2020 (Reedtz et al., 2022)



1.8 Thesis sub-project 2: A child perspective in NAV

The project concerning child-focused practice in The Norwegian Labor and Welfare Administration (NAV) offices was initiated by The Ministry of Labor and Social Inclusion (earlier named The Directorate of Labor and Welfare, as it is referred in Paper 3). The aim of the initiative was to strengthen the child focus practice at NAV offices and ensure implementation of The United Nations Convention of the Rights of the Child (UN CRC). The project was national, with six participating counties. As a part of the project, a family assessment tool for use among NAV counselors to ensure a child-focused practice was developed. RKBU North was involved in the development of the tool, which was inspired by Child Talks.

2 Methods

This thesis includes papers from two different research projects; hence, two different methods were used and will be described in the following chapters.

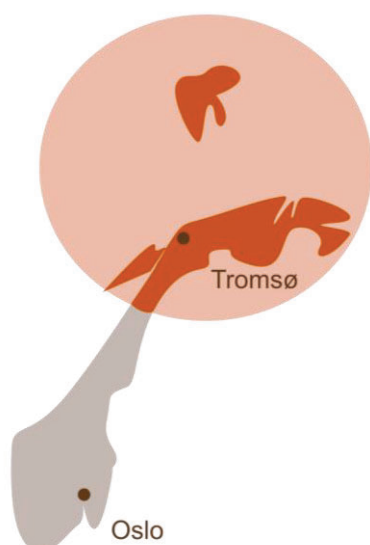
2.1 Thesis sub-project 1: Children of parents with a mental illness

2.1.1 Participants

Participants in Papers 1 and 2 are healthcare professionals and patients with minor children at the division for mental health and substance use disorders at UNN. The FAF was fully or partly completed for 424 patients. The PSOC questionnaire part of the FAF was sufficiently completed for 141 patients. Seventy-eight logbook entries from CT interventions were documented in the EPJ by healthcare professionals. Thirty-five different healthcare professionals performed these CT interventions. The participating hospital (UNN) is responsible for specialist mental health care services in northern Norway and Svalbard. The geographical area of the sample is shown in Figure 7.

Figure 7

Geographical Area that Participants in this Study were from.



2.1.2 Procedure

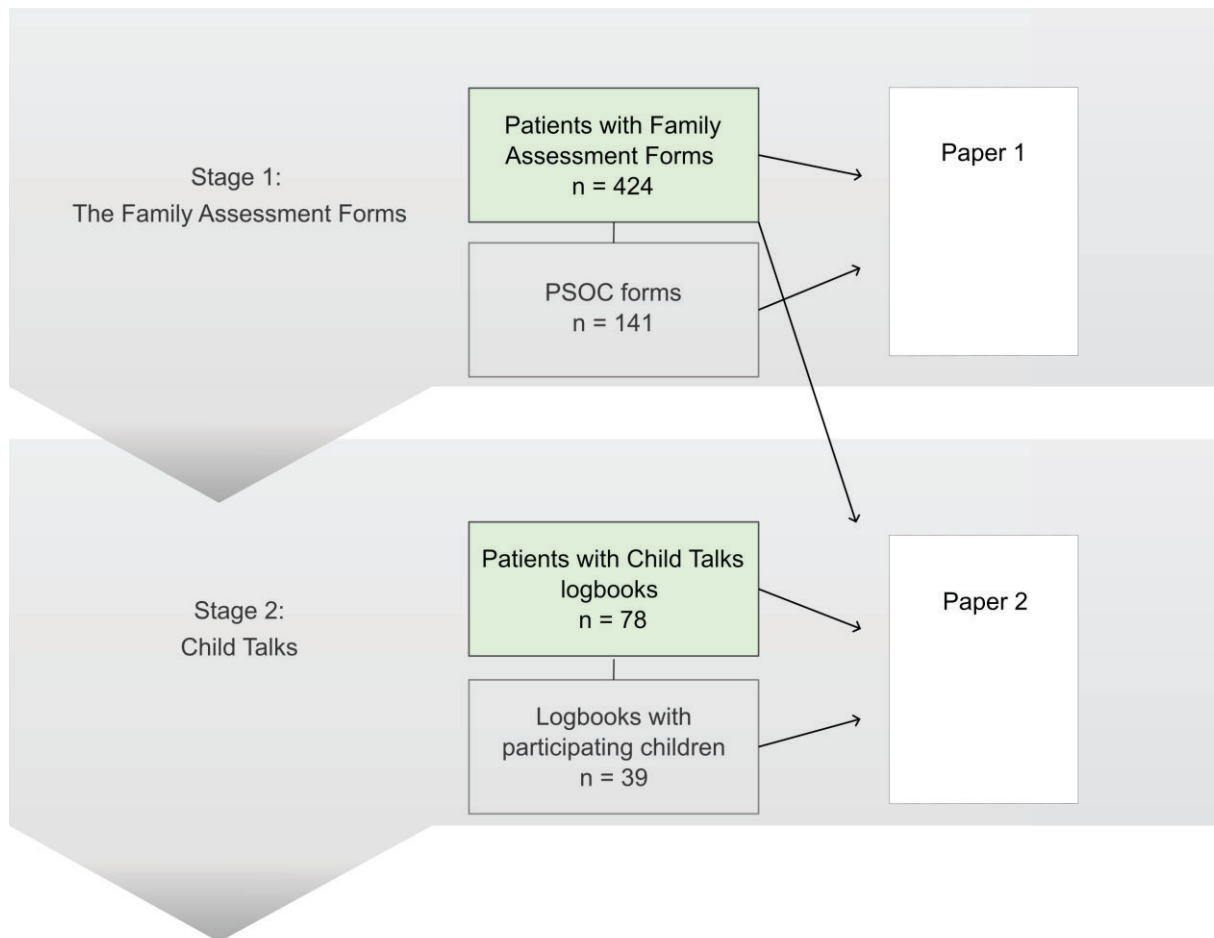
Before the two interventions were implemented at the participating division, the staff was trained by Adults for Children. Adults for Children is a non-governmental organization providing training. Materials for skills training were provided to the child-responsible personnel at the division, and they were gradually given the responsibility for training their colleagues in the new routine themselves. According to the new routine, all patients with minor children were to be assessed using the FAF. The healthcare personnel filled out the FAF in collaboration with the patient. At the end of the FAF conversation, the patient was given the option to participate in the CT intervention. Healthcare professionals filled out Child Talks logbooks after each session. After completion of the CT intervention, patients were invited to fill out an evaluation form. The evaluation form included questions about user satisfaction with CT, parental concern and parental self-efficacy (PSOC). FAF, CT logbooks and evaluation forms were recorded in the electronic patient journals at the participation division from 2010. The data were drawn from the electronic patient journals in 2015.

2.1.3 Data in the current thesis

In this thesis, Papers 1 and 2 are based on data from the BAP project (2010–2015). Data material from the FAF is used in previous publications from the BAP project. CT logbooks and PSCO responses have not been analyzed previously and are the focus of Papers 1 and 2.

Figure 8

Data from the BAP Study in the Current Thesis



In Paper 1, the data material consists of responses to The Parental Sense of Competence scale (PSOC) questionnaire and information from the FAF about children's age and gender, parent's diagnosis, and participation in the CT intervention. Responses to the PSOC questionnaire part of the post-intervention evaluation ($n = 8$) were not included in the analysis due to a very low response rate.

In Paper 2, the data material consists of CT logbooks written by healthcare professionals and information extracted from the FAF. All Child Talks logbooks ($n = 78$) were analyzed to detect participating children and reasons for children's absence. The Child

Talks logbooks with participating children (n = 39) were used in a qualitative thematic analysis. From the FAF, we used information about the number of minor children, child age and gender, living arrangements, parent gender, parent diagnosis and information shared with children about parent diagnosis and treatment.

2.1.4 Measures

2.1.4.1 The Family Assessment form

The FAF consists of questions about the situation and care of a patient's children (name, age, living situation, the children's caregiver while the parent is in treatment, whether the children have received information about the parent's treatment and condition, and the parent's concern for the children). A 16-item measurement of parental self-efficacy Parental Sense of Competence scale (PSOC) is also included in the FAF.

2.1.4.2 The Parenting Sense of Competence scale (PSOC)

The Parenting Sense of Competence scale (PSOC) is a parenting self-efficacy measurement developed by Gibaud-Wallston and Wandersman (1978). The measurement contains two subscales: parenting satisfaction and parenting self-efficacy (Johnston & Mash, 1989).

Parents answer 16 items on a Likert scale. In the present study, the Norwegian version of the measurement was used (Reedtz et al., 2011).

2.1.4.3 Child Talks logbook

The Child Talks logbook is a standardized form for healthcare professionals. Completed forms include a short summary of the Child Talks conversations, entered in the EPJ. The Child Talks logbook consists of open-ended questions and more specific questions about themes talked about in the session, concerns addressed, family support, agreements made, questions asked and follow-up provided.

2.1.5 Statistical analyses

In Paper 1, multiple imputations were performed on item level to estimate missing values. Differences in PSOC mean scores of the different samples were tested using t-tests. Multiple regression models for each subscale of PSOC were tested with the predictors child age, comorbidity and diagnoses. A logistic regression was performed to assess if PSOC scores were associated with participation in CT. Appropriate effect-size measurement calculations were performed for statistical tests.

In Paper 2, simple calculations were made of participation rate for parents and children. Chi-square tests were used to test for differences in scores for participating and non-participating children. When testing for age differences, a t-test was used. Effect sizes were calculated for all statistical tests, with appropriate effect-size measurements.

2.1.6 Qualitative analysis

Child Talks logbooks were analyzed using a six-step phase guide for thematic analyses by Braun and Clarke (2006). All Child Talks with participating children (n = 39) were imported into the qualitative analysis program NVivo 12 Pro. The written logbooks were coded, themes and sub-themes formed, reviewed, adjusted, defined and described. Characteristics and patterns in the conversations with children were explored with an inductive approach, though acknowledging the fact that the framework of the CT logbooks influenced what was written.

2.1.7 Ethical approval

The BAP study was approved by the Data Protection Officer at the University Hospital of Northern Norway (UNN). The regional ethics committees for medical and health research ethics (REK) were presented with the study and confirmed that the project was categorized as a quality assurance project (ref. 2011/2066/REK North). The data used in this thesis were anonymized before the end date for the project, December 31, 2020.

2.2 Thesis sub-project 2: A child perspective in NAV

2.2.1 Participants

Participants in Paper 3 are counselors with user contact working in social services for adults (n = 93). The participants were employed at two different NAV agencies. The participating NAV offices are kept anonymous in coherence with an agreement made with the data provider. Both agencies had received grants from the Directorate of Labor and Welfare through the Childhood Poverty Project. The response rate for the survey was 67%.

2.2.2 Procedure

To assess the degree of implementation of the UN CRC in NAV, a survey was distributed to counselors with user contact in participating NAV agencies in 2015 and 2016. Project contact persons were appointed at the NAV agencies who distributed a link to the survey via e-mail to counselors. RKBU North received the anonymous data on request from The Ministry of Labor and Social Inclusion in 2018.

2.2.3 Measures

The questionnaire was developed by project members and user participants – employees at NAV. To ensure the offices' and participants' anonymity, no demographical variables were included. The questionnaire included four questions about child-focused practice, three questions about knowledge and use of the UN CRC, one question about the usefulness of collaboration with other services and one question about the office routines and systems promoting a child-focused practice.

2.2.4 Statistical analysis

In Paper 3, a confirmatory factor analysis was performed to test the fit of the two created scales for items about “Knowledge and use of the UN CRC” and “Child-focused practice”. Descriptive analyses were used to detect mean scores for the scales. Correlations were used to investigate the strength of relationship between items. A multiple regression analysis was

performed to test predictors for a child-focused practice. A t-test was used to compare means of the created scales for counselors asking about children and non-askers. An ordinal regression analysis was performed to test for differences between counselors asking about children and non-askers for items about collaboration and system, routines and guidelines. Appropriate effect-size measurements were used to describe the size of effects. Effect sizes were interpreted in accordance with Cohen (1988), where $d = 0.2$ is considered a small effect, $d = 0.5$ is considered a medium effect, and $d = 0.8$ is considered a large effect.

2.2.5 Ethical approval

Participants in the study were anonymous during the data collection and throughout the study. Since personal data were not processed in the project, the project was not regulated by the Personal Data Act and hence not notified to The Data Protection Services (SIKT). RKBU North received the anonymous data from the Ministry of Labor and Social Inclusion after approval from all participating offices.

2.3 The design of the overall thesis

In this thesis, the methods used are mainly quantitative methods. However, Paper 2 is inspired by a mixed methods approach, where both qualitative methods and quantitative methods are used to evaluate the delivery of CT. The research questions should always direct the choice of methods (Maxwell, 2013), and by choosing a combination of qualitative and quantitative methods, it was possible to answer all research questions. Points of integration of both methods are in the study design, research questions discussion and the conclusion.

Table 1*Table of the thesis and paper contributions*

| | | | |
|---------------------------------|--|---|---|
| Thesis research question | What is the extent and the quality of a family focus in adult mental health and social services? | | |
| Paper | 1 | 2 | 3 |
| Paper title | Parents with a mental illness and their sense of parenting competence | Support for children of parents with mental illness: an analysis of patients' health records | Child-focused practice in social services for adults in Norway |
| Journal | <i>Advances in Mental Health</i> | <i>Frontiers in Psychiatry</i> | <i>Journal of Social Work</i> |
| Aim of the study | Investigate parental sense of competence among parents with a mental illness. | Evaluate the performance of CT sessions, with a particular focus on sessions with participating children. | Explore the child focus in social work practice of counselors at NAV. |
| Data material | Self-reported survey-based quantitative data | Qualitative data of written logbooks and survey based quantitative data | Self-reported survey-based quantitative data |
| Family-focus | Parenting | Performance of Child Talks and inclusion of children | Child focus in social work |

3 Results

3.1 Paper 1

Mothers with a mental illness scored significantly higher on PSOC parenting satisfaction, both in comparison with the normative Canadian sample ($t(390) = 3.03, p < .005$) and the normative Australian sample ($t(390) = 2.41, p = .02$). The effect sizes of the differences were small to medium: $d = 0.34$ and $d = 0.28$, respectively. Parents with a mental illness also scored significantly higher on PSOC parenting self-efficacy in comparison with the Canadian sample; this was true for both mothers ($t(390) = 9.94, p < .005$) and fathers ($t(259) = 7.43, p < .005$). The effect sizes were very large: $d = 1.13$ and $d = 1.21$, respectively. No significant differences were found for the remaining comparison of PSOC parenting satisfaction scores and PSOC parenting self-efficacy scores, including the comparison with the normative Norwegian sample based on the general public.

Regression models for PSOC parenting satisfaction and PSOC parenting self-efficacy with the predictor variables *child age*, *parent diagnoses* and *multiple diagnoses* were not significant. None of the variables made significant contributions to explaining the variance in the PSOC scales.

Parents participating in Child Talks had lower mean scores on PSOC parenting satisfaction and parenting self-efficacy. For every 1-point increase in the PSOC parenting satisfaction score, the odds of participating in Child Talks decreased by 5%. PSOC parenting self-efficacy scores did not significantly influence the odds of participation in Child Talks.

3.2 Paper 2

Eighteen percent of patients with minor children, who were assessed with the FAF, participated in the CT intervention. In half of the performed interventions, some or all of the patient's children were participating. Thirty-nine percent of the children of CT participating

patients, participated in CT themselves. Of all the children registered in the FAF, only 7% participated in CT. Reasons given for not including children were patients' discharge from hospital, patients' lack of contact with children, lack of consent and lack of response from the child's other parent.

More children of mothers than fathers in treatment were participating in Child Talks. However, the difference of participating children compared to non-participating children in terms of the gender of the parent in treatment was not significant: $\chi^2(1, N = 113) = 3.805, p = .051$. The difference was of a small to medium effect size ($\phi = 0.18$). Participating children and non-participating children were not significantly different in mean age ($t(111) = 1.83, p = 0.07$) or gender ($\chi^2(1, N = 123) = 0.335, p = .563$). However, a significant difference was detected between participating children and non-participating children in terms of whether the children had received information about their parents' hospitalization or treatment ($\chi^2(1,83) = 10.62, p = .001$) and whether the children had received information about their parent's condition ($\chi^2(1,80) = 6.54, p = .011$). The children who were participating had more often received information about treatment and condition with a magnitude of the difference between participating and non-participating children being $\phi = .36$ (medium) and $\phi = .28$ (small to medium), respectively. Participating children more often lived with the hospitalized parent. The difference between participating and non-participating children in terms of living with the hospitalized parent was significant ($\chi^2(1, N = 94) = 11.93, p = .001$) with a medium effect size ($\phi = .36$).

In sessions with children, the three main themes of the conversations reported by healthcare professional were: how the parental mental illness was talked about within the family, the problems and struggles children were experiencing, and healthcare professionals' evaluations and support actions.

3.3 Paper 3

The result of the confirmatory factor analysis resulted in a better fit for the data in the hypothesized model with items loading on two latent scale variables, compared to the general model, where all items loaded on a general factor. The computed scale variable of child-focused practice had a mean score of 3.36 on a five-point scale ranging from never (1) to always (5) ($SD = 0.86, n = 90$). The computed scale variable of knowledge and use of the UN Convention on the Rights of the Child had a mean score of 2.73 on a five-point scale ranging from low (1) to high (5) ($SD = 0.77, n = 93$). There were significant weak to medium positive correlations between most items in the two scales. 41% of a child-focused practice was explained by the variables *knowledge and use of the CRC* and *system/routines/guidelines*. Knowledge and use of the UN convention of the rights of the child made the strongest significant contribution.

Higher levels of perceived benefits of collaboration with other local institutions in cases concerning children was weakly positively associated with NAV counselors more often assessing children's need ($r = .237, n = 91, p < .05$).

Perceived quality of the offices' systems, routines and guidelines to ensure a child-focused practice was weakly positively associated with assessment of children's need ($r = 0.285, n = 93, p < .01$) and asking about children's needs ($r = 0.258, n = 91, p < .01$).

Counselors asking about children scored higher on knowledge and use of the UN CRC. Comparison of mean scores of knowledge and use of the UN CRC for counselors who asked about the children and counselors who did not always ask about the children showed a significant difference ($t(82) = -2.61, p = .011$) with a medium effect size ($d = 0.58$).

4 Discussion

The overall aim of this thesis was to investigate the extent and the quality of a family focus in adult mental health and social services. Children of parents in challenging life situations are at risk for adverse life outcomes (Pillas et al., 2014; Reupert & Maybery, 2016). Yet, results from papers in this thesis revealed a lack of an integrated family focus in services for adults. Findings in Paper 1 pointed toward a possible problem regarding parents' trust when it comes to sharing parenting problems with professionals (Kristensen et al., 2023). Paper 2 revealed a low rate of participation in Child Talks, a low rate of inclusion of children and hence a low adherence to the manual, and problems regarding referrals and contact with other services (Kristensen et al., 2022). Paper 3 revealed that in adult social services, a family focus is at an even more undeveloped level since counselors were not always asking about children or taking their situation into consideration (Kristensen et al., 2021).

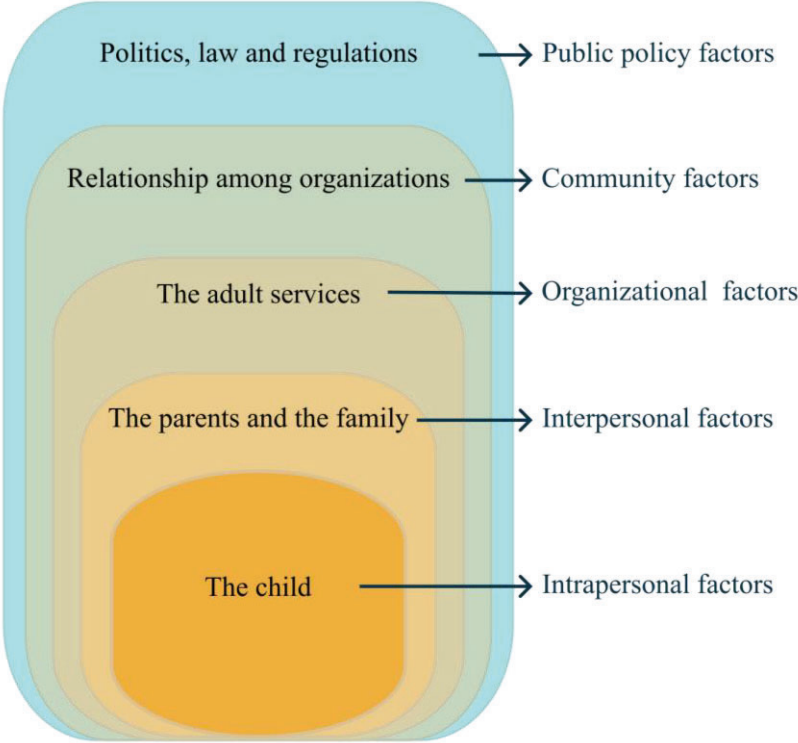
I will in this part discuss the findings of the papers in relation to the knowledge from the research field that was presented in the introduction part. Moreover, I will discuss how my findings can contribute to understanding what is necessary in order to strengthen the family focus in adult services. A family focus in adult services is aimed to promote the child's health (Lannes et al., 2021; Thanhäuser et al., 2017), or more explicitly: to improve communication within the family, improve parenting, detect families in need for additional help and assist in provision of follow-up at other services, and to consider the children's best interest in decisions that are affecting them (Mullick et al., 2001; Reupert & Maybery, 2010; Riebschleger et al., 2019; Van Doesum & Koster, 2008).

I will now propose a model for an integrated family focus in adult services (Figure 9) adapted from the ecological model for health promotion by McLeroy et al. (1988), which was presented in the introduction part (Figure 4). The model of McLeroy et al. (1988) is chosen as

a basis because it incorporates a holistic and ecological understanding of how the different levels affect each other. Hence, the model enables an understanding of practice change as something that is not only happening top-down, but by interplay and relations of dependence between the different levels. McLeroy et al. (1988) highlight the importance of not viewing the elements in isolation when working toward achieving sustainability of health promotion efforts. This view is based on the same belief as the one underpinning the Structuration Theory of Anthony Giddens (Hardcastle et al., 2005) and the Ecological Theory of Bronfenbrenner (1979), according to which individuals and structures affect and lay the foundation of further development for each other. The model by Maybery and Reupert (2009), described in the introduction part, is not chosen as a framework, since it is a hierarchical model where factors are divided into stages. Additionally, family focus practice barriers that are detected in the papers of this thesis and in earlier studies by Eassom et al. (2014), Gregg et al. (2021), Kokorelias et al. (2019), Lauritzen et al. (2015), Maybery and Reupert (2009), Tuck et al. (2023) and Webb et al. (2021) can be incorporated into the proposed model. Webb et al. (2021) used a similar approach to arrange the barriers to and facilitators for implementing perinatal mental health care in health and social care settings in their systematic review. Elements in the sustainability model by Allchin et al. (2022) of how multiple systems are involved in creating sustained family-focused practice also resonate with the proposed model.

Figure 9

Proposed Model for an Integrated Family Focus in Adult Services.



Note: This model is based on the model for health promotion by McLeroy et al. (1988).

The different levels in the model of McLeroy et al. (1988) is here adapted to the context of family-focused practice in adult mental health and social services. Hence, the different levels and factors in the proposed model are limited by their relation to a family focus in adult services. I will now discuss how results from the papers in this thesis relate to the different levels in this model, and also what are important factors for a successful integration of a family focus in adult services.

4.1 Intrapersonal factors – the child

According to the proposed model, factors at the intrapersonal level have implications for the integration of a family focus. The literature provides many arguments for why children

themselves should participate and receive information directly from professionals to improve their health – which is the overall aim of a family-focused practice. First of all, children themselves have reported that they prefer to receive information about parental mental illness from professionals, and they value the opportunity to be able to ask questions (Grové et al., 2016). Moreover, mental health literacy can protect against mental health problems in children (Reupert & Maybery, 2010; Riebschleger et al., 2019). Receiving information about parental mental health strengthens children’s ability to cope with and understand their situation; reduces stigma; reduces loneliness; lowers stress, confusion and concerns about their parent; and lowers the threshold for seeking professional help (Grové et al., 2015; Riebschleger et al., 2017).

Findings in Paper 2 showed differences between Child Talks-participating children and non-participating children (Kristensen et al., 2022). Hence, there were characteristics of the child that had implications for the level of integration of a family focus. Participating children were mostly older, and 80% were more than nine years old (Kristensen et al., 2022). The results also showed that participating children more often lived with the parent with a mental illness. Additionally, participating children had more often received information about parents’ mental illness and treatment before participating in the interventions (Kristensen et al., 2022). The children’s general knowledge and attitudes regarding mental illnesses may therefore be a factor at the intrapersonal level that can facilitate a family focus, as knowledge and attitudes can contribute to children’s willingness and wish to participate in preventive interventions (Riebschleger et al., 2017). However, factors related to the child were never given as the reason for not including the children. A finding in Paper 2 from the thematic content analysis of conversations with included children was that children usually appreciated receiving information from professionals (Kristensen et al., 2022). However, some children did not want information or to visit their parent in treatment. The fact that these children did

not want information did not impact their participation, since they were in fact participating in the intervention. Based on these findings, it seems that there are mainly factors at the interpersonal, organizational, community and public policy levels that impact children's participation in a family-focused intervention, as the factors contributing to improving children's knowledge must be related to areas such as the family, the school and society.

4.2 Interpersonal factors – the parents and the family

The proportion of parents among users of adult mental health or social services seems to be higher or similar to the 32% proportion of the adult population in Norway who parent minor children (Hattrem, 2022; Maybery & Reupert, 2018; Normann & Epland, 2023). Parental mental illness, health issues influencing work abilities and low income can affect parents' level of function, parenting abilities, family relationships and family socioeconomic status (Bøe et al., 2014; Hosman et al., 2009; Oyserman et al., 2005). The impact that parents' situation has on their children's situation is evident (Bürge et al., 2010; Hosman et al., 2009; Norwegian Institute of Public Health, 2022; Pierce et al., 2020; Pillas et al., 2014; Poulain et al., 2020; Reupert & Maybery, 2016; Slomian et al., 2019; Stein & Harold, 2015). Hence, parenting and support of minor children of service users should be an incorporated practice in adult mental health and social services.

The overall participation rate of Child Talks reported in Paper 2 was low (Kristensen et al., 2022). Only 18% of parents assessed with the FAF participated in Child Talks. In the participating families, only 39% of the children participated. Reasons for children not participating in Child Talks were mainly related to the parent. The most common reasons given were that the patient was soon to end treatment or had little contact with their child. Other reasons were that the patient rejected the offer, didn't reply, or that the other parent of the child did not consent (Kristensen et al., 2022). Incorporating a family focus in services for

adults where users are not expecting to discuss family matters may be difficult. Users might find the focus on family and questions about children and parenting out of place, since these services traditionally do not focus on the children. If parents believe that professionals are intervening in a domain that is not their responsibility, they may be disinclined to show the need for or ask for help. The perception of a family focus as inappropriate or as a responsibility of other organizations, found as a family focus barrier among professionals by Gregg et al. (2021), may also affect the patients' attitudes toward a family focus. Parents' trust in the professional is found to be important for the success of a family focus (Webb et al., 2021), but parents may not believe in professionals' ability to help them with issues regarding parenting and children.

In addition to the low participation rate found in Paper 2 (Kristensen et al., 2022), parents also reported higher than expected on their parenting sense of competence in Paper 1 (Kristensen et al., 2023). An explanation may be that parents with mental illnesses feel that they need to prove that they are capable of being good parents because of social stigma and attitudes (Nicholson et al., 1998), and may therefore have overreported their sense of competence. In general, respondents tend to underreport socially undesirable actions and overreport socially desirable ones when asked about sensitive topics (Krumpal, 2013). Communicating clearly that a family focus is an included part of the practice may be important to ensure parents of the professionals' competence, and hence make it acceptable for parents to talk about parenting and children. This is supported by the findings in Webb et al. (2021), where an open, non-judgmental, listening and motivating communication style among professionals facilitated a family focus.

In Paper 1, it was also found that parents with lower PSOC satisfaction scores participated more often in Child Talks (Kristensen et al., 2023). Participant responsiveness –

the degree of participants engaging in or perceiving the intervention as relevant to them – can influence intervention fidelity (Carroll et al., 2007). Hence, the participation rate in Child Talks (Paper 2) may have been influenced by a lack of perceived relevance for families, but for parents with lower PSOC satisfaction scores (Paper 1), the intervention may have been perceived as more relevant, and therefore increased participation.

Findings from the contents of the Child Talks conversations in Paper 2 revealed that some parents were reluctant to inform their children about their mental illness. Some parents were afraid that they would add to their children’s worries (Kristensen et al., 2022). The stigma related to being a parent with a mental illness can explain these findings, and the findings in Paper 1 where parents may have overreported their sense of parenting competence. Stigma is known to be a barrier for families to seek help from professionals (Riebschleger et al., 2017). This explanation is also backed up by the finding in Paper 2 that children who had already received information about their parent’s condition and treatment more often participated in the Child Talks intervention (Kristensen et al., 2022). These families may have been more open about parental mental illness and may therefore have been more willing to participate in a family focus intervention. Knowledge and openness about mental illnesses has been found to reduce stigma and lower the threshold for seeking help for families and children (Riebschleger et al., 2017). Improving families’ knowledge and attitudes calls for actions at higher levels in the family-focused model, such as mental health education in schools and efforts to decrease the stigmatizing of mental illness in the society.

4.3 Organizational factors – the adult services

The organizational level in the proposed model for an integrated family focus consists of the mental health and social services for the adults. These services aim to improve the situation of parents through treatment, economic benefits and counseling (Cuijpers et al., 2015; Lucas et

al., 2008). Improving parents' situation has secondary impacts on the child's situation (Cuijpers et al., 2015; Hosman et al., 2009). Adult services can also influence the children's situation more directly through family intervention, consideration of children and provision of needed help (Lannes et al., 2021; Reupert & Maybery, 2016). Efforts may reduce children's stress levels and improve mental health literacy, well-being, health, socioeconomic status, nutritional intake, neighborhood and housing (Gottlieb et al., 2017; Havinga et al., 2021). Omitting a family focus also has consequences, as it can impact and have negative consequences for the children's life (Feldman et al., 2020).

Adult mental health and social services are at different stages in the development of an integrated family-focused practice relating to legislation and regulations, implementation of efforts and the scientific knowledge base. Adult mental health services have come the furthest. However, as shown in Figure 2, there is a large overlap between receivers of treatment in mental health care and receivers of counseling in adult social services. This implies that many users of adult social services are parents of the same high-risk-group of children. Arguments for why adult social services should incorporate a family focus are established and the research and practice field needs to follow.

Findings of Paper 2 showed that the family-focused practice in adult mental health services, including children in meetings, was not implemented. Even though children should participate in the second meeting and optionally the third meetings according to the intervention manual (Van Doesum & Koster, 2008), only 39% of the children in families who received the intervention participated (Kristensen et al., 2022). Including children require more involvement and more extensive efforts within the organization and at the other levels of the model to achieve an integrated family focus (Allchin et al., 2022; Godkin & Allcorn, 2008). Such efforts include more collaboration, more training and more resources in the

services (Maybery & Reupert, 2009). The integration of a family focus in these services both enables and requires actions, as a family focus requires and will have implications for, adjustment of laws, procedures and regulations, and organizational structures within and between services (Hardcastle et al., 2005; McLeroy et al., 1988). Hence, a family focus at the organizational level has implications for all other levels represented in the model.

The adherence to the Child Talks manual and the implementation fidelity were low since few children were included in the intervention (Kristensen et al., 2022). Low fidelity can be caused by low quality of intervention training or low levels of support by staff (Carroll et al., 2007). In earlier studies from the BAP project, a lack of training, knowledge and experience was reported as a barrier by professionals (Lauritzen & Reedtz, 2013). Poor training was also detected as a barrier to a family focus practice in the systematic review by Webb et al. (2021). By contrast, professional training, accurate descriptions, clear and concise instructions, and support are found to have a positive effect on work performance (Stajkovic & Luthans, 1998).

There are individual and organizational psychological and social phenomena that can explain why implementing new practices in adult services may be difficult. The phenomenon of diffusion of responsibilities can explain why professionals may assume that the children are taken care of by other services for whom children are a main responsibility (Darley & Latane, 1968). Professionals' approach to a family focus is found to be influenced by their belief in a family focus and their perceived role, responsibility and competence (Tuck et al., 2023). If professionals believe that someone else are more skilled at helping, they are less likely to take any actions (Darley & Latane, 1968). The low integration of family focus in adult services found in Papers 2 and 3 (Kristensen et al., 2021; Kristensen et al., 2022), and the lack appropriate actions by professionals when children and families shared severe

problems (Kristensen et al., 2022), may have been caused by professionals' perceived responsibility and competence. A lack of confidence and a lack of training in providing support to families are found to be barriers to a family-focused practice (Gregg et al., 2021). Professionals might also have been reluctant to focus on parenting due to a fear that users or patients will perceive it as an interference in a domain that is not their responsibility. In fact, professionals who perceive a family focus as inappropriate, damaging or a task outside of their responsibility are found to be less likely to engage in family-focused practices (Gregg et al., 2021) This barrier has also been detected by Maybery and Reupert (2009).

In accordance to the omission bias, when humans are faced with a decision to take actions, the results of negative consequences by omission are preferred over negative consequences caused by active actions (Feldman et al., 2020). For professionals, this might be translated into choosing not to get involved in parenting and the child's situation, and hence risking the negative consequences of not having a family focus over the negative consequences of having a family focus. Possible negative consequences of not having a family focus may include not providing needed help for a child and, secondarily, not preventing adverse child outcomes. Possible negative consequences of having a family focus can be perceived as harming the therapeutic relationship, having less time for other tasks and harming the children more than helping (Lauritzen & Reedtz, 2013). These perceived consequences align with barriers found to a family-focused practice, such as lack of time and heavy workloads (Webb et al., 2021). The consequences of omission of a family focus, such as not contributing to improving children's life outcomes, are less visible and more long-term than the consequences of having a family focus, which has immediate and visible consequences, such as less time for other tasks. Hence, professionals' decision to have a family focus may be influenced by omission bias.

Integration of a new practice requires organizational change, which again requires that all members in the organization have a common goal (Eassom et al., 2014). Organizational structures and professionals' reluctance to change make it difficult to change established practices (Hardcastle et al., 2005). As stability is threatened by change, professionals can be resistant to change in an organization (Hardcastle et al., 2005). In accordance with the Structuration Theory by Anthony Giddens, the social structure at adult services influences the professionals' actions, both by enabling and constraining them. Professionals' actions can both reproduce and transform the structures. Habits and ways of executing the profession are part of the social structure at the adult services. Changing these practices requires both individual changes among the professionals, such as training and attitudes, and change in the social structures that support the practice. Two important factors for success in practice changes are *establishment of working routines* and *strong leadership* (Eassom et al., 2014). This corresponds with the findings in Paper 3, where the perceived quality of the offices' systems, routines and guidelines to ensure a family-focused practice was weakly positively associated with family-focused practice (Kristensen et al., 2021).

In Paper 1, parents with a mental illness did not view or report feeling less competent in the parenting role compared to the general population (Kristensen et al., 2023). As discussed in the paper, this finding may be explained by factors such as stigma, fear of custody loss or impaired self-awareness (Nicholson et al., 1998; Reupert, Gladstone, et al., 2021). Being aware of such factors is important, and explicitly communicating to families the aim of the conversations can make parents and children feel safer. Introducing the subject *parenting competence* in services that traditionally have a one-sided focus on helping the user calls for good communication skills among the professionals in order to meet the insecurity and suspicion it might awaken among parents. A lack of open and honest communication is found to be a barrier to family focus, while trusting relationships with an open, non-judgmental,

listening and motivating professional is found to be a facilitator (Webb et al., 2021). Moreover, it is important that healthcare professionals are equipped to process traumatic episodes that children are sharing. In Paper 2, some children shared stories of domestic violence, physical and mental abuse, and suicide thoughts, but professionals did not always take appropriate actions (Kristensen et al., 2022). The inadequate follow-up of children corresponds with the result of Nordtug and Grimsgaard (2021). Nordtug and Grimsgaard (2021) found that children of parents with a mental illness who were participating in support groups felt that what they expressed was not always acknowledged by the group leader. The lack of acknowledgment of children's problems may be a communication problem – that is, that the healthcare professionals don't know how to respond to what the children are sharing (Langballe, 2011). Training and procedures for how to handle traumatic episodes the children may share can contribute to making the professionals less reserved when it comes to talking with children as well as improving their confidence. A lack of confidence and training in providing a family-focused practice is, on the other hand, found to be a barrier to an integrated family-focused practice (Gregg et al., 2021). Training should be incorporated in both education and in internal work-place training, as improved skills in talking to families and children can be achieved by education and internal training (Gutiérrez-Puertas et al., 2020; Kerr et al., 2020; Reith-Hall & Montgomery, 2022).

To sum up: At the organization level, the adult services did not attend to and support minor children in accordance with what the outcome risk for these children necessitates. Larger organizational changes, more time and resources, better systems, routines and guidelines will facilitate an integrated family focus in adult services. Interventions and support options need to be evidence-based and fully implemented. In the future, educational programs for health and social services should incorporate a stronger family focus as well as communication training.

4.4 Community factors – relationship among organizations

The next level in the model relates to community factors. Collaboration and good relationships between organizations and agencies are critical to the development and delivery of services, and increasing collaboration is important for health promotion activities (McLeroy et al., 1988). Collaboration has been pointed out as a factor facilitating family focus in other studies as well. In the systematic review by Webb et al. (2021), the authors found that collaboration between services is important to facilitate an integrated family focus in adult services, as collaboration can contribute to easing the work regarding referrals and support from other services. In Maybery and Reupert (2009), lack of collaboration was detected as one of the main barriers to a family-focused practice in adult mental health services.

Results from both Paper 2 and Paper 3 suggested that a lack of collaboration was a factor inhibiting a family focus in adult services. In Paper 2, the thematic analyses of conversations with children showed that children were not referred to adequate services or provided necessary follow-up when they reported having severe problems (Kristensen et al., 2022). In Paper 3, a weak positive association between perceived benefits of collaboration with other local organizations and assessment of children's need was found (Kristensen et al., 2021). Since the direction of causality is unknown, the association can be explained either by better collaboration causing more assessment of children's needs by improved family focus, or by more assessment of children's need making better collaboration necessary. Furthermore, the association can be caused by confounding factors such as positive attitudes toward family-focused practice influencing both collaboration and child assessment practices. Based on the evidence in the literature, however, collaboration seems to be an important factor for the success of a family-focused practice (Maybery & Reupert, 2009; Webb et al., 2021).

Moreover, Atkinson et al. (2007) found collaboration to be advantageous in terms of early identification of problems, improved access to services, and quicker and more appropriate referrals. The finding of Paper 2 of inadequate follow-up of children (Kristensen et al., 2022) underlines the importance of professionals' knowledge about support options for children and families and knowledge of where they can refer children and families in need of additional help. Professionals need to be able to inform families about options for further help. Detection of early signs of illness or problems in children and the initiative of further support and referrals are important aims of the intervention Child Talks (Van Doesum & Koster, 2008). Not providing necessary support through professionals' omission of actions may send the message that the child's or the family's situation is not severe enough. If professionals are trivializing the situation of the children and the families, it may also become more difficult for them to seek help in the future. Knowledge about service options, good relationships between services and collaboration seem to be important factors for achieving a family focus in adult services. On the other hand, a lack of collaboration is found to be one of the barriers to assessment and referrals in a family-focused practice (Webb et al., 2021).

As described by Cooper et al. (2016), there is a range of factors, structures and resources that need to be in place in order to promote successful collaboration. Factors that can facilitate collaboration between services, and thereby contribute to a family-focused practice, are joint meeting points, joint training, understanding, respect and trusting one another. Moreover, communication between services is important, and needs to be frequent, regular, clear, transparent and streamlined (Cooper et al., 2016). Collaborations across services can make the diffusion of responsibilities difficult, weaken power differences, and force a change of structures. Improved collaboration and integration of family services will make help more accessible to families, and children and families better cared for.

4.5 Public policy factors – politics, law and regulations

Factors at the public policy level that can influence health promotion are: resources provided, laws and regulations, increased public awareness and education (McLeroy et al., 1988). For an integrated family focus in adult mental health and social services, the laws regarding children's rights seems to impact the integration of a family focus in adult services, as findings in Paper 3 suggest (Kristensen et al., 2021). In the BAP project, the implemented FAF and The Child Talks intervention fulfill the professionals' legal obligations (Reedtz et al., 2010; Van Doesum & Koster, 2008). The fact that the implemented efforts resonated with the professionals' legal obligations was probably a factor that increased the family focus (Lauritzen et al., 2014) but did however not result in an incorporated family-focused practice (Kristensen et al., 2022).

Both healthcare professionals and adult social services counselors have legal obligations concerning children. Adult social service counselors have to adhere to the UN CRC (The United Nations Human Rights office of the high commissioner, 1989), while healthcare professionals must in addition carry out their practice in accordance to The Health Personnel Act (2010). The Health Personnel Act (2010) is the legislation in which healthcare professionals are specifically trained and required to adhere to by their profession.

The legal responsibility for healthcare professionals is specific regarding when personnel is required to contribute to meeting children's need for information and support, as § 10 a. in The Health Personnel Act (2010) clearly states that the law applies to all minor children of patients with mental illnesses and substance use disorder. However, the wording of the law does not require direct involvement of the children. According to § 10 a. healthcare professionals shall, "when necessary" to safeguard the needs of patients' minor children, talk to the patient about the child's need for information and support and offer information and

guidance concerning support options. The child and other caregivers shall be given the opportunity to participate in such conversations. Healthcare professionals should, in accordance with §10 a., letter c., “contribute” to giving the child and the caregivers information about the patient’s illness, treatment and possibilities for meetings. According to the legal regulations, healthcare professionals are thus not required to give the child information themselves (Helsedirektoratet, 2020). The regulation states that it can be expedient for healthcare professionals to inform the child’s caregiver, who subsequently informs the child, or, as an alternative, the child can participate in a family conversation (Helsedirektoratet, 2020). The inclusion of children in Child Talks was therefore not required by law, even though the manual requested child participation. Professionals may therefore have been reluctant to do extra work that is not explicitly mandatory by law. However, the overall delivery of the Child Talks intervention was also at a very low rate (18% of assessed families). The law seems accordingly not to be the only cause for professionals not having a family focus. In the 11-year follow up of Reedtz et al. (2022), even the identification of minor children, a task where there is no doubt about professionals’ legal responsibilities, was at a too low rate.

Nevertheless, the law’s general and nonspecific formulations regarding responsibility allocation when it comes to informing the children are not contributing to integration of family focus into these services. Accurate work descriptions and concise instructions are known to have a positive effect on work performance (Stajkovic & Luthans, 1998). By law, healthcare professionals are only obligated to “contribute” to attending to minor children “when necessary”. The non-specific responsibility allocation of the law can contribute to diffusion of responsibility, that individuals feel less obligated to accomplish a task or a goal if the responsibility is shared rather than individual specific (Darley & Latane, 1968). Diffusion of responsibility can influence professionals, organizations and political bodies that distribute

fundings and resources. The wording of the law opens up for interpretation with regard to when it is necessary to safeguard the needs of patients' minor children and what actions may be considered as contributing to giving information and support. The wording undermines the aim of the law, which is to enable children and parents to cope with the situations and prevent problems (Helsedirektoratet, 2020). Healthcare professionals have no chance of ensuring that the children's need for information and necessary support is met if they themselves are not talking directly with the children.

The wording of the CRC is, however, more forceful. Article 12 states that state parties "shall assure" children the right to express views freely in matters affecting them, and Article 3 states that the best interest of the child "shall" be a primary consideration in all actions concerning children (The United Nations Human Rights office of the high commissioner, 1989). The wording legally ought the state to assure that children are given this right and that children's best interest is a primary consideration. Moreover, Article 6 of the CRC, second paragraph, order states parties to ensure, to the maximum extent possible, the survival and development of the child (The United Nations Human Rights office of the high commissioner, 1989). In the general comment no 5. from 2003, the Committee on the rights of the child (2003) expects states to interpret the development of the child in a broad sense, including the child's physical, mental, spiritual, moral, psychological and social development. Implementation measures should be aimed at achieving the optimal development for children (Committee on the rights of the child, 2003). It is evident that parental mental illness and parental adversity has a negative impact on children's development (Devenish et al., 2017; Reiss, 2013; Reupert & Maybery, 2016). Therefore, to ensure children's development to the maximum extent possible, services for parents who are in adverse life situations should make extensive efforts to obey the UN CRC.

Despite the UN CRC (The United Nations Human Rights office of the high commissioner, 1989) being less open to interpretation compared to The Health Personnel Act (2010) regarding whether it is necessary to take actions, the results of this thesis shows that a family-focused practice is better incorporated in adult mental health services compared to adult social services. The reason might be that the UN CRC does not specify to which services the law applies, thus diffusing the responsibility to act according to the UN CRC among services.

Findings of Paper 3 revealed that knowledge and use of the UN CRC among professionals in adult social services was associated with a family-focused practice (Kristensen et al., 2021). Professionals who more often asked about minor children scored higher on knowledge and use of the UN CRC, and these professionals scored significantly higher than professionals who did not ask about children on the variable measuring knowledge and use of the UN CRC. The integration of UN CRC among professionals therefore seems be related to a family focus in adult social services. However, more research is needed to control for other variables affecting the relationship between these variables and to establish causality.

Parenting minor children is common among adult health and social service users (Figure 2). The prevention opportunities are therefore huge in these services as social services and health services are often visited in the early development trajectory of children being affected by parents' problems – before the severity of problems develop beyond the point where these children need to receive special services themselves. In addition to the health benefits of prevention, there are also economic benefits to early prevention (Heckman, 2008). Overall interventions for children of parents with a mental illness are found to have short-term effects with a small effect size (Thanhäuser et al., 2017). Since there are so many children that have parents with a mental illness (Maybery et al., 2009; Torvik & Rognmo, 2011), even a small effect of interventions has the potential to have an impact on improving the health and

ability to work for many individuals, now and for generations to come. Why not more efforts are directed toward early prevention in high-risk groups is difficult to understand.

The convention for the protection of human rights and fundamental freedom, article 8, protects one's right to respect for one's privacy and family life, and states that there should be no interference by a public authority in privacy and family life except if it is necessary in the interest of national security, public safety or the economic and well-being of the country, for prevention of disorder or crime, for the protection of health and morals or for the protection of the rights and freedoms of others (The Convention for the Protection of Human Rights and Fundamental Freedoms, 1953). Although exceptions in the law give healthcare professionals and counselors in adult social services the legal authority to interfere in family life to protect health and the rights of the children, the respect for privacy and family life might be an imprinted practice for professionals. Hence, the respect for privacy and family life might make it ideologically difficult for professionals to "interfere" in family life by assessing children's situation, thematizing parenting or providing support for children. "Interference" in family life was suggested to be difficult for professionals in all thesis papers.

The health and economic benefits of prevention is well-known (Heckman, 2008; Schrank et al., 2015; Thanhäuser et al., 2017), yet political actions and service changes are few and too isolated to facilitate early prevention efforts. The resistance to change, explained by the inclination to maintain status-quo (Hardcastle et al., 2005), needs to be acknowledged by political bodies, decision makers and funders in order to facilitate broader efforts of implementation and larger system adjustments to change practice toward a family focus. Moreover, factors such as collaboration, working conditions, education, training, organization and reduction of stigma seem to be important for an integrated family focus practice in adult services.

The paper in which the model by McLeroy et al. (1988) is presented also discusses the sustainability of programs, or as referred to by authors: program survival past the initial funding period. According to McLeroy et al. (1988), organizational changes are necessary to support long-term changes and create an organizational culture that is supportive of the intended practice. Institutional changes are necessary for implementation and sustainability; important facilitating factors are support from management in the organization, training of staff and material support (McLeroy et al., 1988). Similarly, in the model for sustainability of a family-focused practice by Allchin et al. (2022), supporting leadership, building skills and confidence, and tailoring models of care or allocation systems are actions that may help sustain a family focus. The same barriers to working with families are found in (Lauritzen et al., 2015; Maybery & Reupert, 2009).

4.6 Ethical considerations

In sub-project 1, information filled out by healthcare professionals from the FAF, the PSOC form and the Child Talks logbooks were drawn from patients' electronic journals. This data material for Papers 1 and 2 was collected as a quality assurance project (QAP), a categorization approved by the Regional Committees for Medical and Health Research Ethics (REK).

A QAP is defined as a study or evaluation of health services aiming to ensure the quality of the services provided and to control whether the treatment provided produces the intended result (The Ministry of Health and Care Services, 2010). The purpose of the study, which was to evaluate the workforce development to support children of parents with a mental illness and not to obtain new knowledge about health and disease, determined that the project was categorized as a quality assurance project (See appendix 2).

QAPs are not regulated by the Health Research Act since these projects are not defined as health research according to the law. QAPs do not require informed consent from participants, approval from the REK or the Norwegian Agency for Shared Services in Education and Research (SIKT). In QAPs, the data protection officer at the applicable public sector is obligated to control and approve projects that are processing personal data (Personopplysningsloven, 2018).

QAP can be more effectively carried out because of the waiver of informed consent and may contribute to a faster development of better practice, which in the end will benefit the users. From a methodological point of view, not having to gather consent reduces the likelihood of biased results due to missing consent and participants. The safety of the personal health information of participants should however always be a main consideration, and information about participants must be treated according to the legislation and regulations. In that sense, QAPs do raise some ethical concerns regarding the safeguarding of participants' privacy.

In the BAP project, information about patients receiving treatment and their minor children was collected as a QAP. The project was approved in 2011, and since then, the awareness of data protection has increased and the legal rights of participants have hence improved (Personopplysningsloven, 2018). Regulations for processing personal data became stricter through the 2018 personal data act, which required stricter management of information processing by the data protection officer at institutions (Personopplysningsloven, 2018).

The distinction between QAPs and health research projects (HRP) has also become sharper over the years, and the rules for what may be approved as QAP have also become stricter. The distinction between these types of projects has been publicly debated since there

have been gray areas where the categorization of projects is not clear cut (Fellesorganet for REK, 2011; Lo & Groman, 2003; The Ministry of Health and Care Services, 2010). Today, according to SIKT [Norwegian Agency for Shared Services in Education and Research] (2023), information from patient electronic health records is confidential, and if others than healthcare professionals are to access this information to ensure the quality of interventions or services, the project needs to obtain permission from the patient, be granted an exemption or one of the statutory legal exceptions from confidentiality must apply. Additionally, to process the information it needs to be legally founded in the law (SIKT [Norwegian Agency for Shared Services in Education and Research], 2023). However, back in 2011, REK confirmed that the BAP project was to be categorized as a QAP (Appendix 2). The project was approved by the data protection officer at UNN (Appendix 1).

All data in this PhD project have been processed according to the approval from the data protection officer at UNN. The data files used in the PhD project have been anonymized, meaning that they no longer contain any information that can in any way lead to the identification of any of the participants.

The ethical justification for undertaking research involving humans is the scientific or social value of the research. The more sensitive the information collected, and the more vulnerable participants are, the more consideration should be paid to the ethical justification of the research. Hence, as an ethical justification, it is important to use the information collected to pursue new knowledge and add scientific value to the field. The information collected in the BAP project has been used to inform and obtain knowledge about the support of minor children of patients, which secondarily contributes to informing and moving the practice field forward toward better-quality services for children and families.

In sub-project 2, data about counselors' practice in adult social services were collected. This project and the data collected were not health research or health information. The data were anonymous throughout the study. Since no personal data were processed in the project, the project is not regulated by the Personal Data Act and hence not notified to The Data Protection Services (SIKT). RKBU North received the anonymous data from the Ministry of Labor and Social Inclusion after approval from all participating offices. Counselors' participation was informed and voluntary.

4.7 Methodical considerations

I have aimed to be transparent about the limitations both in the published papers and in this thesis. Despite the limitations, there is value in the research, as the findings contribute to a better understanding of family-focused practice aiming to improve support for children of parents in adverse life situations.

All papers are based on self-reported data. The data used in Papers 1 and 2 are registered by healthcare professionals and are based on parents' report of parenting sense of competence, information about the family situation and the content of the performed Child Talks conversation. In Paper 3, the data are based on survey responses from adult social service counselors. Self-reported data can be biased by respondents reporting higher on practices that are socially desirable or that they perceive as correct. Since parenting sense of competence is reported through healthcare professionals, the self-reported bias may be reinforced by a higher desire to report socially desirable answers. In the survey of social service counselors' family focus, respondents may have reported higher on the child-focused practice due to positive attitudes and an understanding of the importance of considering users' children, and hence a desire to have a family focus. Another bias associated with self-reports is the bias of self-assessment, that respondents may not be able to assess and report their

practice correctly. For social service counselors, it may have been difficult to recall and evaluate how often they asked about and considered users' children or how often they used the CRC when counseling users.

The Child Talks logbooks are data material of a secondary source of information, written and processed by healthcare professionals. The logbooks may have been influenced by what professionals considered important to log from the conversations, how they wanted to be perceived as professionals and their memory of the conversations. Observational data and reports from the parents and children would have contributed to richer data from the content of the Child Talks sessions, but this was, for practical reasons, not done. The aim of the exploration of the logbooks was simply to identify the thematic content of the Child Talks sessions including children. The written descriptions by healthcare professionals were judged suitable for this aim. In future studies, observations or several sources of information should be included to get thicker and more credible data.

The sample of parents participating in Child Talks ($N = 78$) was too small to have sufficient power to conduct significance testing of differences between different diagnostic groups of parents with participating children compared to parents with non-participating children. For parents diagnosed with personality disorders or alcohol and substance dependence, three of 17 (18%) parents had children participating in Child Talks. For parents with post-traumatic stress disorder, paranoid schizophrenia or other psychosis, eighteen of 24 (75%) had participating children. It would be interesting to examine whether parental diagnosis is a factor affecting child participation, but a much larger sample than ours would be needed.

Only 141 of the 424 parents who were assessed by the Family Assessment Form fully or partly completed the PSOC questionnaire. The low response rate of 33% may have created

a bias in that parents who felt most confident in their parenting role could have been more likely to respond. A point of discussion in Paper 1 could have considered whether the PSOC measurement might have been moderated by the efforts parents bring into parenting. For parents with a mental illness, their efforts to be well-functioning parents might result in inflated scores. This might be a validity issue when using this measure for this group of parents. One option for future studies would be to supplement self-reported measures with observations. Another limitation was that the samples with which we compared PSOC scores from our sample, were different in terms of nationality and time period. Moreover, we didn't have variables in our sample that made it possible to test for differences in the samples. Hence, it is difficult to know whether the findings are due to a parental mental illness or other factors. Using a more similar sample as the general population comparison should be done in future studies.

Because of the anonymity of participants, demographical data were not collected for Paper 3. This limited the possibilities for examining the relationship between responses and demographical variables such as educational level, work experience or gender. In future studies, it will be especially interesting to test for how education and professionals' attitudes toward a family-focused practice influence the association between a child-focused practice and knowledge and use of the CRC and perceived benefits of collaboration. The response rate of 67% may have caused a response bias in that counselors who were more interested or had a more child-focused practice might have found it more interesting and felt more inclined to participate in the survey. Adult social services are arranged in different ways at different locations, and this study did not address this complexity. Despite several limitations in Paper 3, the study's contribution when it comes to insights into a family focus in adult social services is valuable because there is a lack of research on this topic.

4.8 Implications

Adult mental health services and social services have an unutilized potential as preventive arenas. An integrated family focus in adult services can potentially contribute to improving the life outcomes for many children in a high-risk group. A family focus is, however, not incorporated – despite the implementation of interventions, efforts, laws and regulations aiming to ensure consideration of and support for children.

In this thesis, a model for an integrated family focus in adult services is proposed. The model builds on knowledge of a need for change at several levels to facilitate an integrated family focus. As supported by the findings in Papers 2 and 3 in this thesis, collaboration with other services for families and children seems necessary to provide additional support and referrals for the children. Moreover, making family focus a natural part of the adult services for users calls for efforts at the organizational level, including improvements of the wordings of laws and regulations to make them more specific when it comes to which services are responsible for what specific tasks. In all social and health education, general communication training and child communication training should be mandatory. Social and health education needs to integrate a family focus. Political bodies and stakeholders need to prioritize children and families. Finally, it is important to know that practices implemented are effective and provide the desired results. Therefore, effect evaluations of interventions and implementations are key to improve the outcomes for children of parents in challenging life situations.

We know little about the reasons for why families and children were not participating in Child Talks and little about why and what variables influence the degree to which professionals had an integrated family focus in adult social services. This should be investigated in future studies, especially with regard to adult social services, where the knowledge gap is vast.

5 Conclusion

The main conclusion of this thesis is that the potential of family-focused services is not fulfilled in adult mental health and social services. Although social service counselors did have some degree of a child-focus, it was not incorporated into their daily practice.

Furthermore, the frequency and quality of child focus conversations in adult mental health services was low, and parents did not convey difficulties in parenting. Since a family-focused practice in adult mental health and adult social services is not fully incorporated, the potential for promoting better outcomes for the children of users in adult services is not fulfilled or utilized. Efforts toward a family focus need to be present at multiple levels to succeed. A family focus needs to be integrated at the educational level, in politics, in the laws and regulations, among professionals, and in all services for adults in challenging life situations. Family-focused services can be achieved by clearer laws and regulations with regard to responsibility allocations, through integration of a family focus in all health and social educations and by introducing mandatory communication skills training for talking to children and families in challenging life situations. Moreover, existing structures in services for adults need to change to facilitate collaboration and a holistic family focus in the adult services. Lastly, effectiveness evaluations of interventions, use of evidence-based interventions, high-quality implementation and adherence to the implemented interventions need to be prioritized.

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Paper 1-3

Paper 1



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Parents with a mental illness and their sense of parenting competence

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Parents with a mental illness and their sense of parenting competence

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ABSTRACT

Objective: Research provides evidence that parental mental illness affects child development through parenting behaviour. This study investigates how parents with a mental illness report on their parenting sense of competence.

Method: A sample of 141 parents receiving treatment at a clinic for mental health and substance use disorders participated. The Parenting Sense of Competence scale (PSOC) was used to assess participants' parenting sense of competence. Information about diagnoses, child age and participation in a preventive family intervention called Child Talks was also collected. PSOC scores from our sample was compared to normative samples.

Results: Parents with a mental illness reported having equal or higher PSOC scores compared to the normative samples. Neither children's age, comorbidity nor parents' diagnosis affected PSOC scores. PSOC satisfaction score was a significant predictor for participation in Child Talks, where lower scores were related to a small increase in participation rate.

Discussion: The results indicate that parents with a mental illness do not view or report feeling less competent in the parenting role than the general population. We discuss the validity of the results and if there are factors that may influence parents' reports such as stigma, fear of losing custody and impaired self-awareness.

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Parenting; PSOC; prevention; parental mental illness; parenting sense of competence; parenting self-efficacy

Introduction

The annual prevalence of mental illnesses among parents with minor children is estimated to be 28.9% for Norwegian mothers and 14.1% for Norwegian fathers (Torvik & Rognmo, 2011), 25% for American mothers and 14.4% for American fathers (Luciano et al., 2014). The prevalence of more severe mental illnesses among parents is 7% for mothers and 2.6% for fathers (Luciano et al., 2014). For adults in mental health treatment, it is estimated that about one third are parents of minor children (Maybery & Reupert, 2018; Reedtz et al., 2015; Ruud et al., 2019). When shifting the

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perspective to the children, the estimates of children exposed to parental mental illness vary across timeframe and severity of illnesses included. In Sweden, 11% of children have a parent in treatment (Pierce et al., 2020) and in Norway 10.4% of children have a parent with a mental illness of a severity that requires treatment (Torvik & Rognmo, 2011). When including more moderate parental mental illnesses it is estimated that 23.3% of Australian children (Maybery et al., 2009), 23.1% of Norwegian children (Torvik & Rognmo, 2011), 12.1% of Canadian children (Bassani et al., 2009) and 23.2% of children in the UK (Abel et al., 2019) have a parent with a mental illness. By the age of 16 the cumulative risk raises to 53.1% (Abel et al., 2019).

Children of parents with a mental illness are at an increased risk of social, emotional, cognitive, physical, and behavioural problems and illnesses, due to both hereditary and environmental factors (Hosman et al., 2009; Reupert et al., 2013; van Santvoort et al., 2015). A meta-analysis found that offspring of parents with schizophrenia, bipolar disorder and major depressive disorder had a 1-in-3 risk of developing schizophrenia, bipolar disorder or major depressive disorder, and a 1-in-2 risk of developing any mental illness by adulthood (Rasic et al., 2014). Children of parents with an anxiety disorder are at a specific risk of developing an anxiety disorder themselves, whereas children of parents with other mental illnesses are at a risk of developing any mental illness (Leijdesdorff et al., 2017). Parents with a mental illness are more often unemployed, have financial problems and low socioeconomic status, which are life circumstances adding to the burden for these families (Kristensen et al., 2022; Luciano et al., 2014). Protective factors for families, such as social support, coping-skills and positive parenting can prevent emotional and health problems in children (Hosman et al., 2009).

Parental mental illness is a risk factor for harsh, hostile, and inconsistent parenting, and parenting with less involvement, attendance to the child's needs, encouragement and supportive interaction (Brockington et al., 2011; Oyserman et al., 2005, 2000). Meta-studies have found that parental depression decreases positive parenting behaviour (Lovejoy et al., 2000; Wilson & Durbin, 2010). Associations between mental health problems among mothers and permissive parenting, described as a lack of parenting confidence and follow through, has also been found (Oyserman et al., 2005). The more severe the illness is, the more often the symptoms parents experience influence their functioning and their ability to parent. Some parents with a severe mental illness will manage to parent well, but in general, symptoms from having a mental illness will make it more difficult to practice positive parenting behaviour such as being patient, reasonable, empathic, warm and loving, involved, engaged, and consistent (Brockington et al., 2011). Positive parenting behaviour is fundamental for a well-functioning parent-child interaction and is associated with healthy child development (Coren et al., 2003; Miller-Heyl et al., 1998; Stack et al., 2010), while behavioural and emotional problems in children are associated with adverse parenting behaviour (Sanders et al., 2014).

Parenting competence is related to how effective parents are at managing child behaviour and helping children learn social and practical skills, which promotes healthy child development (Ellis et al., 2018; Jones & Prinz, 2005). Parenting competence, parenting skills, parenting strategies, parenting behaviours and parenting practice are all terms related to a practical dimension of parenting. Parenting competence is related to parenting behaviour and the ability to complete a task successfully as judged by others. In comparison, parenting sense of competence is the parent's own belief and judgement of their

parenting abilities, which requires insight and self-awareness. Parenting sense of competence, parenting confidence, parenting self-efficacy and parenting self-esteem are terms used to describe a parent's beliefs in their ability to parent successfully (Hess et al., 2004). However, the concepts of parenting confidence and parenting self-esteem refer more to the sense of worth as a parent, rather than the capability to fulfil the parenting role (Bandura, 1997). The terms parenting sense of competence and parenting self-efficacy often refer to the same construct and are defined similarly. In this paper we chose to use the term parental sense of competence as aligned with the measurement by Johnston and Mash (1989) used in the present study. The measurement tool, Parenting Sense of Competence (PSOC) was operationalised by Johnston and Mash (1989) into two subscales: Parenting self-efficacy and parenting satisfaction, but is often referred to as a measure of parental self-efficacy (Jones & Prinz, 2005; Wittkowski et al., 2017). Parenting satisfaction is defined as parents' enjoyment in the parenting role (Johnston & Mash, 1989), and is a construct closely related to parenting self-efficacy. Parenting satisfaction is positively associated with parenting competence and parenting self-efficacy (Jones & Prinz, 2005).

It is possible for parents to feel confident about their parenting competence despite low levels of knowledge of parenting and child development and low parenting competence (Conrad et al., 1992; Hess et al., 2004). Overall, as described in a review of the literature, there are positive associations between parents' self-perceived capability in the parenting role and parenting competence (Coleman & Karraker, 1998; Gelkopf & Jabotaro, 2013; Jones & Prinz, 2005; Rogers & Matthews, 2004; Sanders & Woolley, 2005). There is, however, some inconsistency in the research regarding how parents' expectation about their ability to parent successfully is related to parental competence, possibly caused by inaccurate self-reports (Jones & Prinz, 2005). The level of self-efficacy may also reflect the effort that is put into parenting tasks and parents' persistence when facing obstacles and challenging life situations (Bandura, 1997).

The link between parenting sense of competence and parental mental illness was reviewed by Jones and Prinz (2005). The authors concluded that there is a negative association between parenting sense of competence and both parental depression and parental stress. They, and others, also found that, parenting sense of competence may be a predictor for child outcomes and is negatively associated with emotional and behavioural problems in children (Jones & Prinz, 2005; Preyde et al., 2015; Rogers & Matthews, 2004). Jones and Prinz (2005) suggested that parenting sense of competence may impact child development indirectly through parenting competence, but depending on the situation, parenting sense of competence can be a consequence, mediator, transactional or an antecedent variable. A direct link between parenting sense of competence and child outcomes can be explained by social learning principles – by children observing their parent express doubt or frustrations, – secondly influencing the children's own belief of self-worth and capability (Jones & Prinz, 2005).

Parental mental illness is stigmatised (Hinshaw, 2005). Among parents who were users of psychiatric services in the UK, 28.3% had experienced discrimination related to their parenting role (Jeffery et al., 2013). Being a parent with a mental illness is perceived as a violation of social and cultural norms, and the stigma of being a parent with a mental illness can prevent children and parents from seeking support (Reupert et al., 2021). The fear of stigma and loss of custody has been shown to affect the willingness of

parents with a mental illness to seek treatment and disclose parenting difficulties (Ackerson, 2003; Diaz-Caneja & Johnson, 2004), and self-presentation bias may affect the validity of self-reported parenting data (Morsbach & Prinz, 2006). Having and caring for children is the main motivation to get well for many parents, while having their children removed is their biggest fear (Evenson et al., 2008; Nicholson et al., 1998).

Parental mental illness can impair patients' self-awareness (Maybery et al., 2015), make them more suspicious of other peoples' intentions (Bennett & Corcoran, 2010) or make them evaluate themselves in a more negative manner (Parent et al., 2014). Thus, interventions for parents with mental illness often focus on improving parenting skills and educating parents of the impact mental illness has on their children (Schrank et al., 2015). Evidence from systematic reviews suggested that parenting interventions, aiming to support parents with a mental illness in their parenting role, have a positive effect on both parenting and child outcomes (Havinga et al., 2021; Lannes et al., 2021; Schrank et al., 2015; Thanhäuser et al., 2017). In the present study, all participants were offered a short preventive intervention called Child Talks, consisting of three meetings (Doesum & Koster, 2008; Reedtz et al., 2010). Child Talks focuses on psychoeducation, informing and supporting the children and providing further support for the families (Reedtz et al., 2010, 2012).

The high number of parents with a mental illness, and the potential risk this poses to their children, underpins the importance of investigating how mental illness impacts parents' experience of parenting. Few studies have investigated parents who are in treatment for a mental illness and their sense of competence in the parenting role. Parents who feel less competent in the parenting role might benefit from participating in preventive interventions. However, little is known about associations between parents' sense of competence scores and their willingness to participate in preventive interventions.

The aims of the present study are to investigate:

- (1) If and to what extent parents with mental illness differ from parents in the general population in terms of their sense of competence in the parenting role;
- (2) How diagnosis, comorbidity, and children's age influence parenting sense of competence; and
- (3) If scores on parents' sense of competence are associated with parents' participation in the preventive intervention Child Talks

Materials and methods

This is a retrospective cross-sectional study of 141 patients with minor children at the Division for Mental Health and Substance Use Disorders (DMHSD) at the University Hospital of Northern Norway (UNN). The parents were receiving treatment or were admitted to the division in 2010–2015. Patients with minor children were supposed to respond to an assessment form as a part of the new routines in the clinic. The assessment form included the PSOC questionnaire. Next, they were all invited to participate in the Child Talks intervention. The study is approved by the data protection officer at UNN, which allowed us to extract data from filled-out questionnaires in patient journals in 2015. The study is part of

a larger quality assurance project between UNN and the Regional Center for Child and Adolescent Mental Health and Child Welfare at UiT The Arctic University of Norway.

Parenting sense of competence scale (PSOC)

The Parenting Sense of Competence Scale (PSOC) was developed by Gibaud-Wallston and Wandersman (1978). The 16-item Likert-scale questionnaire measures self-reported parenting sense of competence by two subscales: Parenting satisfaction and parenting self-efficacy (Johnston & Mash, 1989). Parenting self-efficacy aims to measure parents' belief in their ability to be a successful parent, problem solving skills, familiarity with parenting and belief in their ability to perform tasks related to parenting (Johnston & Mash, 1989). Parenting satisfaction aims to measure parents' degree of fulfilment, motivation, and absence of frustration in the parenting role, and is an affective dimension of parenting (Johnston & Mash, 1989). PSOC is a commonly used instrument for measuring the construct of parenting self-efficacy (Jones & Prinz, 2005). In this study, the Norwegian translated version of the measurement was used.

Several studies have investigated the factor structure of PSOC (Gilmore & Cuskelly, 2009; Johnston & Mash, 1989; Ohan et al., 2000; Rogers & Matthews, 2004). Gilmore and Cuskelly (2009) used a normative sample to perform a factor analysis of the measure. The authors found that the measurement contained three useful factors that reflect satisfaction with the parenting role, parenting efficacy and interest in parenting. Both the original factor structure by Johnston and Mash (1989) and the factor structure by Gilmore and Cuskelly (2009) are applied in the analysis of our data. For an overview of items included in the subscales, see Table 1.

Cronbach's alphas were calculated to evaluate the internal consistency of the PSOC subscales for the current sample. Values over 0.70 are considered adequate, values

Table 1. Factor structure from two studies with normative comparison groups.

| Item | Satisfaction | | Efficacy | | Interest | | Total | |
|--------------------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------|
| | J&M ¹ | G&C ² | J&M ¹ | G&C ² | J&M ¹ | G&C ² | J&M ¹ | G&C ² |
| 1 | | | ✓ | | | | ✓ | |
| 2 | ✓ | ✓ | | | | | ✓ | ✓ |
| 3 | ✓ | ✓ | | | | | ✓ | ✓ |
| 4 | ✓ | ✓ | | | | | ✓ | ✓ |
| 5 | ✓ | | | | | | ✓ | |
| 6 | | | ✓ | ✓ | | | ✓ | ✓ |
| 7 | | | ✓ | | | | ✓ | |
| 8 | ✓ | ✓ | | | | | ✓ | ✓ |
| 9 | ✓ | ✓ | | | | | ✓ | ✓ |
| 10 | | | ✓ | ✓ | | | ✓ | ✓ |
| 11 | | | ✓ | ✓ | | | ✓ | ✓ |
| 12 | ✓ | | | | | ✓ | ✓ | ✓ |
| 13 | | | ✓ | ✓ | | | ✓ | ✓ |
| 14 | ✓ | | | | | ✓ | ✓ | ✓ |
| 15 | | | ✓ | ✓ | | | ✓ | ✓ |
| 16 | ✓ | ✓ | | | | | ✓ | ✓ |
| 17 | - | - | - | - | - | - | - | - |
| Number of items included | 9 | 6 | 7 | 5 | - | 3 (2 *) | 16 | 14(13 *) |

* Item 17 was not included in our questionnaire. Hence for our sample the Interest score by G&C's factor structure is divided by 2 items, instead of 3, and total PSOC scores by G&C's factor structure is divided by 13 items, instead of 14.

¹J&M is an abbreviation for Johnston & Mash's factor structure, ²G&C is an abbreviation for Gilmore & Cuskelly's factor structure.

over 0.80 are considered good, and values over 0.90 are considered excellent (The European Federation of Psychologists' Associations, 2013). The pooled Cronbach's alpha was adequate for Johnston and Mash's Satisfaction scale ($\alpha = 0.79$), adequate for Gilmore and Cuskelly's Satisfaction scale ($\alpha = 0.77$), good for Johnston and Mash's Efficacy scale ($\alpha = 0.80$), good for Gilmore and Cuskelly's Efficacy scale ($\alpha = 0.80$), but low for Gilmore and Cuskelly's Interest scale ($\alpha = 0.60$).

In a systematic review of self-reported measurements of parental self-efficacy, the psychometric and administrative properties of the measurement PSOC had an overall mean score of 14, on a scale ranging from 0 – to a perfect score of 36 (Wittkowski et al., 2017). The overall quality of the PSOC measurement had a higher score than the average overall score of the parental self-efficacy measurements included (Wittkowski et al., 2017). However, some concerns about PSOC were addressed because of a lack of information of some psychometric properties of the measurement (Wittkowski et al., 2017).

Normative samples

To investigate if and to what extent parents with a mental illness differ from parents in the general population in terms of their sense of competence in the parenting role, we compare scores from our sample to two normative samples. The normative samples found relevant for comparison had large sample sizes and were performed in countries comparable to the Norwegian context with similar education level, birth rates, life expectancy and human development index (United Nations Development Programme, 2022).

Gilmore and Cuskelly (2009) provides normative PSOC scores for a non-clinical sample of 1201 parents, found to be representative of the general population in Australia. Only one parent per family participated. All participants were parents of children under the age of 18. The internal consistency was calculated separately for mothers and fathers (Gilmore & Cuskelly, 2009). Cronbach's alpha for Satisfaction was reported at 0.72 for mothers and 0.76 for fathers, for Efficacy, 0.68 for mothers and 0.74 for fathers, and for Interest, 0.62 for mothers and 0.57 for fathers. The study includes a 17th item, loading on the third factor Interest. In our study, item 17 is not included. Items 12 and 14 load on the factor Interest in the factor structure used in the study by Gilmore and Cuskelly (2009). Originally, items 12 and 14 aimed to measure Satisfaction (Johnston & Mash, 1989). The subscale Interest, without item 17, is found to have an internal consistency of alpha coefficient 0.58 for mothers and 0.62 for fathers (Rogers & Matthews, 2004). The internal consistency for the Interest subscale is low, and has been suggested removed, since it does not measure interest in the parenting role in terms of self-esteem (Rogers & Matthews, 2004).

Johnston and Mash (1989) studied, 512 parents of children aged four to nine years, from a large Canadian city. The data were collected in a door-to-door survey, across neighbourhoods with varying socioeconomic status. The internal consistency of the factors provided by Johnston and Mash (1989) had a Cronbach's alpha of 0.75 for Satisfaction and 0.76 for Efficacy. For comparison reasons, all scale scores are divided by the number of items within the scale.

Compared to the sample of Johnston and Mash (1989), the study of Gilmore and Cuskelly (2009) is from a more recent time period, and their sample is over twice as large. Gilmore and Cuskelly (2009) included parents of children aged 0–18, which is

comparable to our sample. Johnston and Mash (1989) only included parents of children aged 4–9. However, in our sample we did not include item 17, which is used by Gilmore and Cuskelly (2009). Both normative samples and factor structures had limitations. We therefore choose to compare the PSOC for parents with a mental illness to both normative samples, to get a more comprehensive understanding of potential differences.

Statistical analysis

SPSS version 28 was used for the statistical analysis. We excluded cases with more than 50% missing items on one of the subscales. We also removed duplicate cases where parents had answered the form several times. PSOC is a scale measuring parent's sense of competence, where 12 of the 16 questions reflect general responses to parenting. After removal of cases with more than 50% missing items, there were 71 parents who had filled out more than one form, providing answers for each of their children. We calculated the intra-class correlation between PSOC total scores for siblings, and the results showed that there was very low within-family variance ($ICC = 0.93$). We therefore removed duplicate cases using a random number generator, so that only one PSOC answer was used for each parent in the further analysis, resulting in 141 unique parent PSOC scores.

The PSOC scale is a 6-point scale originally (Johnston & Mash, 1989), but the present study used a 5-point scale. We transformed the values from a scale of 0–4 to a scale of 1–6 to enable comparison to the normative samples. In the present study, answering '0', labelled 'strongly disagree', was transformed to a score of 1. Answering '1' was transformed to a value of 2.25, '2' was transformed to 3.5, '3' was transformed to 4.75, and lastly '4 – strongly agree' was transformed to a value of 6.

Multiple imputation was done, on item level, to simulate values for missing data based on the observed data. The method is proven to give more accurate results than running the analysis with case deletion or single imputation methods (Schafer & Graham, 2002). To estimate missing values in the PSOC responses and the gender of parents (11 missing values), we used the following variables with data available in our imputation model as possible predictors: gender of the parent (only used to predict PSOC responses), birth year of the child, gender of the child, total number of children, marital status, the child living with the patient, concerns regarding the child's behaviour, concerns regarding self-help, concerns regarding social-emotional factors, concerns regarding school and the PSOC items. The PSOC items had to be registered as scale variables to have a low enough number of parameters to run the model. We used the PPM method to select at random among the 5 closest predictions to impute variables within the range of the scale. We made 50 imputation datasets. For all further analysis, we used pooled estimates from the 50 imputed datasets.

An independent samples t-test was used to calculate if the mean scores for parents with a mental illness and parents in a normative sample were significantly different. Levene's test is commonly used to check if we can assume that the groups have equal variance, but since we did not have the raw data from the normative samples, we used Bartlett's test. Bartlett's test gave non-significant differences, and we therefore assume equal variance for the two groups. The PSOC scales were scored using two different scoring systems (Gilmore & Cuskelly, 2009; Johnston & Mash, 1989) (see Table 1), to compare parents with a mental illness to two normative samples.

A Norwegian study provides a Norwegian control sample for PSOC scores (Reedtz et al., 2011). Initially, we chose not to use this sample for comparison, as our normative sample, because of the small sample size ($n = 97$) and the high education level of the sample. However, after the initial results indicated high PSOC scores for our sample, we wanted to test if the high scores were partially explained by the nationality of the sample and/or the translation of the Norwegian version of the questionnaire. We therefore conducted a *t*-test, comparing our sample mean scores to the Norwegian control sample.

To assess how children's age, comorbidity, and diagnosis influence PSOC scores, a multiple regression was performed. Since some patients had several diagnoses, all diagnostic categories were recoded as dichotomous variables, to enable inclusion of all data in the analysis. If a patient had two diagnoses within the same diagnostic category it would only be registered as one event. The number of diagnoses in each diagnostic category in the multiple regression therefore differ from the number of diagnoses in each category presented in Table 2. We tested two multiple regression models, one for the outcome variable PSOC Satisfaction score and one for the outcome PSOC Efficacy score. The predictors in the models were the age of the child, whether or not the patients had more than one diagnosis (comorbidity), and the eight diagnostic categories, listed in Table 2. We calculated for each of the predictors the increase in the proportion of total variance explained for the models when adding the independent variables to the model by squaring the semipartial correlation coefficient. For the multiple regression analysis, we checked for multicollinearity. The assumption of multicollinearity was not violated, with no tolerance values less than 0.10 for either the models for Satisfaction or Efficacy. The normal *p*-*p* plots of the regression standardised residual suggested no major deviations from normality. The scatterplots for residuals and predicted values showed a balanced distribution along the value 0 in both models. However, the Mahalanobis distance indicated that we had some outliers in both models. The critical value for Mahalanobis distance for 10 independent variables at $p = 0.001$ is 29.59 (Tabachnick et al., 2007). For the Satisfaction model, nine cases had Mahalanobis distance values exceeding the critical value. For the Efficacy model, fourteen cases exceeded the critical value. The values of these cases were checked manually and were found adequate. Cook's distance did not exceed 1 for any of the cases.

Logistic regression was performed to assess if PSOC scores were associated with parents' participation in *Child Talks*. Due to the small sample, separate analyses for mothers and fathers were not conducted. For the logistic regression we used the scores based on the factor structure of Johnston and Mash (1989), since we do not have item 17, and tested regression models for both subscales. We used a significance level of 0.05 for all tests.

Results

Descriptive statistics for our sample

Based on the original data of 141 participants, there were 90 mothers and 40 fathers in our sample. The pooled estimates from imputed datasets categorised 5 of the 11 participants who lacked gender data as mothers and 6 as fathers (in total 95 mothers and 46 fathers). The parents had between 1 and 5 minor children, and on average 1.8

children. Most patients normally had the daily responsibility for their minor children, and 134 of 141 of the children included in the analysis lived with the parent in treatment for a mental illness. The children were aged between 0 and 18, except for one patient’s child, who was aged 28. This parent had other minor children. There were 52.5% girls in the sample.

The patients’ records provide diagnosis based on the ICS-10 version 2010, and diagnostic categories used in the multiple regression analysis are based on the categories in this version. For readability reasons, we gave the categories simpler names: mental and behavioural disorders due to psychoactive substance use (F10–F19) is named substance use disorders; schizophrenia, schizotypal and delusional disorders (F20–F29) is named schizophrenia; mood (affective) disorders (F30–F39) is named depression; neurotic, stress-related and somatoform disorders (F40–F48) is named anxiety disorders; behavioural syndromes associated with physiological disturbances and physical factor (F50–F59) is named eating disorders; disorders of adult personality and behaviour (F60–F69) is named disorders of adult personality; behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90–F98) is named behavioural and emotional disorders with early onset; factors influencing health status and contact with health services (z-diagnoses) (Z00–Z99) is named z-diagnoses. We were missing diagnostic information for 2 of 141 patients. The total number of diagnoses is 170, since 24 patients also had a second diagnosis and 7 also had a third diagnosis.

Table 2 provides descriptive data about the distribution of scores for the variables we include in the statistical analysis. The data presented in Table 2 is based on the pooled data. The PSOC Satisfaction and PSOC Efficacy scale ranged from 1 to 6.

Table 2. Descriptive data for variables included in the statistical analysis.

| | n | Descriptive data for continuous variables | | | | | | Descriptive data for categorical variables | |
|---|-----|---|------|------|--------|-----------------|-----------------|--|---------------------|
| | | Range | SD | Mean | Median | 25th percentile | 75th percentile | Frequency of event | Percentage of event |
| PSOC Satisfaction ^{a, b} | 141 | 1.93-6.00 | 0.87 | 4.41 | 4.48 | 3.78 | 5.04 | - | - |
| PSOC Efficacy ^{a, b} | 141 | 1.54-6.00 | 0.89 | 4.61 | 4.75 | 4.04 | 5.29 | - | - |
| Child age ^c | 141 | 1–28 | 5.30 | 9.52 | 10.00 | 5.00 | 13.50 | - | - |
| Comorbidity ^c | 141 | 0–1 | - | - | - | - | - | 25 | 17.73 |
| Substance use disorders ^c | 139 | 0–1 | - | - | - | - | - | 22 | 15.83 |
| Schizophrenia ^c | 139 | 0–1 | - | - | - | - | - | 11 | 7.91 |
| Depression ^c | 139 | 0–1 | - | - | - | - | - | 76 | 54.68 |
| Anxiety disorders ^c | 139 | 0–1 | - | - | - | - | - | 40 | 28.78 |
| Eating disorders ^c | 139 | 0–1 | - | - | - | - | - | 3 | 2.16 |
| Disorders of adult personality ^c | 139 | 0–1 | - | - | - | - | - | 10 | 7.19 |
| Behavioural and emotional disorders with early onset ^c | 139 | 0–1 | - | - | - | - | - | 5 | 3.60 |
| z-diagnoses ^c | 139 | 0–1 | - | - | - | - | - | 3 | 2.16 |
| Child Talks participation ^d | 141 | 0–1 | - | - | - | - | - | 32 | 22.70 |

^aPredictor variable for logistic regression and outcome variable in multiple regression analysis, ^b Predictor variable in logistic regression analysis, ^c Predictor variable in multiple regression analysis, ^d Outcome variable in logistic regression analysis.

Parents with a mental illness compared to parents from normative samples in terms of parenting sense of competence

When comparing our sample to the original normative sample in Johnston and Mash (1989) both mothers and fathers with a mental illness scored significantly higher on total PSOC scores, with a large effect size for mothers and a medium effect size for fathers. When compared to the normative sample of Gilmore and Cuskelly (2009) significant differences were not found, and the effect size was small for mothers and near zero for fathers. See Table 3 for detailed information.

Table 3. Means (standard deviations) for PSOC total scores for mothers and fathers. Results from comparing the means and the effect size.

| | PSOC total Johnston & Mash | | PSOC total Gilmore & Cuskelly | |
|--|---|---|---------------------------------------|---------------------------------------|
| | Mothers | Fathers | Mothers | Fathers |
| Parents with a mental illness ¹ | 4.55 (0.78), <i>n</i> = 95 | 4.38 (0.79), <i>n</i> = 46 | 4.46 (0.83), <i>n</i> = 95 | 4.33 (0.82), <i>n</i> = 46 |
| Normative data ¹ | 3.96 (0.62), <i>n</i> = 297 | 4.07 (0.56), <i>n</i> = 215 | 4.35 (0.64), <i>n</i> = 586 | 4.33 (0.66), <i>n</i> = 615 |
| <i>t</i> -test | <i>t</i> (390) = 7.56, <i>p</i> < .005* | <i>t</i> (259) = 3.15, <i>p</i> < .005* | <i>t</i> (390) = 1.35, <i>p</i> = .18 | <i>t</i> (259) = .00, <i>p</i> = 1.00 |
| Cohen's <i>d</i> | -0.84 | -0.45 | -0.15 | .00 |

¹Scores are divided by the number of items in the scale for comparability reasons. Significant results are marked with a *.

For mothers, the differences in Satisfaction scores of our sample in comparison with both normative samples were significant, with a small to medium effect size (see Table 4). Mothers with a mental illness scored significantly higher on the Efficacy subscale when compared to the sample of Johnston and Mash (1989), with a large effect size. The difference was small and not significant when compared to the sample of Gilmore and Cuskelly (2009). For the Interest subscale, a small non-significant difference was found.

For fathers, the differences in Satisfaction scores in our sample compared to the two normative groups were not significant and had small effect sizes. For Efficacy scores for fathers, our sample scored significantly higher compared to the sample of Johnston and Mash (1989) with a large effect size. When compared with the sample of Gilmore and Cuskelly (2009), the difference was small and non-significant. The difference in Interest scores for fathers in our sample compared to Interest scores in the normative sample of Gilmore and Cuskelly (2009) was small and non-significant.

The difference in Satisfaction mean scores for our sample (*n* = 141, *M* = 4.41, *SD* = 0.87) compared to the mean scores of the Norwegian control sample (*n* = 97, *M* = 4.46, *SD* = 0.67) was very small and not significant *t* (236) = 0.48, *p* = 0.63. The difference in Efficacy mean scores for our sample (*n* = 141, *M* = 4.60, *SD* = 0.90) compared to the Norwegian control sample (*n* = 97, *M* = 4.54, *SD* = 0.54) was not significant either, *t* (236) = 0.59, *p* = 0.56.

Table 4. Means and standard deviations for PSOC subscales scores for mothers and fathers, and results from comparing the means and the effect sizes.

| | Satisfaction J&M | | Efficacy J&M | | Satisfaction G&C | | Efficacy G&C | | Interest G&C | |
|--|---|--|---|---|--|--|---|---|---|--|
| | Mothers | Fathers | Mothers | Fathers | Mothers | Fathers | Mothers | Fathers | Mothers | Fathers |
| Parents with a mental illness ¹ | 4.49 (0.84) <i>n</i> = 95 | 4.23 (0.93) <i>n</i> = 46 | 4.62 (0.96) <i>n</i> = 95 | 4.57 (0.77) <i>n</i> = 46 | 4.06 (1.04) <i>n</i> = 95 | 3.98 (0.99) <i>n</i> = 46 | 4.52 (1.11) <i>n</i> = 95 | 4.44 (0.91) <i>n</i> = 46 | 5.50 (0.70) <i>n</i> = 95 | 5.11 (1.03) <i>n</i> = 46 |
| Normative data ¹ | 4.23 (0.69) <i>n</i> = 297 | 4.41 (0.64) <i>n</i> = 215 | 3.60 (0.84) <i>n</i> = 297 | 3.63 (0.78) <i>n</i> = 215 | 3.78 (0.97) <i>n</i> = 586 | 4.00 (0.97) <i>n</i> = 615 | 4.41 (0.81) <i>n</i> = 586 | 4.19 (0.86) <i>n</i> = 615 | 5.39 (0.73) <i>n</i> = 586 | 5.26 (0.73) <i>n</i> = 615 |
| <i>t</i> -test | <i>t</i> (390) = 3.03 <i>p</i> < .005* | <i>t</i> (259) = -1.58 <i>p</i> = .11 | <i>t</i> (390) = 9.94 <i>p</i> < .005* | <i>t</i> (259) = 7.43 <i>p</i> < .005* | <i>t</i> (390) = 2.41 <i>p</i> = .02* | <i>t</i> (259) = -0.13 <i>p</i> = .90 | <i>t</i> (390) = 1.05 <i>p</i> = .30 | <i>t</i> (259) = 1.77 <i>p</i> = .08 | <i>t</i> (390) = 1.29 <i>p</i> = .20 | <i>t</i> (259) = -1.17 <i>p</i> = .24 |
| Cohen's <i>D</i> | -0.34 | 0.23 | -1.13 | -1.21 | -0.28 | 0.02 | -0.11 | -0.28 | -0.15 | 0.17 |

¹Scores are calculated by dividing the sum by number of items included in the scale. Significant results are marked with a *.

Associations between parent's diagnoses; comorbidity; children's age and PSOC satisfaction and efficacy

Satisfaction

The regression model with the children's age, comorbidity and the eight diagnostic categories as predictors explained 11.5% of the variance in PSOC Satisfaction scores (mean of R squared for the 50 imputed data blocks). The overall model was not significant. No variables made significant contributions. The increase in the proportion of total variance explained by adding age of children to the model was 0.50%, for comorbidity 0.55%, for substance use disorders 2.60%, for schizophrenia 0.29%, for depression 1.05%, for anxiety disorders 1.40%, for eating disorders 0.75%, for disorders of adult personality 0.19%, for behavioural and emotional disorders with early onset 0.80% and for z-diagnoses 1.11%.

Efficacy

The regression model with children's age, comorbidity and the eight diagnostic categories as predictors explained 5.5% of the variance in PSOC Efficacy scores (mean of R squared for the 50 imputed data blocks). The overall model was not significant. None of our variables made a significant contribution. The increase in the proportion of total variance explained by adding age of children to the model was 0.09%, for comorbidity 0.34%, for substance use disorders 1.02%, for schizophrenia 0.00%, for depression 0.26%, for anxiety disorders 0.33%, for eating disorders 0.27%, for disorders of adult personality 0.28%, for behavioural and emotional disorders with early onset 1.31% and for z-diagnoses 0.00%.

Logistic regression assessing if PSOC scores impact participation in Child Talks

Of the 141 parents, 109 did not participate in the Child Talks intervention. The mean of the PSOC Satisfaction scores for participating parents ($n = 32$) was $M = 37.09$, and $M = 40.44$ for non-participating parents ($n = 109$). The mean of PSOC Efficacy scores for participating parents ($n = 32$) was $M = 31.46$, and $M = 32.48$ for non-participating parents ($n = 109$).

The model with PSOC Satisfaction scores as a predictor for participation was significant at the 0.05 level ($p = .04$; OR = 0.95). For every 1-point increase in the PSOC Satisfaction score, the odds of participation in the Child Talks intervention decreased by 5%. The model with PSOC Efficacy scores as a predictor for participation was not significant ($p = .42$; OR = 0.98).

Discussion

Aims of this study were to investigate how parents with a mental illness reported on their parenting sense of competence compared to the general population of parents. Secondly, we aimed to investigate how diagnosis, comorbidity, and children's age influenced parenting sense of competence, and lastly, we aimed to investigate if PSOC scores were associated with parents' participation in Child Talks. Results showed that parents with a mental illness reported equal or higher PSOC scores compared to normative samples. Neither child age, comorbidity nor diagnosis affected PSOC scores, and lower

PSOC satisfaction scores were significantly associated with a small increase in the participation rate of Child Talks.

We were surprised to find that the sample of parents with a mental illness scored higher on PSOC than parents from normative samples, since there is broad evidence that parental mental illness influences parenting competence and child outcome negatively (Brockington et al., 2011; Coren et al., 2003; Leijdesdorff et al., 2017; Lovejoy et al., 2000; Miller-Heyl et al., 1998; Oyserman et al., 2005, 2000; Rasic et al., 2014; Sanders et al., 2014; Stack et al., 2010).

One possible explanation is that parents reported feeling more competent than they were because of fear of being judged and fear of losing custody of their children. This explanation is in line with earlier studies where the risk of disclosure to third parties, the fear of legal reprisals and the tendency to present oneself in a favourable light were found to be possible factors influencing parents' self-reporting of parenting practices (Ackerson, 2003; Jeffery et al., 2013; Morsbach & Prinz, 2006). For participants in this study, PSOC reports were saved in their electronic patient journals, which may explain their reluctance to provide accurate PSOC reports. Studies have found that the fear of losing custody makes mothers with mental illnesses reluctant to disclose difficulties or to ask for parenting help from professionals (Diaz-Caneja & Johnson, 2004; Nicholson et al., 1998), and this may explain the high self-reported scores for our participants. Mothers with a mental illness scored especially high on PSOC in our sample, and it might be that this fear is more present for mothers than fathers.

In a study of Nicholson et al. (2022), stakeholders working with parental mental illness, raised considerations regarding ways to engage with patients about parenting in a non-judgmental and respectful way. Strategies included bringing up parenting when the parent appears to be ready and willing to do so, and in a pace led by the parent (Nicholson et al., 2022). In the current study the PSOC questionnaire was included in the initial assessment of patients with dependent children. Therefore, because of the design of this study, the questionnaire about parenting could not be flexibly provided when the parent was ready to discuss parenting. The timing of the PSOC assessment in this study may have contributed to parents being suspicious and reluctant to give accurate reports.

Another explanation might be that the symptoms of the illness impaired participants' self-awareness, making them feel more competent than they actually are. This reflects earlier research which showed how diagnoses such as substance use disorders and personality disorders may affect self-reported data on parenting due to impaired self-awareness (Maybery et al., 2015). Anxiety disorders or disorders with symptoms of paranoia may make parents suspicious of why healthcare professionals are asking them about parenting (Bennett & Corcoran, 2010), and may therefore also make participants report their sense of parenting competence as high. However, depression disorders may have influenced the scores in the opposite direction, when accounting for the research that suggests that parents with depressive disorders will evaluate their sense of competence in a more negative or realistic manner (Parent et al., 2014). The multiple regression analyses in the present study did not show that the predictor depression made a significant contribution to explain the variance in PSOC scores. However, few events of each diagnosis category limit the predictive ability diagnoses has on PSOC scores in this study.

Thirdly, parents with a mental illness may not perceive their parenting sense of competence as any lower than healthy parents and may not be aware of any impairment the mental illness may have on their ability to parent. This explanation is supported by Rogers and Matthews (2004), who did not find a correlation between parenting efficacy and parental depression, anxiety, and stress. It might be that mental illness does not affect parents' sense of efficacy. Hess et al. (2004) described mothers with low parenting competence, low knowledge of child development, but high parenting sense of competence as 'naively confident mothers', and this description might be suitable for parents in our sample. Mothers with low levels of knowledge of child development and parenting were worse off in terms of parenting behaviour if they had high levels of parenting sense of competence, compared to if they had low levels of parenting sense of competence (Hess et al., 2004). However, for parents practicing positive parenting behaviour, the association with parenting sense of competence was positive (Coleman & Karraker, 1998; Gelkopf & Jabotaro, 2013; Jones & Prinz, 2005; Rogers & Matthews, 2004; Sanders & Woolley, 2005). If our sample has low parenting competence, which previous research suggests, and if the finding of Hess et al. (2004) is transferrable to our sample, it is concerning that our sample scored so high on PSOC. Participating in interventions that aim to increase knowledge about child development and parenting may thus be positive for parents with a mental illness, which is also supported by the findings of Morawska et al. (2009), who found that higher levels of knowledge of effective parenting strategies were related to less dysfunctional parenting.

The outcomes for children of parents with a mental illness tend to be worse than for children of parents who do not have mental health challenges (Hosman et al., 2009; Reupert et al., 2013; van Santvoort et al., 2015). Positive associations between low PSOC scores and poor child outcomes has been found in several studies (Jones & Prinz, 2005; Preyde et al., 2015; Rogers & Matthews, 2004). However, we found that parents in treatment for a mental illness scored high on PSOC, which contrasts with other studies which found negative outcomes for children of parents with a mental illness. An explanation might be that parents rate their sense of competence as weaker only when their child has developed behavioural problems, and not as a direct effect of their illness and their parenting behaviour. See Figure 1 for an illustration of a suggestion of how parental mental illness might be related to PSOC scores.

If parents with a mental illness are not aware of how their illness can influence their parenting competence, it demonstrates a need for parenting interventions that have a psychoeducational focus, as better insight into mental illness is associated with more sensitive parenting behaviour (Mullick et al., 2001).

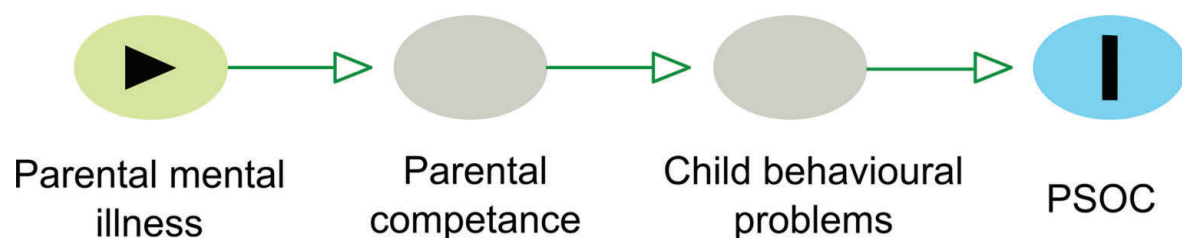


Figure 1. Illustration of the suggested causal relationships between parental mental illness and parenting sense of competence (PSOC). Note: The variables 'Parenting competence' and 'Child behavioural problems' are not measured in this study, but associations are described by previous research.

The Australian sample (Gilmore & Cuskelly, 2009) and the Canadian sample (Johnston & Mash, 1989) that was used as normative references for comparison are likely different from our sample in more ways than in regard to the prevalence of parental mental illness. Therefore, we cannot rule out the possibility that the differences in the PSOC scores are explained by factors such as socioeconomic status, ethnicity, culture and time era. Unfortunately, we were not able to compare the samples' socioeconomic status since we did not have this information about participants in the present study. We did however also compare the PSOC scores in our sample of parents with a mental illness to a highly educated Norwegian sample. Our sample did not score significantly different than this Norwegian sample. This supports our main findings, implying that parents with a mental illness do not score themselves lower on PSOC than parents in general. However, the result from the comparison to the Norwegian sample indicate that some of the effect of the high scores in our sample may be explained by the nationality of parents and/or the Norwegian version of the questionnaire.

We were only able to explain 11.5% of the variation in Satisfaction scores and only 5.5% of the variation in PSOC Efficacy scores by the child age, comorbidity, and diagnostic variables we included in the regression models. None of the variables made significant contributions. For the diagnostic variables, some of the categories had very few events, limiting these predictors' predictive ability. Additionally, if answers were influenced by the fear of losing custody or impaired self-awareness, this could have created disturbances to true associations in the data, and hence affected the possibility of detecting true associations.

We found PSOC Satisfaction to be a significant predictor for participation in Child Talks. The effect PSOC Satisfaction scores had on participation was very small, with an odds ratio of 0.95, where increased PSOC Satisfaction was associated with a slightly lower odds for participation in Child Talks. Parents who felt they needed the intervention might have been more willing to participate, or healthcare professionals may have put more efforts into persuading the parents who shared lower parenting sense of competence to participate. Another explanation may be that the relationship and trust between patients and healthcare professionals was better in cases where the patient reported lower PSOC scores, both influencing parents reported PSOC scores to be more truthful, and hence lower, and influencing the parents' openness and willingness to participate in the intervention.

Future studies might investigate the relationship between PSOC scores and participation in parent training interventions in larger samples. Studies aiming to investigate whether the high PSOC scores among parents receiving treatment for a mental illness is caused by a fear of losing custody and/or a lack of insight in parenting are needed. This research gap was also detected by Jones and Prinz (2005), who called for studies about possible reporting bias for self-reporting parenting sense of competence. Including measurements of parenting competence assessed by an observing third party and questions about parents' fear of losing custody of their children may contribute to important knowledge. This knowledge is important, because different explanations about the mechanisms underlying parents' PSOC reporting, call for different approaches for the practice field. A fear of losing custody calls for an open and sensitive approach by healthcare professionals, while a lack of insight into parenting calls for a more psychoeducational approach.

Strengths and limitations

A strength in this study is that we compared the PSOC scores of parents with a mental illness with 2–3 normative samples, making our conclusions more reliable. Canadian and Australian populations are comparable to the Norwegian population, since all countries score very high (≥ 0.800) on the human development index, have similar life expectancy at birth and expected years of schooling (United Nations Development Programme, 2022). There may, however, be differences between the countries that are influencing the comparability between the samples. Though we did compare our sample to a Norwegian sample to test the influence of nationality and language on the scores. The construct of parenting and what is considered good parenting may have changed over the years, and the fact that the included samples have data collected during different time periods may have biased the results.

In contrast to most studies where mental health status is based on self-reported data, participants in this study were receiving treatment at a mental health clinic and their mental health status was therefore assessed and reported by healthcare professionals. Few studies have examined the link between parenting sense of competence and parental mental illness based on diagnoses set by a psychiatrist or psychologist. Hence diagnoses reported by professionals are a strength of the present study, compared to studies with self-reported diagnoses.

This study has not been designed to assess the validity of PSOC scores for this population. It is unknown if the sample in this study had high parental sense of competence or if they falsely reported elevated parental sense of competence. Measuring outcome scores for children as well, and investigating if PSOC scores differ if the questionnaire is given anonymously and by others than healthcare professionals, might provide insight into these questions in future studies.

Not all assessed patients completed the PSOC form, making a sample bias possible: Patients who were more well-functioning and who felt they were mastering parenting may have more often agreed to fill out the form.

In the present study, the PSOC form used was missing the option ‘somewhat disagree’. However, only the highest; ‘strongly agree’, and the lowest option of the scale; ‘strongly disagree’ were labelled and visible over the questions when filling out the form. The scale was transformed to a scale ranging from 1 to 6 to enable comparison, as explain in the methods section.

The Norwegian translated version of the PSOC scale has not been validated, making it possible that the sample differences are explained by the language difference. In future studies the validity of the PSOC measures for parents with mental illnesses should be investigated.

Of parents who reported on their PSOC, only 32 received the Child Talks intervention. The low participation rate makes the results less certain.

Conclusion

The results imply that parents with a mental illness do not feel or report feeling less competent as parents, compared to normative samples. However, research provides strong

evidence that parenting competence is negatively affected by parental mental illness. The PSOC measurement might not be valid as a measure for parental sense of competence for parents with a mental illness in this setting. Parents who feel they are mastering the parenting role, or who are unwilling to report feeling less competent, are less likely to seek help from other services. The results of this study do not reveal reasons for high parental sense of competence among the participants. However, if our proposed explanations for high PSOC scores among the participants are valid, awareness among healthcare professional about stigma and fear of custody loss, openness, sensitivity and building good relationships with patients may improve patients' trust. If parents in challenging life situations in need for help are not sharing difficulties because of stigma or fear of losing custody, methods and supportive practices towards these parents need to be established. Universal interventions promoting healthy child–parent interactions can be of great value.

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No potential conflict of interest was reported by the author(s).

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Declaration of interest statement

There are no conflicting interests for authors in this study.

Data availability statement

Data can be made available on request to the corresponding author.

Ethics statement

The study was approved by the Data Protection Officer at the University Hospital of Northern Norway (UNN). The regional ethics committee (REK) categorized the project as a quality assurance project (ref. 2011/2066/REK nord). Data used for this study is anonymous.

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Paper 2



Support for Children of Parents With Mental Illness: An Analysis of Patients' Health Records

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Introduction: Children of parents with a mental illness (COPMI) are at risk of behavioral, emotional, and cognitive difficulties and diagnoses. Support and information about parents' mental illness may contribute to improve their lives, which is the purpose of the intervention Child Talks (CT). This study aimed to investigate the participation rate of CT, characteristics of participating patients and children, and themes in sessions with children.

Materials and Methods: Data were collected from 424 electronic patient journals written by healthcare professionals (H) for patients admitted to a clinic for mental health and substance use disorders in the years 2010–2015. Both quantitative statistical analysis and qualitative thematic analysis were carried out.

Results: Eighteen percent of assessed parents with minor children received the CT intervention and children participated in half of them. Participating children more often knew about their parent's treatment and condition when initially assessed, and more often lived with the hospitalized parent. Three main themes were identified in sessions with children; communication about parental mental illness within the family, children's struggles, and healthcare professionals' (HCPs) evaluation of the child's situation and need for further support.

Discussion: Sessions with patients' children appeared to be relatively rare, and participating children did not necessarily receive appropriate information, support, or follow-up. To ensure that HCPs provide quality support and follow-up to COPMI, the routines and the training of HCPs need to be improved.

Keywords: children of parents with mental illness, parental mental illness, mental healthcare services for adults, healthcare professionals, preventive intervention, support of patients' children

Abbreviations: CAMHS, The Child and Adolescent Mental Health Services; COPMI, Children of parents with a mental illness; CT, Child Talks; CWPS, The Child Welfare and Protection Services; DMHSD, The Division for Mental Health and Substance Use Disorders; HCPs, healthcare professionals; PMI, Parental mental illness.

INTRODUCTION

In Norway, 12.2% of children have parents who are receiving treatment for mental illness and/or alcohol use disorder each year (1). According to Norwegian (2), and international estimates (3) approximately one third of patients in adult psychiatric services are parents of minor children. Children of parents with a mental illness (COPMI) have an elevated risk of developing emotional, behavioral, and cognitive difficulties that can result in poorer life outcomes regarding educational level, ability to work, socioeconomic status, and ability to establish meaningful relationships with others (4–8). COPMI are at risk of developing the same illness as their parents, as well as other mental illnesses (9). Half of the children of parents with a severe mental illness (SMI) are at risk of developing a mental illness themselves by the age of 20, and one third are at risk of developing a SMI (10).

The transmission of mental illness from one generation to the next is a complex process. Such transmission is influenced by the interaction of factors related to the mentally ill parent, the child, the family, and the social environment (11). Protective factors can reduce the prevalence and/or severity of problems for COPMI (12). Supportive relationships, coping skills, positive relationships between parents, well-functioning communication within the family, and high socio-economic status are examples of such protective factors (13, 14). Several studies and meta-analysis have found significant effects of preventive interventions for COPMI (15–18). The results imply that preventive interventions with a psychoeducational focus reduce the risk for psychopathology and psychiatric symptoms and increase prosocial behavior for COPMI (15–18).

Knowledge about mental health provides resilience against mental illness (14, 19). Children who receive accurate, non-stigmatizing information about parental mental illness (PMI), treatment, and recovery may be able to understand their parent's behavior, talk to others about their situation, and feel less alone (20). Knowledge and openness about PMI may reduce the stigma and burden of worrying for their parent and make it easier for children to seek professional help (14, 21). A lack of information about PMI can cause misunderstandings and misattributions of the causes of parent's behaviors and treatment, and may increase feelings of concern, confusion, and stress for these children (14). In studies of which information COPMI value, children reported that they preferred to learn about PMI from healthcare professionals (HCPs) and regarded support and information as helpful (22, 23). They valued opportunities to ask questions and wanted to learn about the organization of health services. Several children wanted to be assured that it was not their fault that their parent was ill (22). Children expressed that they needed information about what a mental illness is, different types of illnesses, etiology and prognosis, how to cope with parents' symptoms, where to seek help and support, and how to communicate with others about PMI (14).

Child Talks (CT) is a brief preventive intervention, developed in the Netherlands for COPMI aged 0–25 (24, 25). To this date there are no effect studies of the CT intervention. However, the CT has a clear and well-described theoretical foundation,

focusing on psychoeducation. The intervention is delivered to patients with a mental illness and their children through three sessions. The patient's child should be included in at least one session, to get information, ask questions and share any concerns. The intervention aims to strengthen parents' knowledge of possible consequences for COPMI and increase parents' focus on the child's situation. By providing children with emotional and social support, and information about their parent's disorder, treatment, and recovery, the intervention aims to reinforce children's ability to cope with their situation. Another objective is to detect early signs of psychopathology and/or problem behaviors in children and initiate further support and referrals if needed. The intervention is manual-based and the sessions are described in detail in the CT manual (24). There is also a Logbook associated with the manual that HCPs should complete during or after CT sessions. The Logbook is described further in section "Child Talks Logbooks."

The content of the CT intervention accords to §10 a) of the Health Personnel Act (26). The CT intervention was implemented in the participating clinic at the University Hospital of Northern Norway (UNN) when the amendments to the Health Personnel Act were made in 2010. The law states that HCPs are obligated to contribute to meet COPMI's need for information and support regarding their parents' diagnoses and treatment. If necessary, HCPs should invite children to participate in a conversation to offer information and support. Despite the legal obligations, studies show that COPMI are not provided with the information they are entitled to (27, 28). Fewer than one third of HCPs had conversations with COPMI (28). Moreover, about 40% of parents in treatment reported that their children were unaware they were receiving treatment or being hospitalized, and over 40% reported that their children were not informed about their condition (27).

Most HCPs have positive attitudes toward a family-focused practice in adult mental health services (29). Still, studies have found numerous barriers for a family-focused practice (28–31). Important predictors for a family-focused practice are worker skills, knowledge, resources, and confidence, whereas families' lack of time and fear of involving children are hindering factors (28, 29, 31, 32). Insecurities among HCPs about their role when meeting patients' children and the lack of knowledge of how to have age-appropriate conversations about PMI with COPMI affected HCPs' tendency to invite children negatively (33).

There is a lack of knowledge about how factors related to the parent and the child influence whether children are given information and support by the parent's HCPs. Little is known about the extent to which COPMI participate in psychoeducational interventions and whether the children who do participate are provided with support, information, and follow-up actions. In this study we aimed to address this knowledge gap by analyzing patients' health records.

The main aim of the present study was to evaluate the performance of CT sessions, with a particular focus on sessions with participating children. More specifically, we aimed to investigate:

- (1) parents' participation rate in CT,

- (2) children's participation rate in CT, and reasons for their exclusion,
- (3) age, gender, and psychosocial differences between participating and non-participating children, and
- (4) HCPs' support and information to children.

MATERIALS AND METHODS

Design

This is a retrospective study based on electronic patient journal data for the period 2010–2015. The approval from the data protection officer at UNN allowed us to extract the data from the electronic patient journals in 2015. The study has a mixed-methods approach since both quantitative data from electronic patient journal entries and written reports entered by HCPs to analyses qualitatively were used.

Participants

The total HCPs workforce at the Division for Mental Health and Substance Use Disorders (DMHSD) at UNN was 436 in 2010 (29), whereas 35 HCPs held CT sessions with participating children. Family Assessment Forms were filled out for 424 patients.

Data Material

The data material in this study is information extracted from the Family Assessment Forms and Logbooks from CT sessions, as recorded by HCPs in electronic patient journals. Over the course of the project, two different forms were implemented in the electronic patient journals at the DMHSD at UNN. These two forms were a Family Assessment Form and a Logbook from CT sessions. HCPs were instructed to fill out the Family Assessment Form for patients admitted to the DMHSD who had minor children. Secondly, the patients were to be invited to participate in CT, and HCPs were instructed to write a short report of the sessions in the electronic patient journal, labeled CT Logbooks. Information from these two forms was extracted from the electronic patient journals in 2015.

Family Assessment Forms

The Family Assessment Form consists of five categories of questions: (1) general information about the child, (2) the child's network, (3) concerns for the child, and how the child is coping, (4) the child's knowledge and information about PMI, and (5) the family's need for support and follow-up.

Child Talks Logbooks

Logbooks from cases with participating children were used in the thematic analysis ($n = 39$). In the CT Logbooks, background information such as date, duration of session, place, participants, and parents' diagnoses are requested. HCPs are also asked whether they have any concerns or issues regarding the family. In the following sections, HCPs are asked to respond to openly formulated questions about each session. Five sections are to be filled out for session one, two, and three about which topics and concerns were discussed, support options for the children and families, any questions regarding the child posed by the

parents, any additional details, and agreements for the next session. For session three, there are additional sections for follow-up agreements and advice given to the child and parents, as well as for referrals and necessary follow-up actions that HCPs are to take. In our analyses, we used all the sections from sessions in which children participated. The amount of information and degree of details in the CT logbooks varied. In most logbooks HCPs had written a response in all sections. Some logbooks were several pages long, while others only contained a few paragraphs.

Data Analyses

In the Family Assessment Forms each patient stated how many minor children they had. This information enabled us to calculate the total number of children for the assessed patients, and the number of children for the patients participating in CT. We detected how many children participated in CT from the Logbooks. Based on this information we calculated (1) children's participation rate and (2) number of non-participating children whose parent participated. For non-participating children, we used information from the Logbooks to detect and quantify reasons for their absence.

Descriptive information of participating and non-participating children and parents was compared by analyzing information reported from CT sessions and Family Assessment Forms. For our analyses, we used information from the Family Assessment Form on parent gender, parent diagnosis, child age and gender, and where the children lived. We also used two questions about whether the children had received information about the parent's treatment/hospitalization and condition: "Does your child know that you receive treatment/are hospitalized?" and "Has your child received information about your condition?" The response categories for these two items are "no", "partially," and "yes." Descriptive statistics, t -tests, and chi-square testing were computed in IBM SPSS Statistics 25.

Statistical Analysis

We were not able to test differences between participating and non-participating children regarding parents' diagnoses in reliable ways because of the small sample size, resulting in few parents in each diagnosis category. Partial receipt of information was treated as having received information in the analysis. Chi-square tests were conducted to analyze differences between participating and non-participating children in terms of parent gender, child gender, information received and where the children normally lived. For all chi-square tests, we reported phi (ϕ) for effect size measurement. To test for differences in the mean age for participating and non-participating children, we initially performed a Levene's test to determine if the variance of the groups was unequal or equal. The results from the Levene's test showed that the variance of the groups was unequal. Therefore, we performed a two-tailed t -test with unequal variance for the groups to test for age differences. We calculated the effect size of the mean differences using Cohen's d . The magnitude for all effect sizes was interpreted in accordance with Cohen (34).

Thematic Analysis

Child Talks Logbooks were analyzed to identify the thematic content of the sessions in which children participated, and all CT sessions with participating children were imported into the qualitative analysis program NVivo 12 Pro. The logbooks are a secondary source of information of the CT sessions, written and processed by HCPs.

For the thematic analysis of the CT sessions with participating children, the authors and researchers of the present study used the six-step phase guide by Braun and Clarke (35). This is a flexible approach in which the aim is to identify, analyze, and report the patterns found in the material (35). Our aim was to explore characteristics and patterns in the sessions with participating children; therefore, an inductive approach to the material was chosen.

The first step in the guide by Braun and Clarke (35) is getting to know the dataset by reading it multiple times. We transcribed the forms from paper to electronic format in order to familiarize ourselves with the material. Secondly, we started the initial coding of the material by identifying aspects of the data that reoccurred and which were an important focus in the sessions. The principle of data saturation was used, and hence we ended the initial coding when further coding no longer added new information. In the third step, we formed themes and sub-themes from the codes. In the fourth step, we reviewed all the themes and adjusted

them as necessary so that the themes were more meaningful and comprehensive in respect of the codes included. In the fifth step, we defined the themes by writing a few sentences on their content that were suitable for all the codes included. The final, sixth step consisted of describing the themes in the present paper.

RESULTS

Parents' Participation Rate in Child Talks

Around 5,500 patients were receiving treatment at the DMHSD each year during the project period (2). A total of 424 patients were assessed as having minor children by using the Family Assessment Form, and 78 of these patients (18%) received the CT intervention.

Children's Participation Rate and Reasons for Exclusion

In 39 (50%) of the performed CT interventions all or some of patients' children participated. The 78 patients who received the CT intervention had 157 children in total. Of these children, 62 (39%) took part in the intervention, leaving 95 children (61%) not participating despite their parent receiving the intervention.

Based on the Family Assessment Forms, a total of 864 children were identified. Of these children, 62 participated in CT, resulting

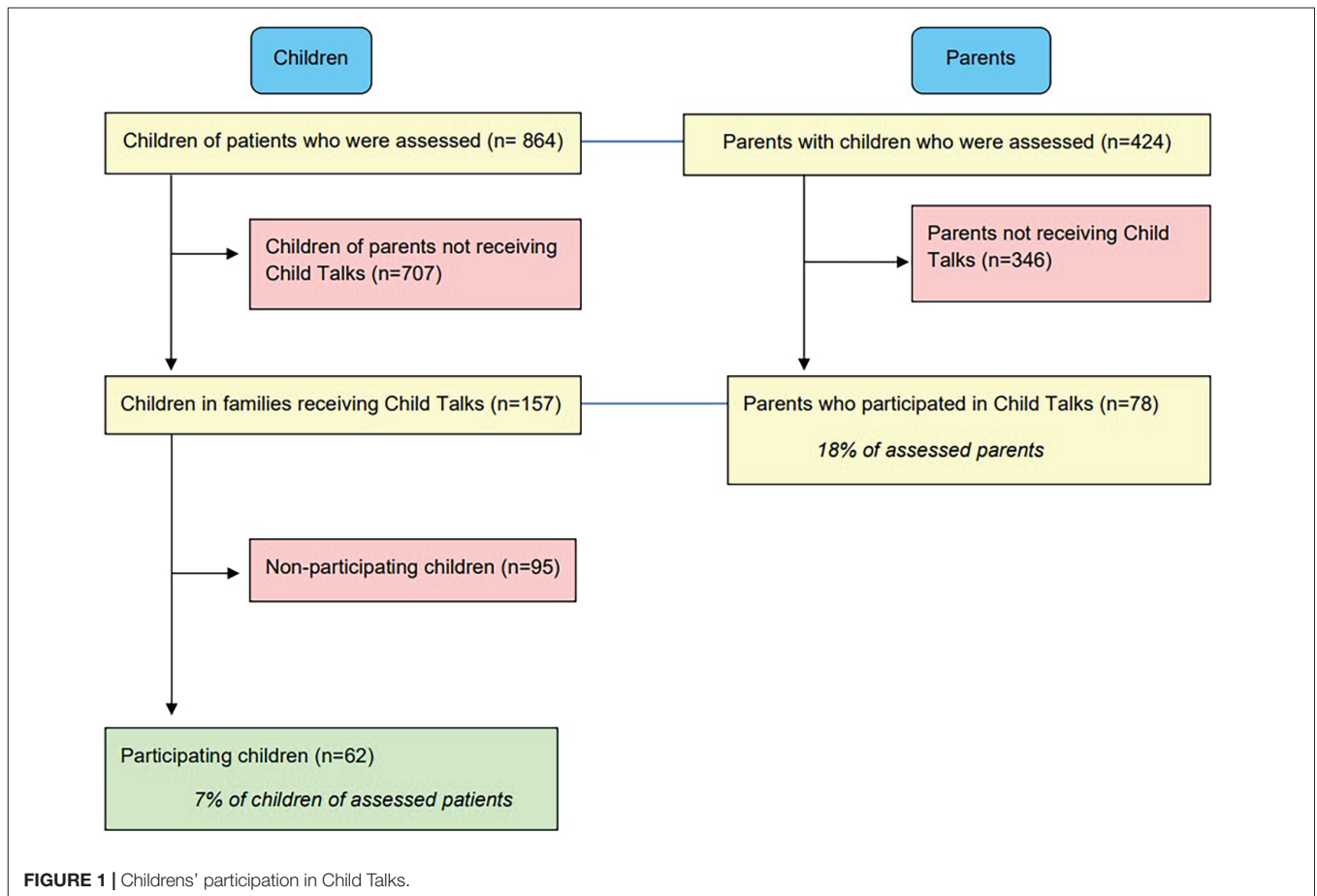


FIGURE 1 | Children's participation in Child Talks.

in a total participation rate of 7% for the identified children. See **Figure 1** for a flowchart of children's participation in CT.

Healthcare professionals provided information about the reasons for children's absence in some of the records ($n = 23$). The reasons stated in records were: (1) the patient was soon to be discharged from hospital and therefore the task of talking to the children was postponed to a later occasion or transferred to personnel in other services ($n = 7$); (2) the patient had little contact with the child/children ($n = 7$); (3) the patient rejected the offer of CT with participating children ($n = 5$); and (4) the other parent of the child did not consent to the child participating, or personnel had not been given a response from the family ($n = 4$).

Comparison of Participating and Non-participating Children

Diagnosis and Gender of Children's Parents

The diagnosis and gender of participating and non-participating children's parents are given in **Table 1**. Twelve parents had multiple diagnoses.

The difference between participating and non-participating children in terms of parent's gender was not significant at $p < 0.05$. The result from the chi-square test was $X^2(1, N = 113) = 3.805, p = 0.051$ and had a small to medium effect size ($\varphi = 0.18$). Information about parents' gender was missing for 44 of parents' children.

Children's Age and Gender

Children participating in the intervention were between 3 and 22 years of age. We observed that the proportion of participating children increased with age (see **Figure 2**). Two children of

preschool age (<6 years) participated (see **Table 2**). Of the participating children, 80% were more than nine years old. **Figure 2** illustrates children's age distribution for participating and non-participating children.

To test for difference in the mean of age of participating children [$M(51) = 11.69, SD = 3.78$] and non-participating children [$M(62) = 10.13, SD = 5.27$], we performed a t -test. The results from Levene's test for difference of variance between the groups were significant at $p < 0.05: F(1,111) = 5.764, p = 0.018$. We therefore performed a two-tailed t -test for which unequal variance for the groups was assumed. Cohen's effect size value ($d = 0.34$) implied a small to medium magnitude of difference between the two groups, but the difference was not statistically significant at $p < 0.05: t(111) = 1.83, p = 0.07$.

Of the participating children, 33 were girls and 23 were boys. Of the non-participating children, 36 were girls and 31 were boys (see **Table 2**). Information about gender was missing for 6 participating and 28 non-participating children. A higher proportion of girls than boys participated. However, this difference was not statistically significant at $p < 0.05, X^2(1, N = 123) = 0.335, p = 0.563$ and had a very small effect size ($\varphi = 0.05$).

Information Provided to Children

Participating children knew that their parent was receiving treatment or was being hospitalized more often than children who did not participate in the sessions, measured at assessment point. Of the participating children, 97.7% (42 out of 43) were aware of their parent's treatment or hospitalization, whereas 72.5% (29 out of 40) of the non-participating children were aware of this. However, answers to this question were missing for 19 participating children and 55 non-participating children. We compared participating and non-participating children by performing a chi-square test and found a significant difference of $p < 0.05$ between the groups, $X^2(1, N = 83) = 10.62, p = 0.001$, with a medium magnitude of difference ($\varphi = 0.36$).

Participating children had also received information about their parent's condition more often than non-participating children, at assessment point. Of the participating children, 85.7% (36 out of 42) were aware of their parent's condition, compared to 60.5% (23 out of 38) of the non-participating children. Answers to this question were missing for 20 participating and 57 non-participating children. The results from the chi-square test comparing the two groups showed a significant difference at $p < 0.05$ level, $X^2(1, 80) = 6.54, p = 0.011$, with a small-to-medium effect size ($\varphi = 0.28$).

Where the Children Lived

For participating children, 94% (47 out of 50) lived with the hospitalized parent. In the case of the non-participating children, 65.9% (29 out of 44) were registered as living with the patient. Answers to the question of where the children lived were missing for 12 out of 62 participating children and 51 out of 95 non-participating children. A chi-square test conducted to assess the difference between participating and non-participating children in terms of living with the hospitalized parent showed a

TABLE 1 | Characteristics of parents with participating and non-participating children.

| Characteristics of parents | With participating children ($n = 39$) | Without participating children ($n = 39$) |
|--------------------------------------|--|---|
| Diagnosis | | |
| Alcohol and substance dependence | 2 | 8 |
| Paranoid schizophrenia and psychosis | 7 | 1 |
| Manic episodes | 0 | 1 |
| Bipolar disorder | 5 | 4 |
| Major depression disorder | 15 | 17 |
| Anxiety disorder | 7 | 6 |
| Post-Traumatic Stress Disorder | 11 | 5 |
| Eating disorder | 1 | 1 |
| Personality disorder | 1 | 6 |
| | 49 | 49 |
| Patient's kinship to children | | |
| Mother | 33 | 26 |
| Father | 6 | 12 |
| Sibling | | 1 |
| | 39 | 39 |

Information missing on diagnoses of two parents with participating children. Since some parents had several diagnoses, the sum of diagnoses exceeds the number of patients participating in CT.

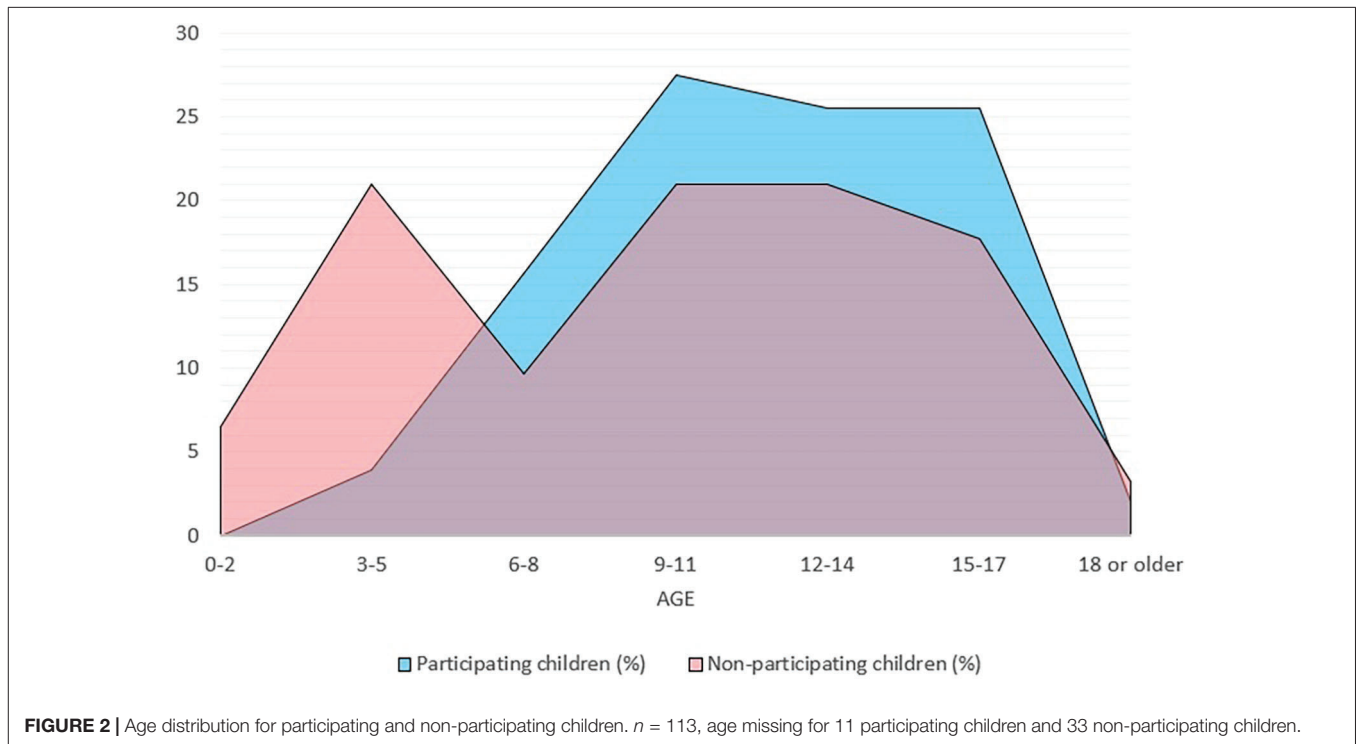


FIGURE 2 | Age distribution for participating and non-participating children. *n* = 113, age missing for 11 participating children and 33 non-participating children.

TABLE 2 | Characteristics of participating and non-participating children.

| Characteristics of children | Participating children (<i>n</i> = 62) | Non-participating children (<i>n</i> = 95) |
|-----------------------------|---|---|
| Gender | | |
| Girls | 33 | 36 |
| Boys | 23 | 31 |
| | 56 | 67 |
| Age | | |
| 0–2 | 0 | 4 |
| 3–5 | 2 | 13 |
| 6–8 | 8 | 6 |
| 9–11 | 14 | 13 |
| 12–14 | 13 | 13 |
| 16–18 | 13 | 11 |
| 18 or older | 1 | 2 |
| | 51 | 62 |

Information missing about gender for participating 6 participating and 28 non-participating children, and information missing about age for 11 participating children and 33 non-participating children.

significant difference at $p < 0.05$, $X^2(1, N = 94) = 11.93$, $p = 0.001$, with a medium effect size ($\varphi = 0.36$).

Themes in Sessions With Participating Children

The thematic analysis of the written reports from CT sessions involving children resulted in three main themes and ten sub-themes. The main themes were communication about PMI within the family, children’s struggles, as well as HCPs’ evaluation

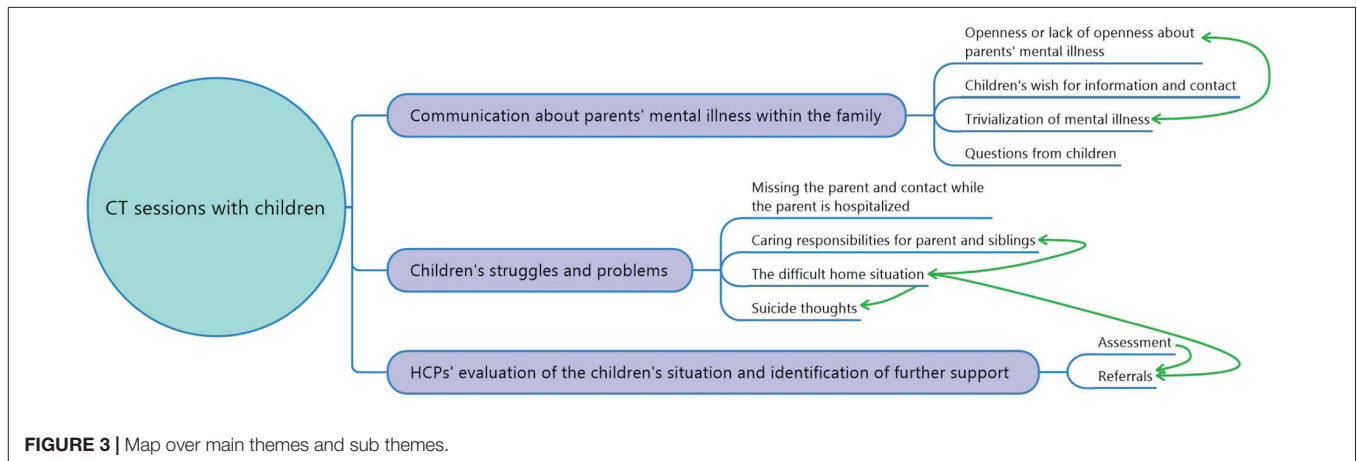
of the child’s situation and identification of further support. See **Figure 3** for an overview of main themes and sub-themes.

Informing Children About Parental Mental Illness

Healthcare professionals frequently explained to parents why talking openly about mental health within the family is important. Some of the parents were open about their illness, and many said they wanted to be even more open. In many families, however, there was little to no communication about the parent’s illness. Hence, for some children the CT session was the first time they received information about their parent’s illness. The children usually expressed that they were glad to receive information from HCPs. However, some children did not want information and did not want to visit or have contact with the mental health services.

In some cases, the parents were unwilling to talk about mental illness and prevented their children from receiving information or being given the opportunity to talk about their situation. Reasons were that they did not want their children to be unnecessarily worried or to focus on the negative characteristics and psychiatric diagnosis of the sick parent. A mother who was diagnosed with depression, anxiety, and an eating disorder protected her 10-year-old daughter (ID 35), from words such as “mental illness” and “psychiatric hospital.”

The information that children received was not always correct or clarifying. Proper explanations about parents’ illness, symptoms and behavior were often missing. Some children knew that something was wrong or that their parents were struggling, but not what or how. Often parents and HCPs used word such as “exhausted” or “having headache” when explaining parents’ mental illness.



Questions from children appeared in a few records. The questions reported concerned the care of younger siblings, heredity, and the home situation. Children did not usually ask directly, but rather expressed their curiosity about a theme in the session.

Children's Struggles and Problems

Children reported missing their hospitalized parents and being worried about them. Two boys aged 10 and 11 years (ID 78) missed their father while he was hospitalized and reported being worried about him. This was also given as the reason for the youngest boy having trouble concentrating at school. Some children kept in contact with the hospitalized parent by using video calls and some had also visited their hospitalized parent on several occasions. Some children missed the way things used to be before their parent became ill, like a 15-year-old girl (ID 17) who said that she was missing her "healthy" mother. She missed spending time with her mother in the evenings, lighting candles, and watching movies. She also missed tasty and healthy meals.

Several children in the records were worried about, and had great responsibilities for, the care of their sick parent and/or younger siblings. A 12-year-old girl (ID 42) had to physically stop her mother from dying by suicide. The girl was worried about what might happen once her mother was discharged from the hospital. HCPs emphasized the importance of making the daughter aware that it was not her responsibility to take care of and look after her mother, yet they advised her to contact the police if her mother did anything like that again. The girl also expressed her concerns for the care of her younger siblings while her mother was hospitalized, especially the one-year-old. She was not sure her father would be able to take care them. She had trouble sleeping at night. The girl was advised to contact help services if things became difficult or if she needed someone to talk to.

Some children were overinvolved in the illness of their parent, such as a 12-year-old boy (ID 18) whose mother had been diagnosed with anxiety:

The boy said he was going to look after his mother until he became an adult. He was worried about his mother when she got her anxiety attacks. When she got the anxiety attacks, he massaged her.

Another child, a 16-year-old boy (ID 60), frequently had to participate in his mother's doctor appointments and translate letters from the Ministry of Foreign Affairs. He was also involved in the conflict between his parents and described how he had to stop his father from being violent with his mother:

In the beginning, after they came to Norway, his father was physically violent toward his mother. One night he got up and told his father that if he ever beat her again, he would call the police. The father went out and did not return until much later. Since the incident the father has never beaten her. The boy cried while telling this. He said this was the very first time he had cried in front of his sister.

Many children had a difficult home situation, living in families with severe, long-lasting problems. Many of the children had experienced frightening episodes at home. The children's situations at home were often described as unpredictable, stressful, and characterized by high conflicts levels and violence between family members. In one case a 16-year-old girl (ID 39) who was living with her mother, who had been diagnosed with a psychotic illness, was physically abused:

There was general concern for the family because of the mother's mental state. There was also concern for the daughter's situation and whether she was given help for her own mental health problems, which she had had for several years. Her mother was unstable and had on several occasions pushed and thrown things after the girl. The mother had also called her names. It was difficult for the daughter because her mother was suspicious and seemed to be in a paranoid state of mind.

The patient in the example above was discharged from the hospital and sent home to her daughter. A report of concern was sent to The Child Welfare and Protection Services (CWPS). The daughter was advised to contact the school nurse when she returned to school at the end of the summer.

Several children had more or less concrete thoughts about dying by suicide. For one of these children, HCPs stated that the child's mental health problem was taken care of by their general practitioner. In another case a 16-year-old boy (ID 60) was invited to call HCPs if he wanted to talk, after he had told them that he had thought about cutting his main artery if he was sent back

to Afghanistan. He had even looked in the kitchen drawer for a knife. For a child who had attempted to die by suicide earlier, HCPs were concerned for the child's mental health problems and whether appropriate help was provided.

Evaluating and Supporting the Children

In many of the records, HCPs observed and evaluated the situation of the children and the parent's caring abilities. In some cases, HCPs explicitly wrote down the agenda for evaluating the children, for example to "look at the interaction between the mother and the daughter" or to "observe the relation and the interaction between the children and parents." In one case (ID 26), the HCPs evaluated the attachment and how the child acted around his parents. HCPs even talked with the four-year-old boy while his parents were waiting outside.

Healthcare professionals explored the children's network and support options as part of the intervention. Many sessions led to referrals to CWPS and The Child and Adolescent Mental Health Services (CAMHS), but in some cases where children described severe problems, no referrals were made. HCPs frequently encouraged parents and children to contact their general practitioner, their teacher, or the school nurse. Responsibility for establishing contact with help services or professionals was often left with the child. Some families were already in contact with CWPS and/or CAMHS. School nurses were frequently recommended as a support option. In the case of the 10-year-old girl (ID 35) who was being shielded from words such as "mental illness" and "psychiatric hospital," the school nurse was recommended as a support option because the parent and the child knew of her. Likewise, in a case with a 17-year-old boy (ID 09), the school nurse was emphasized as a support option as a neutral person the boy could talk to about everyday life and other relevant topics of conversation for adolescents. In addition, HCPs often gave children and parents the opportunity to have several sessions and to get in touch with them outside of the sessions if they needed to talk. The HCPs also gave children the opportunity to call them if they had any questions. In some cases, there was a mutual agreement that the family would benefit from staying in touch with the ward.

DISCUSSION

Is the Participation Rate of Patients at an Acceptable Level?

Of the thousands of patients at the DMHSD at UNN during the period 2010–2015 (2), only 424 were assessed with the Family Assessment Form. This means that for most of the patients, there were no records of minor children they might be parenting. Furthermore, only 78 patients received the CT intervention, meaning that only a small fraction of COPMI were attended to in the manner mandated by legislation in Norway. These results are in line with previous research, suggesting that it is challenging to implement new routines related to COPMI in Norway (36, 37) and illustrating the need for a better implementation strategy.

Is the Participation Rate of Children at an Acceptable Level?

Seven percent of children identified in the Family Assessment Forms participated in CT. However, the number of children identified in the Family Assessment Form does not represent all minor children of patients at the DMHSD. In fact, around 5,500 patients were receiving treatment at the DMHSD each year during the project period (2), and likely one third of them had a mean of 1.75 minor children each (3, 27, 38), which equals more than three thousand minor children of patients each year. The participation rate based on the actual number of minor children of patients will therefore be considerably lower than 7%.

According to the CT manual, children should participate in the second session and optionally in the third session (24). However, children were only present in half of the cases in which the CT intervention was utilized, and since not all siblings participated in cases including children, children's participation rate in received CT was only 39%. Children's participation rate reveals that the intervention manual is not being adhered to, and consequently, the obligation of HCPs to provide COPMI necessary information about PMI, support and follow up does not seem fulfilled. It is especially important that HCPs provide information to COPMI since previous research has shown that parents themselves often did not inform their child about their treatment/hospitalization or condition (27).

The main reasons for children not participating reported in this study were reluctance of one or both parents, little contact with the children or ending of the parent's treatment. In cases where the parent does not have custody or contact with the children, inviting the children to participate in a session is not appropriate, thus these patients would not have been invited to participate in the CT intervention. Large demographical distances between the clinic and the children's home might have made children's participation difficult in some cases, especially for the youngest children. In cases in which parents were reluctant to bring their children to a CT session, HCPs are in a good position to argue in favor of child participation. The reasoning behind including children is available in the CT manual and motivating parents and planning how to inform the children is the core activity in session one (24). Aligned with previous research, HCPs seem to need better awareness of the importance of giving children information and support, greater skill at motivating parents to invite their children, and greater skill, or perhaps greater confidence, in performing conversations with children present (28, 31).

Which Factors Influence Child Participation?

In terms of factors relating to the parent, differences between participating and non-participating children regarding parents' diagnoses could not be tested in reliable ways because of the sample size. However, the parent's gender might be a factor influencing child participation, with a difference between participating and non-participating children close to our chosen significant level, with a small to medium effect size. COPMI

more often lived with their mothers as a sole caregiver and therefore were in the care of relatives while their mother was hospitalized (27). A more dramatic change in these children's life situations calls for more information and support, which might explain why children of mothers participated more often. This is also in correspondence with our results showing that participating children more often lived with the parent in treatment. Furthermore, deciding and planning for child participation is easier when the child is fully under the custody of the patient.

Mostly older children participated in CT. Child participation increased with child age, and the difference between participating and non-participating children in mean age was close to our chosen significance level, with a small to medium effect size. In earlier studies HCPs have reported feeling insecure about who has the responsibility of children visiting patients and how to have age-appropriate conversations (33). Furthermore, the study found that HCPs' confidence level influenced their initiative to motivate patients to invite their children. For the youngest children, it is possible that HCPs' insecurities were amplified, since younger children are less independent and require more adjustments by HCP. HCPs might need more knowledge and training in child development and age-appropriate conversations about PMI. Interventions for COPMI can also be more adaptable and user-friendly for HCPs, by making recommendations for different age groups. For example, for children under two years a visit to the hospital to assure them their parent is safe can be recommended. For children from three years and up, in addition to recommending a visit, guidelines for age-appropriate information and communication principles can be provided in the intervention manual. Increasing HCPs' information and support to the youngest children is of great importance since younger children are the most dependent on their parents, and not mature and autonomous to seek information and support elsewhere. We found no differences in child gender for participation.

In terms of knowledge about PMI, there was a significant difference, of a small to medium magnitude, between participating and non-participating children. Participating children more often already knew about parents' treatment/hospitalization and condition. Families that are more open about PMI might be more willing to have children participating in a conversation with HCPs. This is in coherence with earlier studies in which families' fear of involving children was perceived as an important hindering factor for a family-focused practice by HCPs (32).

Are Children Supported and Informed?

The main themes in the CT sessions with children reflected the objectives of the CT intervention (24): communication about PMI within the family, children's struggles and HCPs' evaluation of the child's situation and identification of further support. However, the content of the CT sessions uncovered a large variation in the quality of the support and information children were provided.

Children were glad to receive information, which is in line with earlier studies which show that children appreciate support

and information from HCPs (22, 23). Parents, however, were sometimes reluctant and unsure about informing their children because they did not want to make their child additionally worried, a barrier for family-focused practice found in another study (32). Our result confirmed, what is described by other researchers (14), that children often know that something was wrong and that not having information could lead to frustration. It was also found that the children were missing their parent and were worried about them. These results underpin the importance of information and contact with the parent in treatment for COPMI (14, 19–22).

Healthcare professionals evaluated and explored children's situations but were reluctant to refer to other services or provide further support. High conflict levels within the family, domestic violence, physical and mental abuse, mental health problems and suicide thoughts among children were described. However, few appropriate actions were taken by HCPs. Despite HCPs' obligation by law to refer children to the CWPS when concerned with their living situation, HCPs did not take appropriate actions in all cases. In previous studies HCPs have reported hesitation against referrals because of insecurities of whether there were grounds for referral, whether a referral would benefit the child and whether a referral would harm the family and their relationship with the patient (39). The lack of action by HCPs does not only take away children's chance for help but does also trivialize the problems and struggles the children are experiencing. HCPs need to know which support they can offer, and which actions to take. Educating HCPs about follow-up options and help services for children might contribute to providing COPMI better support.

Strengths and Limitations

One limitation of this study is missing data for several variables, particularly for the non-participating group of children. The results must therefore be interpreted carefully. The small sample size may be a factor contributing to the lower sensitivity of the t-test, resulting in less reliable results.

The journal data were a secondary source of information of the CT sessions, written and processed by HCPs, based on their perception of what is important and of interest. What was written in the logbooks was partially decided and influenced by the CT logbook and the questions HCPs were to answer. However, the questions were openly formulated and did invite HCPs to give detailed descriptions of the conversations and share a range of information. Despite this, it varied how much and how specific the written information about the conversations were. By focusing on the themes that were discussed in sessions, rather than looking for meanings behind the text, the data material was suitable to answer the associated research aim in the present study. The benefit of the research design is that it enabled a reduction of the disturbance and influence of an observing researcher. A researcher present in sessions might have made participants more hesitant to speak openly about sensitive and personal subjects. In addition, HCPs should be able to perform the sessions at a time they found appropriate in respect of the

patient's course of treatment and time management. Having to plan for a third person's participation would have made the feasibility of the project weaker.

Only CT Logbooks in the electronic patient journal were assessed; hence information written elsewhere was not available and not included in the analysis. What is logged from the sessions is partially prearranged from the Logbook forms. Since the Logbook forms are directly based on the manual's description of the intervention, the data may incorrectly confirm the HCPs' adherence to the manual. The HCPs were aware that the reports were going to be used in a quality-assurance project and they might therefore have reported the session more in line with the guidelines of the manual. There was, however, sections in the Logbook form with open formulated questions, which gave HCPs the opportunity to share a wide range of information.

Future Research

To facilitate and strengthen the degree to which children are given information and support they are entitled, more research is needed to gain detailed knowledge about factors influencing children's participation. Future research should identify reasons why HCPs are not including children and investigate whether it is due to lack of consent from parents, institutional constraints, or unfulfilled professional needs. It would be useful to know whether certain characteristics of the parent's illness, such as a sudden onset or a significant change in the parent's functional level and behavior, influence the need to give and receive information among HCPs, parents, and children. Whether child participation is influenced by parent gender also needs to be explored in future studies after adjusting for where the child usually lives. In addition, the difference between participating and non-participating children in terms of received information about PMI should be investigated when adjusting for confounding factors, such as the child age.

CONCLUSION

Child Talks is an intervention that seeks to reinforce COPMI's ability to cope with their family situation by the provision of age-appropriate information about their parent's illness and treatment. The intervention also aims to provide additional support and follow-up for the children who require it. Of patients who were registered as having minor children, less than one fifth received the intervention, and only half of the patients who participated also had their children participating. Of the registered minor children, less than one in ten received CT. Ideally, children who participate in the intervention emerge better informed, supported and are, when necessary, provided with follow-up. However, this study shows that even participating

children were not always followed-up or judged to have been adequately informed. Routines and training of HCPs to support parents with mental illness and their children need improvement. Initial identification of children of patients is important, and subsequent support and provision of adequate services to the identified children always needs to follow.

DATA AVAILABILITY STATEMENT

The original contributions presented in the study are included in the article/supplementary material, further inquiries can be directed to the corresponding author.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by the Data Protection Officer at the University Hospital of Northern Norway (UNN). The regional ethics committee (REK) categorized the project as a quality assurance project. Written informed consent from the participants' legal guardian/next of kin was not required to participate in this study in accordance with the national legislation and the institutional requirements.

AUTHOR CONTRIBUTIONS

KK made the analysis and the draft of the manuscript. CR was the primary investigator in the main project. CR and CL collected the data in collaboration with the project coordinator, Lisbeth Mørch, at UNN. All authors contributed to the writing of the manuscript.

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Paper 3

Child-focused practice in social services for adults in Norway

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Abstract

● *Summary:* Children of social service users are at risk for developing mental health problems as well as social and behavioral problems. Social service counselors should therefore be aware of service users' children and provide support for them. In fact, they are obligated by law to consider children's views and their best interests in cases affecting them. Despite this, little is known about social service counselors' child focus in their practice. In this study, self-reported survey data from 93 counselors working for the Norwegian Labor and Welfare Administration (NAV) were analyzed to explore their child focus.

● *Findings:* Findings suggest that a particular focus on children is no part of common practice among NAV counselors; nor is use or knowledge of The United Nations Convention on the Rights of the Child (CRC). Knowledge and use of the CRC may be a predictor of child-focused practice. The results showed a significant difference of medium effect size between NAV counselors who ask about children and NAV counselors who do not when it comes to knowledge and use of the CRC.

● *Applications:* Policy makers and practitioners should utilize NAV's potential as a preventive arena. For NAV counselors to be aware of and support children of social service users they need a stronger focus on children and hence know and use the laws concerning children's rights. Incorporating children's rights into social workers' education and internal training may strengthen the focus on children in NAV counselors' practice.

Keywords

Social service, family support, children's rights, prevention, social work

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Introduction

The Norwegian Labor and Welfare Administration (NAV) administers the social welfare system in Norway. NAV manages and provides schemes such as unemployment benefits, work assessment allowance, sickness benefits, pensions, child benefits and cash-for-care benefits (Arbeids og velferdsetaten, 2019). In addition, NAV offers financial assistance and counseling, guidance, temporary accommodation, qualification programs, and more. Work assessment allowance and disability benefits are provided to social service users who cannot work, or are temporarily without work, due to health issues. Economic benefits support social service users who are not able to provide for themselves through employment, own funds or other economic benefits. Counselors in the local NAV offices have various educational backgrounds. Commonly, counselors have a bachelor or a master's degree in social work, child welfare, social science, pedagogic, economics, or law (NAV, 2019c). The counselors are employed as social workers, primarily in contact with adult social service users. Counselors administer the schemes and guide users who have difficulties regarding labor, need financial assistance, or public housing (Arbeids og velferdsetaten, 2019).

When receiving economic benefits, social service users should be able to provide for themselves. However, four out of ten clients struggle to make ends meet (Statistics Norway, 2018a). In 2017, ~26% of economic benefit receivers had children under 18 years to provide for. Around 70,000 children depend on economic benefits their parents receive (Skjøstad, 2019). Half of the receivers were single providers. Twenty-eight percent of these families were tenants in public housing, which is a temporary housing measure for disadvantaged people. In addition, 2,000 parents who received economic benefits were homeless (Skjøstad, 2019). Moreover, according to data from Statistics Norway (2018b), almost 54% of economic benefit-receiving parents were unemployed and did not attend education, courses, or other job-related initiatives. In Norway, around 10% of children live in families that are persistently poor, and the numbers are increasing (Brattbakk & Andersen, 2017). Due to the coronavirus crisis, unemployment rates for the Norwegian workforce increased from 2.3% to 10.4% over a few weeks in March 2020 (Bratsberg et al., 2020), and the report by Bratsberg and colleagues shows that people with low income, low educational level, and fewer economic resources were more likely to lose their jobs during the crisis. In addition, families with children were more often laid off compared to families without children. This means that the number of children depending on the economic benefits their parents receive is likely to be much higher today than the numbers from earlier years might otherwise indicate. The report does not give exact numbers but shows that approximately 100,000 children live in families where parents seek unemployment benefits (Bratsberg et al., 2020). In other words, the crisis has had a particularly severe impact on and added additional burdens to families with low socioeconomic status.

In Norway, as in other countries, socioeconomic status affects health and mortality outcomes (Mackenbach et al., 1997; Zahl et al., 2003). Growing up in families with low socioeconomic status is a risk factor for developing cognitive, behavioral, social, and emotional problems among children (Cohen et al., 2010; Duncan et al., 1994;

McLoyd, 1998). Norwegian adolescents in families with lower income and lower educational level had poorer health and lower rates of high school completion (Sznitman et al., 2017). The study by Sznitman et al. (2017) found that household income affects high school completion rates for Norwegian adolescent through its effects on adolescent health. A life-course study of children born in New Zealand found that children who grew up in families with low socioeconomic status had poorer physical and dental health as adults (Poulton et al., 2002). In addition, dependence on alcohol and tobacco as adults was weakly linked to low childhood socioeconomic status. An upward move in socioeconomic status did not reverse or reduce the effects on adult health (Poulton et al., 2002). A review study by Bremberg (2002) for the Swedish institution for public health found large differences between children of parents with low socioeconomic status and children of parents with high socioeconomic status. For children of parents with low socioeconomic status physical health problems were 60% more common, mental health problems 70% more common, and risk factors for health problems 80% more common (Bremberg, 2002).

Being out of work is associated with negative mental health outcomes (McKee-Ryan et al., 2005). Researchers have found a medium to strong effect of unemployment on mental health in meta-analyses (McKee-Ryan et al., 2005; Paul & Moser, 2009). These studies also found that the longer the unemployment lasted, the stronger the negative effect on mental health was. Paul and Moser (2009) found that unemployed individuals are more than twice as likely to have psychological problems compared to employed individuals. The causal link between unemployment and mental health problems is complex. Psychological and financial consequences of unemployment affect health negatively through factors like mental stress due to joblessness and financial insecurity, financial challenges, and social exclusion (Wilkinson & Marmot, 2003). The negative effect unemployment has on the mental health of an individual can also affect their children.

Children of parents with a mental illness have up to a 50% chance of developing a mental illness themselves (Leijdesdorff et al., 2017), and they are at risk for developing both the same diagnosis as their parent and any other mental diagnosis (van Santvoort et al., 2015). One-third of offspring of parents with a severe mental illness develop a severe mental illness themselves by early adulthood, and one out of two of these children develop a mental disorder (Rasic et al., 2014). Offspring of parents with depression have a three times higher risk of suffering from major depression, and a twice as high risk of suffering from other mood disorders and anxiety (Weissman et al., 2016). Children of mentally ill parents can lack developmental support and are at risk for child abuse, neglect, identity problems, academic failure, substance use, medical problems, mortality, behavioral problems, dysfunction, and other emotional problems (Brennan et al., 2000; Clark et al., 2004; Sundfær, 2012; Weissman et al., 2016).

According to NAV, 36% of all disability benefits receivers had a mental disorder as their main diagnosis in 2016. Around 20% of the receivers had minor children. Notably, the prevalence of mental disorders among receivers of disability benefits was higher in age groups where individuals are more likely to have minor children (18–39 years = 61.5%, 40–49 years = 46.3%) (NAV, 2019b). In the years 2015–2020, 42% of

work assessment allowance receivers had a mental disorder as their main diagnosis (NAV, 2019a). From another point of view, 52% of patients with a mental disorder who were parents and 53% of patients with a substance use disorder who were parents reported receiving unemployment benefits from NAV. If including parents receiving sickness benefits the percentages were respectively 69% and 65% (Ruud et al., 2015, p. 47).

It is evident that NAV provides services for many users with mental health issues who are parents. The children of users with mental health issues are at risk for poor outcomes later in life. Additionally, NAV counselors meet parents of children growing up in poverty. NAV counselors are therefore in a unique position to become aware of and support children who are at risk. Especially for children of parents who are immigrants, NAV has a unique opportunity to detect and support children at risk. Immigrants have less contact with health care institutions, despite the fact that the prevalence of mental illness is higher for immigrants from countries where the average income is low to medium (Reneflot et al., 2018). However, immigrants are highly represented among social service users of NAV (Dokken, 2015).

Safeguarding children's interest—Mandatory by law

The United Nations Convention on the Rights of the Child (CRC) was incorporated into Norwegian law in 2003, and has precedence over ordinary legislation (The United Nations Association of Norway—UNA Norway, 2019). Children have the right to express their views in matters affecting them, and their views should be given due weight, as stated in article 12. According to article 3, children's best interests must be the primary concern when making decisions that may affect them (United Nations, 1989). Therefore, as obligated by law, NAV counselors must take the views of children of social service users into consideration in all cases where children are affected. Social service counselors need to have a family focus and offer support for families with children. In order to have such a child focus, awareness of the CRC is essential.

Children do not only have the right to be involved; they also want to be involved and provided support. In a study presenting young people's perspectives of the support they want, 94% of the children of a parent with a mental illness answered that they did want some kind of support (Grove et al., 2016).

Implementation of the CRC

Implementation of laws and interventions in human services requires thoughtful and effective implementation strategies at multiple levels (Fixsen et al., 2005). In a study by Lauritzen and Reedtz (2013), health care workers' awareness of and support for patients' children were assessed. Results indicated that in order to change practice, there must be development on several levels in the organization and in the workforce. Health care workers who supported children of patients had higher levels of knowledge

about children's rights, and this might be a factor facilitating a child focus (Lauritzen et al., 2015).

In an empirical analysis of how the CRC is put into action among people working with child poverty, Heimer and Palme (2016) address the issue of children being only indirect receivers of income or services through the family as a unit. According to a report from the Swedish Ministry of Health and Social Affairs (Nyman & Lönnerheden, 2004), social workers usually only focus on the needs of the adult service users and rarely reflect on the child's situation. In a qualitative study conducted in Norway, six NAV counselors were interviewed (Krane et al., 2018). None of the counselors spoke with the children directly, despite the children's right to have a saying in cases affecting them. Krane et al. (2018) point out that the family's economy significantly impacts the conditions for children's upbringing, and talking to the children could help ensure that their needs are secured, both short term and long term.

The Ombudsman for Children in Norway (2017) is concerned that decisions affecting children are too often made without review and assessment of the best interest of the child. A report from The Norwegian Board of Health Supervision (2013) revealed serious shortcomings in the majority of the inspected municipalities, in particular with respect to lack of information and assessment of children's situations and needs when providing financial support benefits. According to the Ombudsman, the results were disturbing, and 49 of 70 municipalities committed offenses. The CRC is not sufficiently implemented in practices at NAV, and there is a need for training and guidance of counselors at NAV on the CRC (The Ombudsman for Children in Norway, 2017). Professionals working with children need knowledge about the CRC, in addition to knowledge about and guidelines for how to apply the convention in practice. The Ombudsman for Children in Norway (2017) recommends systematic training for professionals and information on CRC in all relevant educational institutions. To prevent child poverty in Norway, it is important to train social workers to discover children who are stigmatized and marginalized (Tjelflaat, 2014). Social workers are in a position to help these children by securing a good childhood and prevent further problems, and they must therefore also cooperate with other institutions in the process of helping (Tjelflaat, 2014).

Aims

There are few studies on child-focused practice in social services for adults. The fact that children are not the primary clients at NAV has not only influenced practice among NAV counselors, but also the research field. The research field also mainly concentrates on child-focus practice in services that are in direct contact with children. Yet, insofar as children's rights and children's welfare is a matter of concern, it is important to know how and to what extent NAV counselors take children of social service users and their interests into consideration. The overall purpose of this study was to explore the child focus in current social work practice of counselors at NAV. Additional aims were to:

- (1) assess NAV counselors' levels of knowledge about the CRC and to what extent NAV counselors applied this knowledge in their social work practice.
- (2) investigate how knowledge and use of the CRC, usefulness of collaboration and perceived quality of the office's system, routines and guidelines were associated with a child-focused practice in NAV, and subsequently investigate which of these factors predict a child-focused practice.
- (3) investigate differences in terms of knowledge and use of the CRC, usefulness of collaboration and perceived quality of the office's system, routines, and guidelines for NAV counselors asking about children, compared to NAV counselors not asking.

Method

Procedures and participants

This was a cross-sectional study. The two participating NAV agencies in this survey had received grants from the Directorate of Labor and Welfare through the Childhood Poverty Project. To ensure variation in the sample, the agencies were of different sizes and located in different municipalities and regions. The contact person at the NAV agencies distributed the survey to the staff.

In smaller agencies, all employees are responsible for a diversity of services provided by NAV, while in bigger agencies employees are more specialized. All counselors in participating agencies with user contact were invited to take part in the survey, regardless of their area of responsibility, because a child focus should be a fundamental premise for all the organization's activities. Participants were provided with a link to the survey in the data collection program SurveyXact via email. Reminders were sent three times over a three-week period. In 2015/2016, 93 social workers completed the survey. The overall response rate was 67%, representing 11 workers from the smaller agency and 82 from the larger agency. Demographic information about the participants was not collected to ensure the participants' anonymity.

The largest participating agency in this study serves around 75,000 people, and the other agency serves around 4,000 people. In these two municipalities, around 450 receivers of social help benefits had children under 18 years, representing more than 820 children living in families that received social help benefits. Nationwide, a total of 66,902 children live in families that receive social help benefits (Statistics Norway, 2018b). In the municipalities included, 22% of social benefits receivers had minor children in 2016. Nationwide, the 2016 number was 25%. NAV also provides other benefits and services and is therefore in contact with social service users with and without children. However, these numbers indicate what percentages of NAV clients are also parents, and how many children are affected.

Measures

The county governor in Troms, the project coordinator, and two NAV counselors developed the survey. Only one demographic item was included in the survey, identifying at

which of the offices the participants worked. Other demographical items were not included to avoid the possibility of indirectly identifying participants. To ensure the agencies' anonymity, the variable identifying workplace was removed. The survey included the following topics: child-focused practice, knowledge and use of the CRC, collaboration, and the office's systems, routines, and guidelines.

Child-focused practice. To measure the NAV counselors' practice considering a focus on the clients' children, four items were included:

- (1) "In your work as a counselor: When you meet a new user, do you ask whether the user has dependent children or caring responsibilities?"
- (2) "Do you assess the case differently if the user has children?"
- (3) "In meetings with users who have children, do you assess the children's needs?"
- (4) "Do you ask users what their children need?"

All four items measuring child-focused practice were scored from "never" (1) to "always" (5). These four items were included in the scale "Child-focused practice." The reliability analysis of the scale had a Cronbach's α coefficient of 0.78, indicating an acceptable internal consistency of the scale.

NAV counselors who did not answer "always" to item 1 were given an open-ended follow-up question: "What is the reason that you do not always ask if the user has children?" The answers were recoded into five different categorical values: "I do not think of it or remember to," "I already know," "It is not relevant," "I do not prioritize it," and "I consider it unlikely because of the user's age or situation."

A new variable "Askers" was created by recoding the variable "Reasons for not asking about children" into two groups: (1) "NAV counselors who do not ask about children" and (2) "NAV counselors who ask about children." Those who always ask and those who already know were assigned to the group "NAV counselors who ask about children," and those who do not think of or remember to, find it not relevant, do not prioritize it or consider it unlikely because of the social service users' age or situation were assigned to the other category.

Knowledge and use of the CRC. To measure NAV counselors' knowledge and use of the CRC, three items were included and scored using a 5-point Likert scale:

- (5) "How relevant do you consider the CRC to be for your work at NAV?," scored from "totally irrelevant" (1) to "highly relevant" (5).
- (6) "How well do you know/what is your level of knowledge about children's rights, as determined by the CRC?," scored from "no knowledge" (1) to "high degree of knowledge" (5).
- (7) "Is the CRC something you use in the assessment when you supervise clients, or when you process or conclude in cases involving clients who have children?," scored from "never" (1) to "always" (5). The alternative "not relevant" (6) was recoded to "never" (1).

These three items were included in the scale “Knowledge” and tested for reliability. The Cronbach’s α coefficient was 0.73, indicating that the scale had acceptable internal consistency.

Collaboration. One item measured how NAV counselors perceived the usefulness of collaborating with other institutions in cases involving children by asking “How do you perceive how useful it is for the office to collaborate with local institutions in cases concerning children?” The response scale went from “extremely useless” (1) to “extremely useful” (5). A “don’t know/not relevant” alternative was also included in the survey.

The office’s systems, routines, and guidelines. One item measured NAV counselors’ perception of the office’s systems, routines, and guidelines for promoting a child-focused practice by asking “Do you think the office has systems, routines and guidelines etc. that promote a child-focused practice?” Response options were given on a five-point scale from “no systems” (1) to “very good systems” (5).

Statistical analysis

Data from the survey were exported from Excel files into SPSS. Statistical analyses were done using SPSS (Version 25), except for the confirmatory factor analysis (CFA), which was performed in Mplus (Version 8).

We created a model with the two latent variables “Knowledge” and “Child-focused practice” from seven items based on the thematic content of the questions. To test the fit of the created scales, a CFA was conducted. We compared the general model where all seven items loaded on the same general latent variable to our model with the two latent variables. The reliability of the scales was also tested.

Descriptive analyses were performed to describe the level of knowledge and child-focused practice among NAV counselors.

The relationships between child-focused practice and knowledge and use of the CRC, perceived quality of the offices’ systems, routines, and guidelines, and usefulness of collaboration were explored using Kendall’s tau correlation coefficient, two-tailed.

To detect how well the factors of knowledge and use of CRC and perceived quality of the office’s systems, routines, and guidelines were predicting a child-focused practice, a multiple regression analysis was conducted. The dependent variable was the child-focused practice scale variable. “Collaboration” was not included in the analysis as a predictor due to missing values. Including the variable would result in a sample size too small for generalizability.

An independent sample *t*-test was performed to compare mean scores of knowledge and use of the CRC for NAV counselors who do ask about children and for those who do not, using the variable “Askers” ($n = 84$). We tested for difference in knowledge and use of the CRC using the scale variable “Knowledge.” We calculated the effect size in the *t*-test using Cohen’s *d*. Criteria used to evaluate the Cohen’s *d* were in accordance with Cohen’s (1988) effect criteria, where $d = 0.2$ is considered a small effect, $d = 0.5$ is considered a medium effect and $d = 0.8$ is considered a large effect.

Additionally, we conducted an ordinal regression analysis to test for differences between the two groups for the ordinal variables “Collaboration” ($n = 59$) and “System/Routines/Guidelines” ($n = 84$).

The data had few missing values overall. The variable “Collaboration” had some answering in a response category labeled “not relevant/I don’t know.” This category was labeled “missing” before the independent sample t -test and the ordinal regression analyses were conducted.

Results

Confirmatory factor analysis

The two tested models from the CFA are illustrated in Figure 1. The general model, model 1, where all items load on the same general latent variable, had a value of 40.728 on the χ^2 test of model fit, and was significant ($p = .0002$). The root mean square error of approximation (RMSEA) estimate was 0.143, the comparative fit index (CFI) was 0.96 and the Tucker Lewis index (TLI) was 0.95. In the hypothesized model, model 2, four items load on the scale “Child-focused practice” and three items load on the scale “Knowledge.” In model 2, the χ^2 test value had decreased to 20.274, and was not significant ($p = .08$), indicating a nonsignificant misfit. The RMSEA estimate had also decreased to 0.078, and CFI and TLI values had improved (CFI 0.99 and TLI 0.98). A good model should have RMSEA values under 0.05, and CFI and TLI scores larger than 0.95 or 0.97 (Schermelele-Engel et al., 2003). These results indicate that model 2 is a better fit for the data and is more appropriate for representing what is measured than model 1.

Ideally, the sample size for conducting a CFA should be over 100. Despite our sample being small, we did have a simple and small model with only three to four indicators for each of the two latent variables. We did not have any estimation errors, which also implies that the amount of data is acceptable for testing the models.

Level of child-focused practice and knowledge and use of CRC

As many as 74.2% of NAV counselors answered that they “never” (43%) or “rarely” (31.2%) used the CRC when assessing cases involving social service users with children ($n = 93$) (Figure 2).

The computed scale variable “Child-focused practice,” measuring individual degree of assessment of children’s needs and how cases are influenced by information about children, had a mean score of 3.36 ($SD = 0.86$, $n = 90$).

As shown in Figure 3, 43% of NAV counselors do not ask whether the social service user has children because they do not remember to do so, consider it unlikely because of the social service user’s age, life situation etc., consider it irrelevant, or do not prioritize asking.

The mean score of the computed scale variable “Knowledge,” measuring knowledge and use of the CRC, was 2.73 ($SD = 0.77$, $n = 93$).

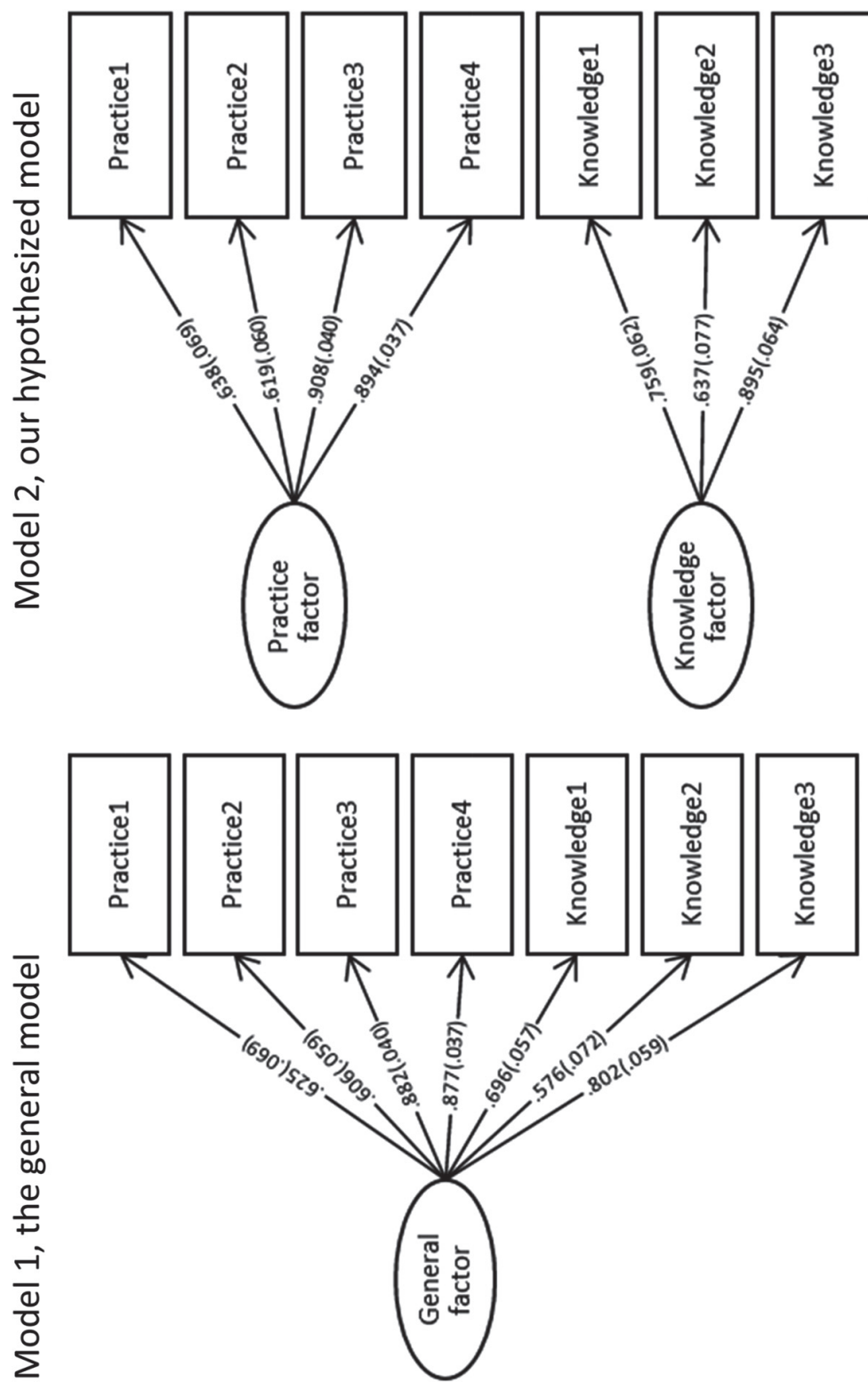


Figure 1. Illustration of the general model and the hypothesized model.

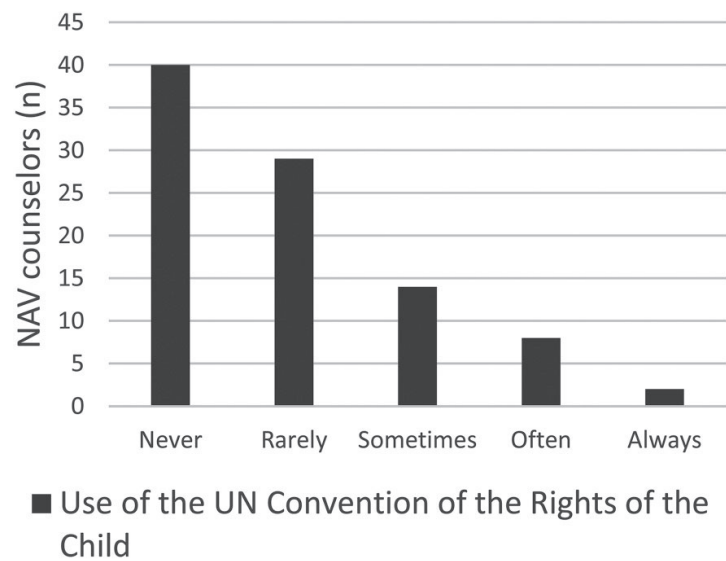


Figure 2. Distribution of NAV counselors' frequency of use of the CRC.
 Note. NAV = Norwegian Labor and Welfare Administration; CRC = United Nations Convention on the Rights of the Child.

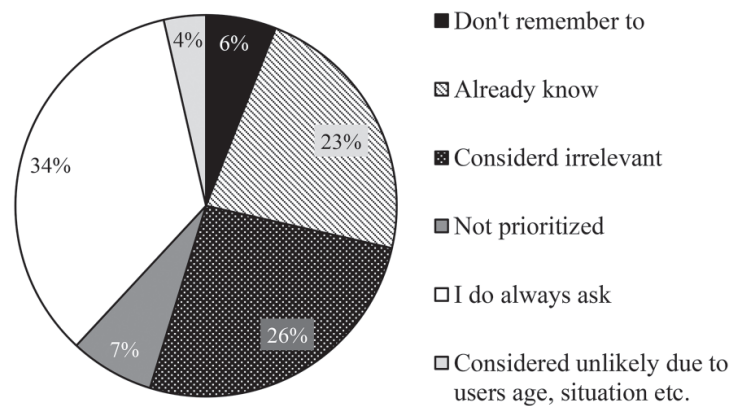


Figure 3. Reasons Norwegian Labor and Welfare Administration (NAV) counselors do not always ask if users have children.

Relation between child-focused practice, knowledge, collaboration, and systems/ routines/guidelines

Correlations between child-focused practice and knowledge are shown in Table 1. Identifying children was weakly positively correlated with perceived relevance of the CRC ($r = .148, n = 92$), and was not significant at the 0.05 level. Identifying children's needs was weakly positively correlated with perceived relevance of the CRC ($r = .219, n = 91$), and was significant at the 0.05 level. The variable measuring if cases were influenced by the social service user having children and the variable measuring if the counselor used the CRC had a weak positive correlation, significant at the 0.01 level. All remaining correlations between variables measuring child-focused practice and

Table 1. Kendall's Tau correlations between measures of child-focused practice and knowledge.

| Variable | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---------|---------|---------|---------|---------|---------|
| 1. Identify children ($n = 92$) | – | 0.248** | 0.405** | 0.447** | 0.148 | 0.344** | 0.310** |
| 2. Case influence if children | | – | 0.406** | 0.456** | 0.321** | 0.313** | 0.249** |
| 3. Assessment of children's needs | | | – | 0.667** | 0.328** | 0.378** | 0.472** |
| 4. Identify children's needs ($n = 91$) | | | | – | 0.219* | 0.384** | 0.404** |
| 5. Relevance of children's rights | | | | | – | 0.267** | 0.454** |
| 6. Knowledge of children's rights | | | | | | – | 0.521** |
| 7. Use children's rights | | | | | | | – |

Note. $N = 93$. * $p < .05$ (two-tailed). ** $p < .01$ (two-tailed).

Table 2. Kendall's Tau correlations between measures of child-focused practice and collaboration and systems/routines/guidelines.

| Variable | 1 | 2 | 3 | 4 | 5 | 6 |
|--|---|---------|---------|---------|--------|---------|
| 1. Identify children ($n = 92$) | – | 0.248** | 0.405** | 0.447** | –0.079 | 0.115 |
| 2. Case influence if children | | – | 0.406** | 0.459** | 0.072 | 0.112 |
| 3. Assessment of children's need | | | – | 0.667** | 0.237* | 0.285** |
| 4. Identify children's need ($n = 91$) | | | | – | 0.099 | 0.258** |
| 5. Collaboration ($n = 66$) | | | | | – | 0.238* |
| 6. Systems/Routines/Guidelines | | | | | | – |

Note. $N = 93$. For the collaboration variable, 27 cases with the responses “don't know/ not relevant” were excluded. The variable “Identify children” had one missing, and the variable “Identify children's need” had two missing. * $p < .05$ (two-tailed). ** $p < .01$ (two-tailed).

knowledge and use of the CRC had a medium, positive correlation (between 0.310 and 0.472), and was significant at the 0.01 level. High levels of knowledge and use of the CRC are associated with more child-focused practice.

Associations between child-focused practice, “Collaboration” and “Systems/routines/guidelines” are shown in Table 2. Higher levels of perceived benefits of collaboration with other local institutions in cases concerning children are weakly positively associated with NAV counselors more often assessing children's need ($r = .237$, $n = 66$, $p < .05$). Perceived quality of the offices' systems, routines, and guidelines to ensure a child-focused practice was weakly positively associated with assessment of children's need ($r = .285$, $n = 93$, $p < .01$) and identifying children's needs ($r = .258$, $n = 91$, $p < .01$).

Univariate general linear model

The results from the linear regression for child-focused practice (Table 3) show that the total variance explained by this model was 41%. Knowledge and use of the CRC makes the strongest significant unique contribution to explaining child-focused practice.

Table 3. Linear regression for child-focused practice.

| Child-focused practice scale | B |
|--------------------------------------|---------|
| Systems/routines/guidelines (none) | -1.384 |
| Systems/routines/guidelines (bad) | -0.440 |
| Systems/routines/guidelines (medium) | 0.370 |
| Systems/routines/guidelines (good) | 0 |
| Knowledge scale | 0.891* |
| R^2 | 0.414 |
| F | 15.016* |

Note. $n = 90$, * $p < .0005$.

Table 4. Independent sample *T*-test of differences between Norwegian Labor and Welfare Administration (NAV) counselors who ask about children and NAV counselors who do not ask about children in terms of the knowledge scale.

| | Counselors who do ask $n = 48$ | | Counselors who do not ask $n = 36$ | | <i>t</i> | Cohen's <i>d</i> |
|-----------------|--------------------------------------|-----------|--|-----------|----------|------------------|
| | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> | | |
| Knowledge scale | 8.77 | 2.43 | 7.44 | 2.13 | -2.605* | 0.58 |

Note. * $p < .05$ (two-tailed).

T-test and ordinal regression analysis—comparing NAV counselors who ask to NAV counselors who don't ask

As shown in Table 4, there was a significant difference in the mean score of knowledge and use of the CRC for NAV counselors who do ask about children ($M = 8.77$, $SD = 2.43$) and NAV counselors who do *not* ask about children ($M = 7.44$, $SD = 2.13$; $t(82) = -2.61$, $p = .011$ two-tailed). The magnitude of the differences in the means (mean difference = -1.33 , 95% CI: -2.34 to -0.31) was of a medium effect size (Cohen's $d = 0.58$), according to Cohen's (1988) effect criteria.

There were no significant differences between askers and non-askers for "Collaboration" (Wald = 3.141; $p > .05$) or for "Systems/routines/guidelines" (Wald = 2.772; $p > .05$).

Discussion

This study explored the practice of NAV counselors in terms of having a child focus in their social work practice. We also aimed to determine NAV counselors' level of knowledge about the CRC and the degree to which this knowledge was used in their social work

practice. According to the CRC, counselors should give children a chance to express their views. When counselors are making decisions the needs and the situation of user's children should be a primary concern. The level of child focus among NAV counselors was not in compliance with the legislation.

Child-focused practice

NAV counselors rated their level of child-focused practice at 3.36 on a 5-point scale, indicating that a child-focus informed their practice, on average, between "sometimes" and "often." For various reasons, 43% of NAV counselors reported that they did not always ask if a social service user had children, meaning that almost half of the NAV counselors had not established a routine for always asking whether the social service users were parenting minor children. In addition, approximately one out of four considered asking about the issue to be irrelevant. By law, NAV counselors are obligated to consider the children in all cases affecting them. This means that it is reasonable to claim that the number of NAV counselors who consider the needs of the children of social service users is lower than it should be. When most social workers do not even ask whether social service users have children, it is obvious that common practice is not in line with the requirements of the law. A study on health professionals' awareness and support of patients' children found results suggesting that to have a focus on children it is not enough to include this obligation in the law (Lauritzen & Reedtz, 2013). Factors inhibiting a child focus were found on several levels. Some of the challenges were related to organization and management, for example, lack of routines, time, training, or interventions. Other challenges were lack of interest, lack of time, reduced capacity within the staff, and reluctance from the users themselves for involving the children (Lauritzen & Reedtz, 2013). This suggests that legislation alone is not sufficient to ensure that there is a child focus in social services.

In this study, higher levels of knowledge and use of the CRC were associated with a child-focused practice. It is not surprising that there was a correlation between the measurements "use of the CRC" and "a more child-focused practice," because use of the CRC more directly implies asking about children and their needs. However, knowledge of the convention and perceived relevance among NAV counselors were also associated with a child-focused practice. Knowledge and use of the CRC (Knowledge scale) made the strongest significant unique contribution in our model to explaining a child-focused practice, and it can therefore be a predictor of child-focused practice. This implies that it is important to make knowledge about the requirements of the law part of the training program for new counselors at NAV. We were not able to test for confounding factors due to limitations in the data of background variables and other possible variables influencing both knowledge and child focus. In further studies, we recommend controlling for counselors' area of responsibility, education, and attitudes toward a child focus.

Perceived higher quality of systems, routines, and guidelines was weakly associated with assessment and identification of children's needs. Because most of the participants in the study were from the same office, most of them used the same systems, routines, and guidelines. It might be that counselors who perceive the quality of systems, routines, and

guidelines as higher also entertained more positive attitudes toward a child-focus practice. Furthermore, higher perceived benefits of collaboration were weakly associated with higher levels of assessment of children's needs. It is uncertain whether counselors who think collaboration is useful have a stronger focus on children for example because of a successful collaboration, or if a stronger focus on children makes collaboration with other institutions in cases that concern children more useful for the counselors. In addition, factors such as education and positive attitudes toward a focus on children can explain both the usefulness of collaboration and having a more child-focused practice. Further studies should explore these factors to provide more knowledge about factors predicting a child-focused practice. In order to be able to make recommendations for the practice field based on these associations, more research is needed about underlying factors.

Legal basis—levels of knowledge and use of the CRC

NAV counselors' levels of knowledge and use of the CRC were on average rated a little below a medium level. Given that the CRC is a part of the legal basis for NAV counselors, their level of knowledge and use of the convention should be higher. We were surprised to find that the majority of NAV counselors (74%) reported that they never or rarely used the CRC when assessing cases involving social service users with children. However, it is possible that NAV counselors did have knowledge about the importance of considering the children in making decisions affecting them without knowing that this is a right given by law, and without linking it to the CRC. Therefore, this measurement does not provide the total picture of NAV counselors' level of knowledge about the actual content of the convention. However, earlier studies and reports support the finding that social care workers lack knowledge about children's rights (Krane et al., 2018; Nyman & Lönnerheden, 2004; The Ombudsman for Children in Norway, 2017).

Counselors asking about children

When comparing counselors who asked about children to those who did not, there were no significant differences between the groups with regard to collaboration and office routines, guidelines, and systems. There was, however, a significant difference of a medium effect size (Cohen's $d = 0.58$) for level of knowledge and use of the CRC. "Knowledge" was found to make the strongest significant unique contribution to explaining a child-focused practice. Similar results were found in a study conducted by Lauritzen et al. (2015), where health personnel who identified children of social service users were significantly different from those who did not in terms of knowledge about children and the legislation. The results may indicate that more knowledge about children's rights might explain a child-focused practice. However, it has been well documented that knowledge alone is not enough to change practice (Fixsen et al., 2005). A continued focus on implementation drivers and prerequisites is therefore necessary to increase the focus on children of social service users within social services. Some prerequisites for successful

implementation are financial and personnel resources, well-described tools, staff training, and policy support (Fixsen et al., 2005).

Limitations of the study

A limitation of the study is that we were not able to test for confounding factors. For example, associations between a child-focused practice and level of perceived benefits of collaboration might be explained by education or attitudes toward child protection services. NAV counselors' education might both explain their level of child focus and their level of knowledge and use of the CRC. For instance, counselors with education in child welfare might have a stronger focus on children than counselors with education in economics. Our data material does not encompass the complexity of the NAV system, and more in-depth understanding of the various aspects of the system might help us understand the lack of child focus among counselors. We recommend further studies that include more participants from several randomly picked offices, as well as inclusion of background variables and variables measuring NAV counselors' attitudes toward cooperating organizations involved in safeguarding children. Such studies may contribute to a better understanding of what factors promote a stronger focus on the children of social workers' clients.

The three items included in the measure "Knowledge" on the 5-point Likert scales are labeled differently. Computing items with different scale labels can lead to bias in the scale variable and thus affect the results. However, after discretionary considerations we found that the scales are corresponding to a sufficient degree despite different wording in labels. Another limitation of the study is our sample size ($n = 93$), which is below the recommended limit ($n = 100$) for conducting a CFA. We therefore decided not to use the latent variables from the CFA in the following analyses. We simply used the CFA to be able to tell whether the created scales "Knowledge" and "Child-focused practice" was a meaningful way to group the variables included in the scales. We chose to use Kendall's tau coefficient to test correlations between variables because of the small data set and because Kendall's tau is a better estimate for correlation in small samples.

There is a weakness of the measurements of collaboration and systems, routines, and guidelines. Measuring only how NAV counselors perceive the quality of collaboration and systems, routines, and guidelines at the office gives us limited information about the objective quality of these elements and how they influence child-focused practice. An inclusion of validated measurements for collaboration and systems, routines, and guidelines would be beneficial to determining whether these factors are predictors for child-focused practice. This limitation also applies to the other measurements in the study. However, the CFA analysis strengthened the measurements for child-focused practice and knowledge and use of the CRC.

Most of the participants in our sample were from the same NAV agency. Having a diverse sample from different offices would likely have made our sample more representative for NAV counselors at NAV agencies as a general group. The participating agencies had received grants from the poverty project, which may have influenced the

agencies by increasing awareness of children and by making more resources available to support a child focus in their work. Other agencies might therefore have an even lower child-focus practice.

The study was based on self-reported data. The actual level of child-focused practice might therefore deviate from our reported findings.

Conclusion and implications

The overall purpose of this study was to explore the current social work practice among NAV counselors when it comes to having a child focus. We found that NAV counselors had some degree of focus on the children of social service users. However, a focus on children was not routinely incorporated into daily practice. Knowledge about the CRC was associated with a focus on children.

To our knowledge, this is the only study investigating the degree to which practices among NAV counselors are child focused, and the only one to study counselors' knowledge and use of the CRC. The study suggests that a stronger focus on children of social service users is needed in the social work field, as well as in the political field and in research. NAV is a public agency, and both their goals and funding are partly decided by the sitting politicians. The politicians can influence NAV's focus areas and its financial resources.

NAV provides services for individuals with mental health issues and low socio-economic status, and social service users are hence often parents of children at risk. The potential for prevention of transgenerational mental illness is considerable in the adult social service sector, and this is something that should be utilized. Counselors at NAV can potentially detect children at risk that are difficult to identify elsewhere. Future studies need to investigate other factors predicting a child-focused practice. Such factors might be background variables for counselors like education, gender and age, their attitudes towards a child focus, and amount of workload. The organization of the NAV office and the counselor's area of responsibility should also be studied as predictors. Prevention effects when awareness and support of children is provided must also be examined. These effects can be studied comparing long-term outcomes for children of service users in offices with a child focus to children of service users in offices practicing as usual.

Research ethics

During data collection, the project was categorized as a quality assurance project. Participation was informed and voluntary. Participants were anonymous during the data collection and throughout the study. Personal data were not processed and data protection services were therefore not notified of the project. After approval from all participating offices and the Directorate of Labor and Welfare, UiT—The Arctic University of Norway, RKB North received the anonymous data from the directorate and the project manager. As required, participating agencies will not be identified in this publication.

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Appendix 1

Personvernombud ved UNN - Anbefaling av behandling av personopplysninger.



Lisbeth Mørch
Allmennpsykiatrisk klinikk
9291 Tromsø

Deres ref.:

Vår ref.:
2011/2915

Saksbehandler/dir.tlf.:
Per Norleif Bruvold, 77755855

Dato:
04.08.2011

ANBEFALING AV BEHANDLING AV PERSONOPPLYSNINGER

Viser til melding om behandling av personopplysninger, mottatt 04.08.2011.
Meldingen gjelder prosjektet/registeret:

0211 Barneperspektivsamtaalen.

Formål: Sikre at behandlingen i klinikken følger lovens formål når det gjelder å identifisere og gi støtte til barn av psykiske syke foreldre. Gjennom å innføre en spesifikk kartleggingsprosedyre og et forebyggende tiltak ønsker prosjektet å undersøke hvilke faktorer som fremmer og/eller hemmer praksisendringer i psykisk helsevern for voksne. Barneperspektivsamtaalen består av 2-3 samtaler med foreldre og barnet, der målet er å gi informasjon om foreldres situasjon, støtte barnet og støtte pasienten i rollen som foreldre. Formålet med prosjektet er å sikre kvaliteten på oppfølgingen pasienter som er foreldre og deres barn får.

Prosjektet er en kvalitetsstudie i samarbeid med Universitetet i Tromsø og andre sykehus hvor Universitetssykehuset Nord-Norge HF er behandlingsansvarlig. Registeret betegnes som et internt kvalitetsregister i denne fase. Data lagres aidentifisert.

Prosjekter innenfor medisinsk og helsefaglig forskning igangsatt etter 01.07.2009 skal forhåndgodkjennes av REK. REK godkjenner også fritak fra taushetsplikten samt opprettelse av biobank i henhold til den nye Helseforskningsloven. Personvernombudets (PVO) rolle er å ha oversikt over forskningsprosjekter samt se til at informasjonssikkerheten og personvernet blir ivaretatt. PVO vil fremdeles godkjenne behandlings- og kvalitetsregistre.

PVO har vurdert prosjektet, og finner at behandlingen av personopplysningene vil være regulert av § 7-26 i Personopplysningsforskriften og hjemlet etter Helsepersonelloven § 26, j.fr Personopplysningsloven § 33, 4. avsnitt. Det er ikke nødvendig å innhente samtykke fra pasientene og godkjenning fra REK er heller ikke nødvendig.

PVOs anbefaling forutsetter at prosjektet gjennomføres i tråd med de opplysningene som er gitt i selve meldingen, i øvrig korrespondanse og samtaler samt i henhold til

Personopplysningsloven og Helseregisterloven med forskrifter. Videre forutsettes det at data anonymiseres etter prosjektavslutning ved at kodelista slettes, jfr. Pkt 8.6 i meldeskjemaet samt at tilgang til kodelista tillegges prosjektleder. Kodelista oppbevares nedlåst.

Det er opprettet et eget område (mappe) på \\asterix7\felles.avd\forskning (o:\) med navn 0211 hvor all data i forbindelse med prosjektet skal lagres. Tilgang til dette området er begrenset til kun prosjektleder og den som prosjektleder definerer. PVO vil også kunne få tilgang til området, jfr pkt. 8.5 i meldeskjema.

Det gjøres oppmerksom på at det skal gis ny melding (remelding) dersom registeret ikke er slettet eller ikke ferdig innen 3 år og som ligger til grunn for PVOs anbefaling.

PVO gjør oppmerksom på at dersom registeret skal brukes til annet formål enn det som er nevnt i meldingen må det meldes særskilt i hvert enkelt tilfelle.

PVO ber om tilbakemelding når registret er slettet.

Med hjemmel etter Personopplysningslovens forskrift § 7-12 godkjenner PVO at behandlingen av personopplysningene kan settes i gang med de endringer som er nevnt i dette skriv.

Med vennlig hilsen

UNIVERSITETSSYKEHUSET NORD-NORGE HF

Per Bruvold
Sikkerhetssjef IKT/Personvernombud

Kopi: Klinikksjef Magnus Hald
Charlotte Reedtz, Universitetet i Tromsø

Appendix 2

Letter of confirmation from REK.

| | | | | |
|----------------|-----------------------|-----------------|------------------|-----------------------|
| Region: | Saksbehandler: | Telefon: | Vår dato: | Vår referanse: |
| REK nord | Veronica Sørensen | 77620758 | 21.10.2011 | 2011/2066/REK nord |

Letter of confirmation

Charlotte Reedtz
Det helsevitenskapelige fakultet
9037 Tromsø

Project "Evaluation workforce developments to support children of mentally ill parents"

The regional ethics committee (REK) can confirm that project, witch is categorized as quality assurance project , is not required to be submitted before the committee.

Projects to be submitted to the Committee are projects concerning "medical and health research on human beings, human biological material or medical information", cf. § 2. "Medical and health research" are defined in Health Research Act § 4 a) as "operations performed using scientific methodology to obtain new knowledge about health and disease". It is therefore the purpose of the study that determines whether a project should be submitted to REK.

In this project, Evaluating workforce developments to support children of mentally ill parents, REK have received all necessary documentation that the data protection officer (DPO) has approved of the protocol for this project. We have received a written commission form the DPO at UNN HF directed to the head of the general psychiatric department, clarifying the objective and what data will be included in the study.

Letters from REK are approved transmitted electronic without signature.

Sincerely

May Britt Rossvoll
Secretariat leader

Veronica Sørensen
Executiv officer

