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Regional Center for Child and Youth Mental Health & Child Welfare

Implementing interventions in adult mental health services to identify and support children of mentally ill parents

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A dissertation for the degree of Philosophiae Doctor –2013

Implementing interventions in adult mental health services to identify and support children of mentally ill parents

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Dissertation for the degree of PhD
2013

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Acknowledgements

This dissertation is a part of a large study that was initiated, planned and financed by The Regional Center for Child and Youth Mental Health and Child Welfare (RKBU North) at the Faculty of Health Sciences, Uit – Arctic University of Norway. The study was carried out at the University Hospital of Northern Norway (UNN).

Initially I would like to thank all the health care workers who participated in the project. Thanks for great collaboration, positive attitudes and excellent input to our project. Thank you in particular to Elin Madsen and all the other child responsible staff at the hospital. You do a great job. Thanks to Geir-Øyvind Stensland and Didrik Kilvær for welcoming us into the clinic and for a fruitful collaboration in the early stages of the project. To Lisbeth Mørch for being a coordination-link between the university and the hospital, you made my life so much easier.

Another important collaborative partner in this project is the non-governmental organization "Adults for Children" (Voksne for barn). Randi Thalseth, Jan Steneby and Anne Helgeland- thank you very much for participating in our project. The workshops were so much fun, roleplaying (loved and hated by the participators) taught us a lot about actual situations that may occur in practice when talking to families about a parent's mental health issues.

I would also like to thank The Faculty of Health Sciences for giving me the grant and the opportunity to stay a semester at Columbia University in New York. Furthermore, to Dr. Essock, Anne Skrobala and Claudia Rahman at the Division of Mental Health Services and Policy Research at Columbia University for welcoming me. I wrote the main chapter of my dissertation at Columbia, overlooking the beautiful university campus.

My work has been carefully supervised by the best of supervisors. Charlotte Reedtz, your knowledge and your academic talent is inspirational! I have learned a lot working with you. You were always well prepared and put a lot of time and effort into the feedback you provided on my work. I also find you very fun to work with, and I hope we will be able to continue our work together for years to come.

In addition I have been lucky enough to have two fabulous co-supervisors. Monica Martinussen and Karin Van Doesum, I have very much appreciated working with you both. You have provided me with many interesting perspectives that only someone with your impressive knowledge and experience could offer.

For my "roommates" in the PhD-den (such a great place to be) - Henriette, Kamilla, Anne-Kari & Reidunn: I have no doubt in my mind you will go far! Being in the same

boat as you guys has been a lot of fun and I have learned a lot from you. Please accept my sincere apologies for constantly interrupting your inspired moments. To our department statistician, Bjørn-Helge: What would we do without you? For Renee, Frode, and Gørill: Thanks for interesting conversations and discussions, for reading my work and giving valuable input, and for encouragement in the process of finishing all the compulsory PhD-courses. Thanks to Mariann for helping me tie the knots at the end. Thanks to Lauren for efficient and excellent proof-reading.

For my friends and family: Thanks for your support and help with everything! I could certainly note have done this without you.

Last but not least, my daughter Sofie. Thank you for reminding me what is really important in life. You are the best!

Camilla Lauritzen,
11.12.13

Summary

This dissertation is a result of a large-scale longitudinal project (the BAP-study) where the overall aim was to monitor and evaluate the implementation of clinical change to identify and support children of mentally ill parents within the participating clinic. The design includes a pre-test, post-test and one-year follow-up. The first stage of the study involved assessment of the status quo in the clinic in terms of identification routines and current practice. This was done through web-based questionnaires to all staff and management personnel in the clinic ($N = 219$). The entire workforce at the participating clinic was then trained in the interventions *Family Assessment* and *Child Talks*. To assess whether or not the interventions had led to changes in clinical practice, a new survey was conducted at post-test (2013) ($N = 185$). The long-term implementation strategy of the BAP-study seems to have contributed to a slightly modified clinical practice in terms of increased *identification* of mentally ill patients and their children. In terms of *support* for the families affected by parental mental illness, the changes are not yet significant.

Abbreviations used in this dissertation

BAP:	Barn av psykisk syke [Children of Mentally Ill Parents]
VFB:	Voksne for barn [Adults for Children]
UNN:	University Hospital of Northern Norway

List of articles

1) Reedtz, C., **Lauritzen**, C., & Van Doesum, K. T. M. (2012). Evaluating workforce developments to support children of mentally ill parents: Implementing new interventions in the adult mental health care in Northern Norway. *British Medical Journal Open.* 2:e000709 doi:10.1136/bmjopen-2011-000709

2) **Lauritzen**, C., Reedtz, C., Van Doesum, K. T. M., & Martinussen, M. (in press). Factors that may facilitate or hinder a family focus in the treatment of parents with a mental illness. *Journal of Child and Family Studies.*

3) **Lauritzen**, C., & Reedtz, C. (2013). Support for children of mental health service users in Norway. *Mental Health Practice*, *16*, 12-18.

4) **Lauritzen**, C., Reedtz, C., Van Doesum, K. T. M., & Martinussen, M. (submitted 2013). Implementing new routines in adult mental health care to identify and support children of mentally ill parents.

Introduction

Many studies have documented that mental illness is very common and has grown in magnitude, such that it currently constitutes the most common reason for absence from work in the western part of the world (Mykletun, et al., 2006; Norwegian Institute of Public Health, 2009). Mental illness is defined as a psychological pattern, potentially reflected in behavior, that is generally associated with distress or disability and is not considered part of normal development (World Health Organization, 2000). The most common mental health problems are anxiety, depression and substance abuse issues (The Norwegian Institute of Public Health, 2009).

In a 2009 report on mental illness in Norway, The Norwegian Institute of Public Health (2009) estimated that up to 50% of the population will suffer from mental health problems at some point during their lifetime. A study from Oslo found a lifetime prevalence of 52.4%, however, only 10-15% of this figure referred to those with serious mental illness (Kringlen, Torgersen, & Kramer, 2001). According to Kringlen and colleagues, the incidence of mental disorder is higher in women than in men, with the exception of problems with alcohol and drug abuse.

Studies conducted in Norway also point to a relatively high prevalence of mental health problems in children. It is generally agreed that 15 to 20% of children between the ages of four and ten suffer from mental health problems to the extent that it interferes with their daily functioning (Mathiesen, Karevold, & Knudsen, 2009). In the Bergen Child Study, 7% of the child population was found to have mental health problems within the

diagnostic criteria (Bøe, Øverland, Lundervold, & Hysing, 2011). According to Wadell and colleagues, mental health problems are the most important health issues among children today (Wadell et al., 2002).

Internationally, the picture is similar. A total of 25% of the world's population has been estimated to suffer from some kind of mental health problem (World Health Organization, 2001). In Australia 45% of the population is expected to experience problems with their mental health during their lifetime (Reupert, Maybery, & Kowalenko, 2012). According to a study by Wittchen and Jakobi (2005), 82.7 million adults in Europe, which accounts for an estimated 27% of the entire European population, meet the criteria for at least one psychiatric diagnosis.

Based on both national and international studies, it is fair to assert that mental illness is common among children, adolescents and adults.

Prevalence of parents with mental illnesses

Patients seeking help for mental disorders are not less likely to be parents than other adults (Reedtz, Mørch, Stensland, & Lauritzen, 2013). In a cross-sectional study conducted by the independent, non-commercial research organization SINTEF (Lilleeng, Ose, Hjort, Bremnes, Pettersen, & Kalseth, 2008), 13% of patients at in-patient clinics and one third of patients at out-patient clinics are parents who have custody of their children. This study was conducted among patients who received treatment by the mental health services in Norway in 2008.

The Norwegian Institute of Public Health has estimated the number of children living with mentally ill parents based on prevalence studies performed on the entire adult population that show the number of adults who qualify for the diagnosis of mental disorder or alcohol abuse disorder (Torvik & Rognmo, 2011). They estimated that approximately 410,000 children in Norway (37.3% of the total child population) had either one or two parents with a mental illness in the past year. This included mild depression and anxiety as well as more serious mental health problems such as psychosis. When minor mental health problems are excluded, the prevalence of children living with mentally ill parents is 260,000 (23.1%) (Torvik & Rognmo, 2011).

In Great Britain, a survey of psychiatric conditions reported that about 10% of women and 6% of men with a mental illness were parents (Parker, Beresford, Clarke, Gridley, Pitman, Spiers, & Light, 2008). In Australia, it was estimated that one in five families consist of one or two parents with mental illness (Reupert, Maybery, & Kowalenko, 2012; Maybery, Reupert, Patrick, Goodyear, & Crase 2009). In the United States, 65% of women and 52% of men identified as having a psychiatric disorder were also parents (Nicholson, Biebel, Williams, & Katz-Leavy, 2002).

Parental mental illness as a risk factor

Being a parent can be challenging and difficult in itself. It is easy to understand how having an illness may constitute an extra challenge to the parenting role. The idea that the children of psychiatric patients should be given attention and consideration is a fairly new

one. Before the 1990's there was hardly any awareness of the consequences parental mental illness had on children among services available (e.g. child protection services, social services or health care services), and hardly any research existed on the topic (Nicholson, 2009; van Doesum, & Hosman, 2009). During the 1990's and the beginning of the 2000's a substantial development in the level of attention and knowledge production started to come about, for instance, in terms of attachment theory and family systemic views on child development (Cowling & Mc Gorry, 2012; Ytterhus, 2012). In the past 10-20 years, there has been an immense shift in focus when it comes to adult mental health services' regard for the impact of parental mental health on the offspring of patients. There is now a growing evidence base in several areas, including prevalence rates, interventions and implementation studies (Cowling & Mc Gorry, 2012).

Parental mental illness is considered a powerful risk factor with the potential for serious impact on children. Mental illness may affect parenting behaviors in a variety of negative ways. For example, parents with depression have more difficulties in interacting with their children, are more intrusive, less involved and less responsive (Kowalenko, Mares, Newman, Williams, Powrie & vanDoesum, 2012; Murray & Cooper, 1997; Van Doesum, 2007). Maternal depression has been found to have a negative impact on children's social, behavioral, emotional and cognitive development (Goodman & Gottlieb, 2002). Furthermore, studies have shown that mentally ill parents are more likely to be hostile in their relationship to the child; i.e., they tend to be angry, critical and irritable (Kowalenko et at, 2012, Van Doesum, 2007). A harsh parenting practice may be the result of parental mental illness and increases the risk of problem behavior in children (Reedtz, 2010). Although a child's risk of developing mental health problems is generally thought to be

multi-factorial (Reupert, Maybery & Kowalenko, 2012; Kowalenko et al., 2012), parental mental illness is a significant risk factor for children. Furthermore, parental mental illness is linked to the child's sense of attachment security (Van Doesum, 2007). Highly sensitive responsiveness on the part of the mother has been found to promote secure attachment and healthy development of the child. There is strong evidence that maternal depression has a negative effect on the quality of the mother-child interaction (Van Doesum, 2007, 2005). More than one third of these children develop serious and long-lasting problems (Rutter & Quinton, 1984; Kowalenko et al., 2012). Early in life, these children run a higher risk of abuse and neglect, depression, eating disorders, conduct problems and academic failure. Later in life, they are at a higher risk of depression, anxiety disorders, substance abuse, eating disorders and personality disorders (Beardslee, Versage, Velde, Swatling, & Hoke 2002; Goodman & Gotlib, 2002; Goodman, Rouse, Connell, Broth, Hall, & Heyward, 2011).

Nonetheless, parental mental illness alone does not necessarily mean that children themselves will automatically develop problems. Many parents with mental illnesses are adequate caregivers, but there are many other related factors that may add to the risk; the family context (e.g., divorce), violence, presence or absence of the other parent, lack of social support, severity and chronicity and genetic characteristics of the parent's illness all play a part (Kowalenko et al., 2012; Reupert et al., 2012). Additionally, several protective factors, such as coping skills, activities outside the home and close relations with other adults, may reduce risk factors for these children (Hosman et al., 2009).

Parental mental illness affects parenting behavior (Reedtz, 2010; Van Doesum, 2007), and parenting behavior is related to the development of socio-emotional problems in children (Hutcings & Lane, 2005). According to Van Doesum (2007), parental mental illness is one of the major known risk factors for the onset of psychopathology in the population. However, parental behavior is also seen as a malleable risk factor. Parenting quality is considered to be the most potent, but also the most modifiable, risk factor for developing mental health problems, such as emotional and behavioral problems, in children (Reedtz, Mørch, & Handegård, 2010).

Children of mentally ill parents are often referred to as "the invisible children" because there have been no systematic routines to detect whether or not patients receiving mental health services also have children (Aamodt & Aamodt, 2005). According to the SINTEF study, "the invisible children" are often found in statistics on children with self-injury disorder as well as adolescents who develop addictions (Lilleeng, Ose, Hjort, Bremnes, Pettersen, & Kalseth, 2008). According to the same study, between 30 and 50% of children who grow up with a mentally ill parent develop depression, by the age of 19, if no measures are taken to help them (Lilleng et al., 2008). As early as 1984, Rutter and Quinton estimated that these children have a high risk of developing mental health problems. In their study, they estimate that up to 66% of children who grow up with a mentally ill parent develop problems themselves.

In summary, the past two decades have produced multiple studies indicating that children with mentally ill parents are at risk of developing mental health problems themselves

(Beardslee, Versage, & Gladstone, 1998; Gladstone, Boydell, Seeman, & Mckeever, 2011; West, & Prinz, 1987).

Psycho-social risk factors and mental health problems

Families affected by mental illness are more likely to experience poverty and social isolation (Kowalenko et al., 2012). Many studies have documented the link between social status and mental health. For instance, according to Aneshensel and Sucoff, (1996), mental health problems during adolescence were found to be inversely associated with social status. Research has shown that people of higher social standing, as measured by education, occupation or income, live longer and have better health than people of lower social standing (Norwegian Directorate of Health, 2005). Low social status is associated with symptoms of decreased mental health (Lauritzen & Sivertsen, 2012). Families affected by parental mental illness are also likely to have social problems as well. According to several studies, additional risk factors such as poverty, unemployment, marital discord, violence in the family and absence of the other parent are more common in families with parental mental illness (Reupert, Maybery & Kowalenko, 2012).

Mental health prevention and preventive interventions

Labeling parental mental illness as a malleable risk factor means that there are measures that may be taken to counteract the risk. There is a substantial amount of research documenting that teaching parents positive parenting strategies to promote children's self-confidence, pro-social behaviors, problem-solving skills and academic success reduces the risk for those

children (Reedtz, 2010; Webster-Stratton, & Taylor; 2001). In order to develop preventive interventions for children of mentally ill parents, the focus should be on the malleability of psychological and social risk and to improve protective factors such as parenting behavior, social support and coping skills.

In a report from 2004, the World Health Organization concluded that, in order to reduce the health, social and economic burdens of mental disorders, it is essential for countries and regions to pay greater attention to prevention and promotion of mental health at the level of policy formulation, legislation, decision-making and resource allocation within the overall health care system (WHO, 2004:15). As a result of the increased focus on prevention of mental disorders, there is growing evidence showing that preventive efforts can influence risk and protective factors and reduce the incidence and prevalence of some mental disorders (WHO, 2004). Internationally, there is already a variety of intervention programs available and there is now an expanding evidence base to demonstrate the effectiveness of a number of these interventions (Beardslee, Wright, Gladstone, & Forbes, 2007; Fraser, James, Anderson, Lloyd, & Judd, 2006; Reupert, & Maybery, 2011; Van Doesum, Riksen-Walraven, Hosman, & Hoefnagels, 2008).

A well-known prevention framework was developed by Mrazek and Haggerty; "Reducing risks for mental disorders: frontiers for preventive intervention research" (Mrazek & Haggerty, 1994). In this framework, there are three identified categories of prevention:

1) Universal prevention. Prevention measures that target the general population.

2) Selective prevention. Prevention measures that target high-risk groups.
3) Indicated prevention. Prevention measures that target high-risk groups or individuals with minimal but detectable signs or symptoms of mental disorder, however not defined as treatment.

The activities addressed to prevent the trans-generational transmission of mental illness from one generation to the next are typically placed within this framework under selective prevention, due to the substantial documentation showing children of mentally ill parents as being a high-risk group (van Santvoort, 2012). Nevertheless, in many cases the children will already have developed detectable symptoms of problems related to mental health when the families or the children are brought to the attention of services available (e.g. child protection services, social services or health care services). Many families are "discovered" by services due to emerging signs of problems in the children, such as conduct issues or internalizing behavior; cases that are reported by teachers or school nurses to child protection agencies (Clausen & Kristoffersen, 2008).

Existing interventions for families affected by mental illness

It is widely accepted that parenting behavior influences the development of socio-emotional and behavioral problems in children (Hutchings & Lane, 2005). There is strong and growing evidence that preventive interventions can result in risk reduction and the strengthening of protective factors related to first onset of mental health problems (Beardslee, Solantaus, Morgan, Gladstone, & Kowalenko, 2012). In a recent meta-analysis, interventions to prevent mental disorders in the offspring of parents with mental

illness appeared to be effective (Siegenthaler, Munder, & Egger, 2012). Several studies have emphasized that parenting programs are among the most powerful and cost-effective interventions available to prevent child maltreatment and socio-emotional and behavioral problems in children (Foster, Prinz, Sanders, & Shapiro, 2008; Sanders, Calam, Durand, Liversidge, & Carmont, 2008). However, according to a review done by Reupert and colleagues (2012), more evaluation is needed to specifically examine the comparative efficacy of different approaches and determine which interventions work, how they work and for whom. Although some interventions have been evaluated in randomized controlled trials, further evaluation is required (Reupert, Cuff, Drost, Foster, Van Doesum, & Van Santvoort, 2012). The U.S. intervention, *Family Talk* (Beardslee, Wright, Gladstone, & Forbes, 2007) and the Finnish intervention, *Let's Talk* (Solantaus, Paavonen, Toikka, & Punamäki, 2010) are examples of interventions that have been proven effective in reducing children's emotional symptoms and level of anxiety.

Many existing interventions for families affected by mental illness, such as Beardslee's preventive family intervention (Beardslee, Salt, & Porterfield, et al., 1993) and the Dutch intervention *Child Talks* (Van Doesum & Koster, 2008), contain components of psycho-education (Cowling & McGorry, 2012). Psycho-education refers to education that provides information and knowledge to enhance the understanding and possible consequences of the disease (New York State Psychiatric Institute, 1998). According to Honig and colleagues, psychiatric psycho-education has been shown to play an important role in the treatment of mentally ill patients. Psycho-educational interventions are also generally thought to contribute to the de-stigmatization of psychopathology, and studies have shown that such interventions play an important role in reducing symptoms and

relapse rates in mental illnesses such as bipolar disorders and schizophrenia (Honig, Hofman, Rozendaal, & Dingemans, 1997).

Psycho-education is a common component across programs for parents with mental illnesses and their children (Reupert, Cuff, Drost, Foster, van Doesum, & van Santvoort, 2012). In the particular context of parental mental illness, psycho-education is seen as a tool to reduce feelings of guilt and shame from materializing in the children and their parents. Mevik and Trymbo (2002) stated that "the lack of information and knowledge provided to the family by the mental health care services reinforce the attitude of remaining silent about the disease, and thereby taboos are being maintained within the family". The lack of openness is also thought to restrain children from venting emotions such as anger, despair and insecurities about their own life situation and that of their parents (Mevik & Trymbo, 2002).

Little is known about the effects of psycho-education from a preventive perspective. In several qualitative studies on families affected by parental mental illness, numerous families reported great benefits from age-appropriate information for children. Families additionally stated that receiving support from the health care system helped them to be more open about mental health issues (Mevik & Trymbo, 2002; Haukø & Stamnes, 2009). Further research and assessment of which interventions work, how and for whom, is nonetheless required to test this assumption (Reupert et al., 2012).

Implications for clinical practice

In addition to what is known about the benefits of preventing transmission of problems from one generation to the next, it has also been suggested that incorporating a child perspective in adult mental health care may lead to further improved health outcomes for patients who are parents. According to Kowalenko and colleagues (2012), it is generally assumed that successful treatment of parental mental illness can be associated with reduced psychopathology in offspring. However, treatment that does not take into account the parent-child perspective has been proven less efficient (Kowalenko et al., 2012; Forman, O'Hara, Stuart, Gorman, Larsen, & Coy, 2007; Van Doesum et al., 2008). According to these studies, depressed mothers were less responsive to their infants, experienced more parenting stress, and viewed their infants more negatively than did non-depressed mothers. The treatment only affected the level of parenting stress, which improved significantly but was still higher than the stress level for non-depressed mothers in the control group. Treatment for maternal depression should also target the mother-infant relationship as well as the mothers' depressive symptoms (Forman et al., 2007).

Intervening early and targeting adverse influences on children and parents may improve outcomes for children (Kowalenko et al., 2012). According to Beardslee and colleagues (2010), early interventions that support parents with a mental illness and their children can mitigate vulnerabilities and increase resilience, thereby contributing to the positive development of the next generation. Additionally, early family interventions may

improve parental mental health as well as family functioning (Beardslee, Ayoub, Avery, Watts, & O'Carroll, 2010).

According to Cowling and McGorry (2012), it is essential to establish effective multidisciplinary relationships between GP's and mental health practitioners. This is due to the fact that most people who seek professional support for mental illness, not only in Norway but in many countries across the world, approach their general practitioner first. The GP's are, therefore, in a prime position to identify and support families suffering from mental illness (Baulderstone, Morgan, & Fudge, 2012).

Interdisciplinary collaboration between local community-based services (e.g., GP's) and hospitals is seen as a very important organizational strategy in order to provide sufficient services for families affected by parental mental illness. As of today, the interaction between state-run hospitals and local health care services in Norway is inadequate (Hanssen, 2008; Lauritzen & Reedtz, 2012). A recently passed reform on the collaboration of health care services in Norway (The Coordination Reform) has emerged from the realization that collaboration routines are poor. The implementation of this reform, started in January 2012, implies that Norwegian authorities are committed to initiating the process of strengthening local communities' capacities and to gradually facilitating for local communities to assume greater responsibilities. This means that local communities are gradually to take on more responsibility for health care services in the future, and strategies to collaborate with hospitals and specialist services must be developed. However, the Coordination Reform is not yet fully operative and, therefore,

collaboration between the state-run hospitals and the local communities that constitute their uptake-areas, is weak in many aspects of mental health care services.

Norwegian health legislation

A national study conducted in 2005 showed that the services available to children of mentally ill parents were insufficient (Aamodt & Aamodt 2005). There has long been a consensus among professionals in the field, researchers and the Norwegian government that the services provided for these children are inadequate. In spite of the fact that the risk factors for these children are known, establishing a change in practice to increase identification and support for these children has been challenging. In order to improve the situation for these families, several modifications were made to health legislation (Norwegian Ministry of Health, Ot.prp. nr.84, 2008-2009). The new legislation became effective in January 2010.

The intention behind the legislation amendments was to increase early identification and encourage processes that enable children and parents to better master the situation when a parent is mentally ill. Furthermore, an important aim was to prevent the development of problems for both children and parents. The modified Health Personnel Act (§ 10 a) makes it mandatory for health professionals to 1) identify if patients have children and 2) to provide information and necessary follow-up for children under 18 years who have parents that receive health care for mental illness, substance abuse disorders or serious somatic illness or injury.

Paragraph 10 a further specifies that health care personnel are to carry out conversations with

the patient about the children's need for information or follow-up and to provide information and guidance on relevant interventions or available measures that may be taken. Health care personnel also have an obligation to inform others who care for the child without violating confidentiality. This means they will have to get the parents' consent in order to inform kindergartens, schools and so on. Furthermore, health care personnel should obtain consent to provide adequate follow-up measures, particularly in cases where children need to be referred to other services, such as child protective services, school nurses and/or local health care nurses.

New perspectives on children

The concept of child perspective has received increased attention in child research, politics and pedagogical activities (Skivenes & Strandbu, 2006). A child perspective typically refers to a "child-friendly" perspective, in which children are seen as individuals with opinions that should be taken into account (Skivenes & Strandbu, 2006; Halldén, 2003). During the past hundred years, the way we refer to children has gradually changed. Children have gained increased autonomy, increased rights in terms of legislation and increased respect (Frønes, 1997). Children have been included in democratic processes, and are progressively viewed as independent individuals with certain rights (Larsen & Slåtten, 2006).

The United Nations Convention on the Rights of the Child (CRC) is an international treaty on children's rights, which Norwegian authorities have ratified and incorporated into national legislation governing children's rights (Standbu, 2011). The CRC provides

children with basic rights such as the right to protection, participation, development, health and education (provision). This is generally referred to as “the three P’s of the CRC” (Skivenes & Strandbu, 2006).

This shift in focus is reflected in the new Health Personnel Act. Where children previously had no formal rights when parents were mentally ill, they now have the right to be seen, to receive information and to be given support if necessary (Norwegian Ministry of Health and Care Services, 2009).

An implementation approach to achieving changes in clinical practice

According to a review of the research on implementation research, there is a large gap in the literature describing implementation processes in health service delivery (Greenhalgh et al., 2004). The authors of this review concluded that implementation research would benefit from in-depth mixed methodology studies aimed at building up a rich picture of the process and impact of health service innovations, which subsequently may benefit health services (Greenhalgh et al., 2004). Proctor and colleagues (2008) found that one of the most critical issues in mental health services research is the gap between what is known about effective treatment and what is provided to consumers in the form of routine care (Proctor, Landsverk, Aarons, Chambers, Glisson, & Mittman, 2008). We know much about interventions that are effective, but make little use of them to help achieve important health outcomes for children, adults and families (Fixsen et al 2005). It is, therefore, important to increase research in an effort to better understand service delivery processes and contextual factors to help improve the efficiency and effectiveness of program implementation (Fixsen et al., 2005). The following chapters will include a short summary of the BAP-study and an in-depth presentation of the theoretical implementation framework that was the basis for this dissertation.

Introduction to the BAP-study

The BAP-study is a longitudinal research project developed by The Regional Center for Child and Youth Mental Health and Welfare at the University of Tromsø, in collaboration with the University Hospital of Northern Norway (UNN) and the non-governmental organization Adults for Children (VFB). The project, which has been running since 2010, involves a long-term strategy for changing the clinical practice of the adult mental health services offered at the participating hospital. As part of this project, health personnel in the General Psychiatric Clinic at UNN have started implementing new routines to identify and provide necessary follow-up for the children of psychiatric patients. The subsequent changes in practice are being evaluated by the research group at the University of Tromsø.

The interventions that are implemented include a) a standardized family assessment form to all patients who are parents, and b) a health-promoting and preventive intervention called *Child Talks* (van Doesum & Koster, 2008). There are no studies reporting the impact or effects of these interventions in Norway, yet they have been used in a non-systematic and fragmentary way in clinical practice for several years. During the project period, *Child Talks* has been implemented and offered as standard procedure for all children of parents with mental illness in the clinic. The implementation of both interventions aims to make it easier for adult mental health care practitioners to fulfill the demands of the new legislation regarding identification, in addition to providing information and support for the children of their patients. *Child Talks* involves 2-3 sessions with parents and children aimed at supporting parents in their parenting role and thereby supporting the children. The professionals in charge of the intervention are

staff members employed at UNN. The professionals are trained according to VFB's manualized training; they work in teams and are supervised by experienced therapists/mentors.

The research plan for the BAP-study involves evaluating several aspects of the process of implementing changes in current practice in adult mental health services. The first stage of the study assessed the status quo at the clinic. This was done through web-based questionnaires to all staff and management personnel at the clinic ($N = 219$). Secondly, the staff was trained in the interventions and started to use the assessment form and intervention throughout the clinic. Changes in clinical practice and the maintenance of modified practice were measured at post (2013) ($N = 185$) and will be measured at one-year follow-up (2014). Parents who receive the intervention are asked to fill out evaluation forms after the final session, addressing user-satisfaction, changes in their parental competence and changes in their concerns for their children. These measures will give an indication of the outcomes of the intervention, even though the direct outcomes for children are not being assessed at this point.

Implementation and the BAP-study

The most efficient way of establishing new work methods and routines in an organization is by introducing and implementing interventions that are well described (Fixsen, Naoom, Blase, Friedman and Wallace, 2005). However, the implementation of interventions is a complex endeavour. In addition to changing the service providers' behavior, there is also the matter of restructuring organizational contexts (Fixsen, Blase, Naoom, and Wallace, 2009). To enable organizational changes and workforce developments, strategies should encompass the active building of service providers' capacity to implement innovations with high fidelity and good effect (Metz, Bartley, Ball, Wilson, Naoom, & Redmond, 2013).

In order to ensure the integrity of interventions and encourage the maintenance of the change in practice, it is crucial that we study how to implement and disseminate interventions in an adequate and practical manner. According to relevant research literature on implementation, there is a gap between the knowledge on effective interventions and what is actually done in the field of practice (Fixsen et al, 2005; Greenhalg, Robert, Mavfarlane, Bate, & Kyriakidou, 2004; Reedtz, 2010).

It is important to determine the relevant components and conditions for a successful implementation process. Only when effective practices and programs are fully implemented can we expect positive outcomes (Fixsen et al, 2005). Experiences and outcomes of the implementation process for new interventions have yet to be studied in a systematic way in Norway, and we still know too little about contextual factors that promote or hinder the sustainability of the implementation (Ogden, 2009).

Implementation and implementation research defined

Implementation is defined as a specified set of activities designed to put into practice an activity or program of known dimensions (Fixsen et al., 2005). Studying implementation processes is, therefore, purposeful in order to understand how innovations come about; and the implementation processes should be described in sufficient detail so that independent observers may detect the presence and strength of the specific set of activities related to implementation (Fixsen et al., 2005). In this dissertation, implementation is conceptualized as the work of incorporating interventions or new practices into an organization and adapting them.

The essence of implementation is behavioral change. In relation to health services, this implies that the practitioners "are" the intervention. Subsequently, this means that the actions of those who convert it into practice are either the key to success or a major reason for failure. Nevertheless, implementation efforts cannot solely focus on workforce development. Implementation projects must incorporate every known aspect; from system transformation to changing service provider behavior and restructuring organizational contexts (Fixen et al, 2005; Proctor et al, 2008; Greenhalgh et al, 2004).

Implementation research is defined as "the systematic study of how a specific set of activities and designated strategies are used to successfully integrate interventions within specific settings" (Proctor et al., 2009). To achieve successful implementation of complex changes in healthcare settings, organizational readiness to change is considered a critical precursor (Weiner, 2009). This implies that the implementation strategies should

encompass activities to create motivation to change. Strategies should further include a highlighting of the discrepancy between current and desired performance levels, and the desired outcomes for implementation projects must be operationalized (Weiner, 2009; Lehman, Greener, & Simpson, 2002).

Implementation outcomes

According to Fixen and colleagues' (2005) review on implementation literature, the essential implementation outcomes are threefold:

1) Changes in professional behavior;
2) Changes in organizational structures and cultures, both formal and informal; and
3) Changes in relationships to consumers.

In the BAP-study, we measure all of these outcomes. These results are assessed by analyzing data from the Electronic Patient Journals and by examining self-report data on topics such as professional behavior, organizational structures, attitudes, worker knowledge and readiness to change. Detailed measures are described in the methods chapter of this thesis.

Core components of implementation projects

There is still little consensus on sets of terms and few organized approaches to executing and evaluating implementation practices and outcomes (Fixsen et al, 2005; Proctor et al,

2009; Greenhalgh, 2004). However, Fixsen and colleagues (2005) have pointed out five essential core components to implementation.

Source. The source refers to the original program that was developed. In the BAP-study the source is the *KOPP Program* from the Netherlands, *The Beardslee Intervention* that has been widely used in many countries (e.g. the USA and Finland; Beardslee et al., 2007; Solantaus et al., 2010), and the Norwegian version of the *Child Talks* intervention, adopted in Norway by VFB.

Destination. The destination refers to the practitioners and the organization that adopt the program. In the BAP-study, the destination is adult mental health services at UNN in Northern Norway.

Communication Link. The communication link consists of the purveyors of the program, working actively to implement the program with fidelity. In the BAP-study, the purveyors were the project group led by RKBU North, consisting of VFB (initial trainers), clinicians (child responsible staff) and researchers.

Feedback Mechanism. This refers to a regular flow of reliable information on performance. In our project, there has been a multi-factorial feedback mechanism that includes: manualization of the intervention in collaboration with the program owner, manualized training, evaluation of training, handbook for new practice procedures, staff

consultation and regular meetings with the collaborating parties, and the recording of the new practice in the electronic patient journals.

Influence. The final core component refers to overall policy or the existing system. In the BAP-study, this included the commission documents and the factors (structural, political, social, economic and historical) that laid the premises for the entire project. Important influential factors in this project have been the modified health legislation and the fact that children of mentally ill patients have been a "hot topic" in research and health services the past decade.

If the core components are not taken into account and assessed in implementation projects, the result may be unsuccessful implementation processes. Desirable outcomes are achieved only when effective programs are implemented well (Fixsen et al, 2005). This means that, prior to initiating an implementation project, it is crucial to assess the rationale, theory and existing evaluations of the program that is meant to be implemented.

Theoretical frameworks for implementation

There are many existing models for understanding theory of change, organizational change and project implementation planning (Jacobsen, 2004). In the initial stages of our project design, we used models outlined by Barry and Jenkins (2007) and Fixsen and colleagues (2005). These models were coinciding in the description of important stages of implementation.

Based on these models, we outlined the six essential stages of implementation as described in the following section (Barry & Jenkins, 2007; Fixsen et al, 2005).

Stages of implementation

Exploration and adoption. Initial work in implementation projects generally involves acquisition of information about what is lacking and what is needed, in addition to an exploration of options. The match between program resources and organizational needs should be assessed. In this phase, it is important to assess organizational readiness and potential barriers within the participating organization. The result of the exploration stage should be a clear implementation plan. In the BAP-study, the research group spent two years (2007-2009) on this initial stage. To begin with, we conducted descriptive studies of what was needed within the organization, in this case, The University Hospital of Northern Norway. We moved on to descriptions of the local context and then established a collaboration platform for achieving cooperation and dialogue with participants within UNN. The next step was to choose interventions and activities that were well described and had a theoretical rationale. After having defined the activities, the project moved on to mobilize support on all levels (from management to practitioners), and to formalize cooperation. The formalization led to the signing of a contract based on the needs of the organization as well as the aims of the research. We then established a project group including representatives from the participating clinic, the program owner and the research group who were the purveyors of the interventions to be implemented. A purveyor is an individual or group of individuals representing a program who actively work to implement the program with fidelity and effectiveness. The advantage of having

a well-organized approach to implementation is that the purveyor can accumulate knowledge over time, reveal barriers that need to be overcome, and discover eventual solutions to such. In other words, purveyors can help organizations to stay on track (Fixsen et al., 2005).

Program installation. At this stage, there are numerous tasks that need to be accomplished before the first consumer is seen; e.g., financial strategy, human resources strategy, policy development, creating referral mechanisms, reporting frameworks and assessing outcome expectations. The program installation stage in the BAP-study consisted of a systematic planning process and many collaborative meetings. The project group and project management worked together to disseminate information, increase knowledge and prepare the organization. Management committed to the study by setting aside personnel responsible for particular tasks within the project. The interventions chosen were adapted to the participating hospital at this stage, and procedures were developed for executing change in practice in regards to both research and intervention. Routines and responsibilities were defined and described.

Initial implementation. Change in practice can be perceived as "dramatic" by the organization that is adopting the new routines. Time is thus required for changes to mature and for the necessary skills to be developed. According to applicable literature, implementation projects can be very challenging during the initial stage due to factors such as fear of change, inertia and investment in the status quo. It can be complex and difficult to implement something new. At the initial implementation stage, we started

training personnel in the two interventions to effectuate change in practice. Due to the challenges of the initial implementation stage, the implementation of both interventions was carefully monitored.

Full operation. Full implementation can occur once the new learning becomes integrated into practitioner and organizational practices and procedures. Over time, the innovation becomes "accepted practice" and a new operationalization of "treatment as usual" takes place in the organization. In the BAP-study, we trained "champions" to take over the training of new personnel in the two interventions and to provide supervision and support for them during the implementation process. At the time of submission for this dissertation, the BAP-study is moving into the stage of full operation and the new form of practice is gradually taking place in the organization.

Innovation. Each attempt at implementing a program presents an opportunity to learn more about the program itself and the conditions under which it can be used with good outcomes. At one-year follow-up, we will investigate whether the BAP-study has brought about the intended innovation of practices related to children of patients. Alternatively, more groundwork can be conducted to ensure the success of the implementation.

Sustainability. The goal during the final stage is the long-term survival of the implemented routines in the context of a changing world. The maintenance and sustainability is monitored continuously in the BAP-study by analyses of register data

from the electronic patient journals, web-based questionnaires and interviews with the staff.

These stages constituted the overall framework for the longitudinal implementation BAP-study. According to existing literature on implementation stages (Fixen, et al., 2005), it appears that most of what is known about implementation is related to the exploration and initial stages. Evaluation of newly implemented programs may result in poor outcomes, not because a program is ineffective, but because the results at the implementation site were assessed before the program was completely implemented and fully operational (Metz, et al., 2013).

Longitudinal implementation studies are not only time-consuming, but also require long-term financial commitments from the participating parties. An innovation is more likely to be successful if it starts out with a clear budget and if the allocation of resources is adequate and continuous (Greenhalgh et al., 2004). Due to the fact that implementation projects require dedication of both time and financial resources, it may be difficult to establish projects of this kind. This may be part of the reason for why implementation projects of some magnitude are rare.

Workforce barriers to implementation

The literature on implementation concurs with the idea that the key to successful implementation is behavioral change (Greenhalgh et al, 2004; Fixsen et al., 2005; Metz et al., 2013; Maybery & Reupert, 2006). Having established this idea, and the idea that the

workforce is the key to successful implementation of a new practice, it is important to study potential workforce barriers in detail. Based on existing research, we believe that there are several barriers to implementing inclusion of the child perspective in adult mental health care and that the key to achieving change lies with the professionals in the workforce (Barry & Jenkins 2007, Mayberry & Reupert 2009, Reupert & Maybery 2008). In a study conducted in 2009, Mayberry and Rupert (2009) concluded that there is a large gap between what psychiatric services should provide and what they do in practice when it comes to implementing the child perspective in adult mental health care. Korhonen and colleagues (2008, 2009) stated that there are many factors limiting support for families within mental health services; e.g. health professionals' qualifications. In order to understand why there is a discrepancy between the services delivered in mental health care and the existing knowledge of the importance of a family-focused practice, it is important to study workforce attitudes more extensively. It is crucial that the workforce recognizes or accepts the premise that a change is needed. If not, an innovative project has little hope of surviving (Fixsen et al 2005; Weiner, 2009; Dent & Goldberg, 1999). In order to detect important predictors for workforce barriers to identifying and supporting parents and children in adult mental health services, existing attitudes must be examined.

Innovations in service delivery and organizations

Innovations are commonly defined as *a novel set of behaviors, routines and ways of working that are directed at improving health outcomes, administrative efficiency, cost-effectiveness or user-satisfaction, and that are implemented by planned and coordinated actions* (Greenhalgh et al., 2004, page 582).

Relevant literature refers to a variety of approaches describing how to achieve the adoption of new ideas: *diffusion of innovations* (passive spread), *dissemination of innovations* (active and planned efforts to have the innovation adopted) and *implementation of innovations* (active and planned efforts to mainstream an innovation within an organization) (Greenhalg et al., 2004). The successful adoption of new ideas is often a complex and challenging task, even if the advantages are obvious (Rogers, 2003). However, according to Greenhalgh and colleagues' review of the literature on innovations from 2004, service innovations in health care that have an unambiguous advantage in either effectiveness or cost-effectiveness are more easily adopted. In other words, if potential users see no advantage in the innovation, they generally will not consider it (Greenhalgh, 2004; Rogers, 2003). A particular challenge related to documenting results of preventive efforts is related to the detectability of outcomes long after the innovation has been implemented. The timeframe for the BAP-study constitutes a period that spans generations; i.e., the overall aim of preventing mental illness to pass from one generation to the next. This is an obvious challenge to the innovation taking place. Even so, documenting obvious advantages does not mean widespread adoption is guaranteed (Greenhalgh, 2004).

Achieving a receptive context for change and working with organizations to encourage readiness for innovation is an important premise in the process of providing innovative interventions for organizations.

Degrees of implementation

In their review of implementation literature, Fixen and colleagues (2005) discovered that implementation may involve different connotations for different people. When referring to implementation, different agents refer to a variety of contrasting activities and strategies; and the strategies they refer to represent varied depth and dedication in terms of content allocated to the implementation process. The differing views of implementation may be categorized as degrees of implementation in the following way (Fixsen, et al, 2005):

1) Paper implementation. This refers to putting new policies and procedures into place; e.g. legislation, commission documents and guidelines. However, changing policies and procedures does not change practice in itself (Lauritzen, Reedtz, van Doesum, & Martinussen, 2013; Lauritzen & Reedtz, 2012).
2) Process implementation. This means incorporating new procedures into an organization; i.e. providing new guidelines and supervision, and changing reporting forms, among other things. However, new guidelines, education and supervision alone do not necessarily mean that practice will change. In reality, the "mechanism" to change may not exist because this strategy does not incorporate any tools or specific intervention to guide the change in behavior. (Hernandez & Hodges, 2003)
3) Performance implementation. This is the most extensive degree of implementation, meaning that it provides content and tools to practitioners so that new procedures and processes have functional components for change (Fixsen et al., 2005; Hernandez & Hodges, 2003).

Readiness to change

Unless the organization implementing new interventions accepts the premise that a change in practice is needed, any innovative project has little hope of succeeding (Fixsen et at., 2005). Readiness to change is reflected in the beliefs, attitudes and intentions of organizational members in addition to the organization's capacity to make those changes (Armenakis, Harris & Mossholder, 1993). According to Rogers (2003), a clear rationale for the intended change must be communicated. Rogers also emphasized the need to develop "champions" within organizations who can consistently advocate the implementation process, thereby contributing to workforce and organizational readiness to change.

Any attempt to achieve organizational change is, thus, a waste of time unless the organization is ready. Many scales have been developed to measure readiness of practitioners (Lehman, Greener & Simpson, 2002). Measuring readiness to change is, nevertheless, not as easy as it sounds. There are no widely accepted or standardized methods for measuring readiness to change (Sørlie, Ogden, Solholm, & Olseth, 2010). The most common method is the use of self-report questionnaires filled out by the workforce. One example was developed in the implementation of *The Incredible Years*, a research-based, evidence-based program for reducing children's aggression and behavior problems. We adapted a questionnaire used in the implementation of *The Incredible Years* to assess organizational readiness in the BAP-study (www.incredibleyears.com).

In general, little research exists on the relationship between measures of readiness and subsequent success of an implementation. It is, therefore, important to include measures of readiness in longitudinal implementation studies, and to investigate the association between organizational readiness and implementation success (Fixsen et al, 2005; Sørlie et al., 2010).

Measuring fidelity to assess readiness

Fidelity refers to faithful implementation of the program components. Deviations from, or dilution of, the program components could have unintended consequences for program outcomes (Sørlie et al., 2010). Only when new practices are fully implemented, and innovations are in full operation, should we expect positive outcomes (Fixsen et al., 2005). Monitoring implementation processes in terms of program fidelity is, therefore, important in order to ensure that programs are correctly implemented. In order to assess organizational readiness measures, according to Fixsen and colleagues (2005), it is essential to include items on *context* (i.e., prerequisites that must be in place), *compliance* (i.e. to which extent the practitioner uses the methods described in the program) and *competence* (i.e., level of practitioner skills regarding key aspects of the intervention). For detailed information on how this was measured in the BAP-study, see the Measures section.

The quality of implementation

According to Sørlie and colleagues (2010), implementation can be seen as the link between research and practice. Implementation science has the potential to identify important implementation drivers that ensure positive outcomes when interventions are utilized in the field of practice. However, if interventions are poorly implemented, it may lead to a lack of quality services for consumers (Sørlie, Ogden, Solholm & Olseth, 2010). Hence, the quality of implementation must be prioritized in implementation projects. Even though implementation refers to a planned and targeted systematic process, the process rarely evolves without barriers and resistance (Sørlie et al, 2010). If the new practice fails to provide the expected outcomes, there may be at least two explanations; 1) the intervention has not been as effective as anticipated, or 2) the intervention has been poorly implemented (Mørch, 2011).

In order to assess the quality of implementation, it is common to distinguish between two dimensions: 1) program integrity (whether or not the intervention was properly initiated, whether or not resources were allocated and whether management was supportive and the workforce was positive) and 2) treatment fidelity (tapping into whether or not the practitioners are loyal to the described method/intervention) (Sørlie et al., 2010; Ogden, 2012). Both dimensions are important prerequisites to achieving high-quality implementation. A significant positive correlation between conclusive effects of an intervention and high-quality implementation has been documented in several studies (Derzon, Sale, Springer, & Brounstein, 2005; DuBois, Holloway, Valentine, & Cooper,

2002). Even though the link between high-quality implementation and positive intervention outcomes was empirically documented, implementation studies are rarely integrated in large effectiveness or efficacy trials (Sørlie et al, 2005). Sørlie and colleagues believe that the lack of research on implementation may be due to a lack of knowledge on the importance of high-quality implementation in relation to the actual outcomes of the intervention. By systematically pre-evaluating readiness and resource allocation, providing systematic training and supervision, and evaluating fidelity, a high-quality implementation can be achieved (Armenakis et al., 1993; Lehman et al., 2002; Sørlie et al., 2010).

Objectives of the dissertation

This dissertation is a result of a large-scale longitudinal project, where the overall aim was to monitor and evaluate the implementation of clinical change to identify and support children of mentally ill parents within the participating clinic.

Objectives of article 1

The main goal of article 1 was to develop and describe the design and methodology of a large-scale implementation study to support children of mentally ill parents in a large Norwegian hospital. The article describes the implementation strategy, including several aspects to be examined in addition to the studies covered in this dissertation; e.g., evaluation of the interventions and of user satisfaction.

Objectives of article 2

The purpose of article 2 was to investigate to what extent the adult mental health care workforce identified whether or not patients have children, and to evaluate their attitudes towards including a family focus in treatment prior to the implementation of new routines. A secondary goal was to study which factors predicted workforce attitudes by examining the following predictors: age; gender; education; knowledge on the impact of parental mental illness on children and parenting; knowledge on legislation concerning children of patients; and expectations for possible outcomes of change in current clinical practice.

Objectives of article 3

The aims of article 3 were to investigate which barriers health care workers reported in relation to identifying and providing support for children of mentally ill parents, and to determine which factors health care workers considered important in order to provide

adequate support. A final aim was to develop a model for understanding challenges related to implementing workforce change in mental health care for adults.

Objectives of article 4

The objective of article 4 was to evaluate the process and outcomes of implementing new routines and interventions in adult mental health services in Norway by examining to what extent health personnel had changed their practice in terms of identifying and offering support to the children of patients. A second aim was to study changes in worker expectations, attitudes, knowledge and concerns.

Methods

Data reported in this dissertation

The implementation process, from the initial planning stages to full operation, is expected to last at least 10 years. This dissertation reports on data collected during three initial phases of the project; pre-stages of implementation (T0, article 1), baseline conditions (T1, articles 2 and 3) and pre-test to post-test (T1-T2, article 4). T3 will be reported at a later stage of the project.

T0: Pre-implementation

T1: Baseline conditions

T2: Pre-post

T3: One- year follow-up.

Participants

The participants in all studies were staff and leaders at the adult psychiatry clinic of the University Hospital of Northern Norway. The clinic consists of both in-patient and out-patient wards.

Recruitment

The mental health workers in the clinic were invited to respond to web-based questionnaires via email. Email lists were made available to us by the management of the clinic as part of the

collaboration with our research group. Participation was, however, voluntary, as prescribed in the Helsinki declaration (World Medical Association, 2008).

Interventions

The interventions that were implemented included a standardized *Family Assessment Form* for health care personnel and an intervention for families affected by parental mental illness, called *Child Talks*.

The Family Assessment Form is an intervention to increase the identification and assess the needs of patients who have children. The intervention *Family Assessment Form* consists of two sections. One section is mandatory for all mental health workers according to the law and includes questions on such items as: name/s and age/s of child/children; living situation of the child/children (i.e. with parent/s or not); the child's/children's caregiver while the patient is in treatment; and whether or not the child/children have been informed about the patient's condition. The second section includes questions on parental concerns (PEDS) and parental competence (PSOC) (Glascoe, 2008; Johnston, & Mash, 1989). The rationale for including the two latter scales is that information from parents tends to correctly describe the relative emotional, social and behavioral development of their children. Researchers have demonstrated that most children with significant socio-emotional and behavioral problems are shown to have parents with concerns, and that parents' concerns are often as accurate as quality screening (Glascoe, 2008; Johnston, & Mash, 1989; Reedtz, 2010). Data from the PEDS and PSOC scales will be reported at a later stage of the implementation process.

The intervention *Child Talks* is a health-promoting and preventive intervention where mental health workers talk with the family about the situation of the children and their needs. *Child Talks* comes with a manual (Van Doesum & Koster 2008; Reedtz, Lauritzen, Mørch, & Steneby, 2010) that describes the process of carrying out the intervention. The intervention consists of three separate family conversations; one initial conversation with the patient and possibly his/her partner, followed by two conversations with the patient (and partner) and the children involved. *Child Talks* is to be offered to all patients who are parents, and should be carried out within the first two months of the adult's treatment. The main purposes of the intervention are: a) strengthening the children's ability to cope with the situation by informing them of their parent's problem in addition to offering emotional and social support; b) strengthening the competence of the parents by increasing their awareness of the children's perspectives and informing them of the consequences that a parent's mental illness or substance abuse may have for the children; c) reporting concerns about problems that children may have at an early stage, for example, to the Child Protective Authorities; and d) offering advice about additional help and support available.

Measures

Data was gathered using several different assessment instruments. Detailed measures are presented in each article. However, the following paragraph provides a brief overview of the selected measures.

Questions about status quo in regular practice, changes in clinical practice one year after implementation and at one-year follow-up. The questions were based on the *Family*

Focused Mental Health Practice Questionnaire (Maybery, Goodyear, & Reupert, 2011). The questionnaire was adapted to a Norwegian context to assess regular practice in dealing with children of mentally ill parents at the participating hospital both prior and subsequent to the implementation of new interventions.

Demographic and work characteristics. Personal demographic variables included age, gender and education, in addition to single items on work characteristics such as leadership responsibilities and current position.

Routines for identification. Questions included: "Do you identify children of patients?" (answered with *yes* or *no*), in addition to several items exploring how the identification and documentation of information is carried out in practice.

Expectations regarding effects of implementing an intervention. The expectations of the new routines leading to positive outcomes for the children were assessed using a scale that consisted of 4 items and the mean score of those items was used in the analyses.

Description of knowledge on risk factors for children and legislation. This measure included descriptions of educational background, experience, knowledge of children of mentally ill parents as a risk group and knowledge of the new legislation.

Attitudes towards implementing new routines in adult mental health care to identify and follow-up with children of patients. This scale included eleven items tapping into

readiness to change, attitudes toward the new practice and attitudes on the importance of focusing on children of mentally ill patients. Additionally, attitudes related to concerns about a child-focused practice interfering with the therapeutic alliance were investigated.

Qualitative data on factors hindering the implementation of new routines. Two open-ended questions generated qualitative text data on important factors that may promote or hinder the implementation of new routines. The data was analyzed using a qualitative method called *Framework Analysis* (Lacey & Luff, 2001). The *Framework Analysis* approach is a more recent approach to qualitative analysis within health research that was explicitly developed in the context of applied policy research.

Readiness for change. Workforce readiness for change was assessed via several groups of items; e.g. attitudes, self-assessment of clinical practice quality (Lambert, 2010) and items adopted from *The Incredible Years* (Webster-Stratton et al., 2008).

Procedure

Pre-implementation. The assessment of status quo in mental health services was done through electronic questionnaires (Quest-Back) for all staff and management at the clinic. The questionnaires were completed anonymously. Reminders were generated anonymously by Quest-Back and were sent out at three intervals to those who had not answered.

Preparation prior to implementation. At this stage, materials were developed and adapted, training was carried out and routines were developed for the staff who would be offering *Child Talks*. Furthermore, the interventions were introduced to the entire staff at the participating organizations.

Implementing the interventions. The interventions are twofold. The *Family Assessment* tool is filled out by the therapist in charge of the initial assessment of the patient. The form is included in every journal of patients who are parents. After completing the FA- form, the therapist is to offer the family *Child Talks*. If the patient agrees to it, the intervention consisting of three meetings will take place in the course of approximately four weeks. The staff in charge of *Child Talks* will file a short manualized journal of the meetings and parents will be asked to complete evaluation forms, mainly addressing user satisfaction, after completing the final session.

Maintaining the change in practice. The procedure for the intervention is set up in a way that makes it possible for the participating wards in adult mental health services to continue to offer this intervention as standard procedure among their services once the study has been completed.

Implementation, materials and training. The implementation started with the training of mental health workers in both interventions. The organization, Adults for Children, was initially responsible for training and supervision of personnel at the clinic. The courses included lectures on the legislation and risk factors for children of mentally ill parents, as well as skills

training in terms of the interventions. However, after having conducted four 2-day courses for as many of the staff as we could reach, the procedure for staff training was further developed to increase its reach to the workforce. The research group and VFB developed training manuals and educated *champions* to take over the training of new staff within each ward. A *champion,* in this context, refers to a key role-player within the clinic who is given additional training and responsibilities in order to become a driving force behind the implementation (Soo, Berta, & Baker, 2009). The appointment of clinical *champions* is thought to be a facilitating factor in successful implementation (Soo et al., 2009).

At post-test, we evaluated the impact of implementing the *Family Assessment Form* in terms self-report measures. Changes regarding health professionals' knowledge, attitudes, collaborative routines and clinical practices were also assessed by post-measures using web-based questionnaires to all staff. At one-year follow-up we will evaluate if changes in clinical practice are in full operation.

Implementation quality. The entire workforce had the opportunity to participate in training, workshops and supervision. They were trained according to the program owner's manualized training. Both the training and supervision are continuously evaluated.

Intervention integrity. The professionals are required to follow the manual for the interventions, and will complete standard checklists for each session of *Child Talks* to ensure this. The checklists are integrated into the electronic patient journal and are analysed to study the integrity of the intervention. Analyses of this information, as well as staff interviews, are

planned in order to investigate fidelity. The *Family Assessment* tool is to be documented in the electronic patient journals.

Ethics

The study was approved by the data protection supervisor at the University Hospital of Northern Norway. While the research mainly focuses on practical implications of new legislation and does not aim to acquire new knowledge about *health* or *disease* directly, the study does not require permission from the Regional Committee for Biomedical Research Ethics in Norway. Nevertheless, the study was conducted in line with the Helsinki Declaration of ethical principles for medical research involving human subjects published by the World Medical Association (WMA, 2008).

Summary of the articles

Summary of article 1

Reedtz, C., **Lauritzen**, C., & Van Doesum, K. T. M. (2012). Evaluating workforce developments to support children of mentally ill parents: Implementing new interventions in the adult mental health care in Northern Norway. *British Medical Journal Open.* 2:e000709 doi:10.1136/bmjopen-2011-000709

Article 1 is a methodological article, describing the theoretical background and rationale for developing new routines to change clinical practice in order to include a child focus in adult mental health services. The main aim of article 1 was to describe the design of the first large-scale implementation study on this topic in Norway. The article describes the study protocol of implementing the interventions, *Family Assessment* and *Child Talks,* for children of parents with mental illness.

Summary of article 2

Lauritzen, C., Reedtz, C., Van Doesum, K. T. M., & Martinussen, M. (In press). Factors that may facilitate or hinder a family focus in the treatment of parents with mental illness. *Journal of Child and Family Studies.*

The purpose of article 2 was to investigate to what extent the workforce in adult mental health care identified whether or not patients have children. A secondary goal was to examine differences between professionals who identify the children of patients and those who do not. Lastly, another aim was to study which factors predicted workforce attitudes. The sample ($N = 219$) included health professionals at a large university hospital in Northern Norway. In general, the respondents had positive attitudes towards the identification of patients' children, as indicated by the high mean values of both identifiers and non-identifiers. However, of the total sample of 219 who reported that they worked directly with patients, 56% did not register whether patients had children. There were no significant differences between the group who said they did identify and the group who said they did not, except for the two scales measuring knowledge (*Knowledge Children* and *Knowledge Legislation*). The regression analyses indicated that age, education and expectations were significant predictors for positive attitudes. The findings indicated more positive attitudes among younger participants with a medium educational level (compared to high level), and with positive expectations for the intervention. Furthermore, concerns about interfering with the patient-therapist relationship were predicted by knowledge, level of education and expectations.

Summary of article 3

Lauritzen, C., & Reedtz, C. (2013). Support for children of mental health service users in Norway. *Mental Health Practice*, *16*, 12-18.

The aim of article 3 was to investigate which barriers health care workers experienced in relation to identifying and providing support for children of mentally ill parents, and to determine which factors health care workers considered important in order to provide adequate support. A final aim was to develop a model for understanding challenges related to implementing workforce change in adult mental health care.

Several challenges were identified. The main challenges were related to organizational issues such as lack of time, lack of resources, lack of training, lack of management support and lack of economic resources and tools. Additionally, the informants identified staff-related challenges such as lack of interest and commitment and lack of knowledge and experience. Even though health legislation has been altered to facilitate new practice, adult mental health care services still have a long way to go and there is a continuing need for clear and effective strategies to fully incorporate the child perspective into adult mental health care.

Summary of article 4

Lauritzen, C., Reedtz, C., Van Doesum, K. T. M., & Martinussen, M. (Submitted 2013). Implementing new routines in adult mental health care to identify and support children of mentally ill parents.

The objective of article 4 was to evaluate the process and effects of implementing new routines and interventions within adult mental health services in Norway. The purpose of study was to investigate to what extent health personnel had: a) changed their practice in terms of identifying the children of patients; b) changed their practice in terms of supporting patients' children; and c) changed their attitudes regarding the need to modify clinical practice on these matters. A further goal of the article was to assess whether the implementation of new routines had led to changes within the workforce in terms of expectations, attitudes, knowledge and concerns.

There was a significant increase in self-reported identification behavior from pre to post. To investigate whether or not the workforce had changed its practice in terms of providing support for the children, we tested for differences in experiences with family conversations. There was a significant change between the group at pre-test and the group at post-test. The pre-test group scored significantly ($d = 0.14$) higher than the post-test group, indicating a decreased activity in terms of family conversations. Furthermore, at pre-test a total of 91% reported that the services provided by their clinic were very good, good or adequate. At post-test, this number had decreased to 82 %.

There were no differences in *Concerns* between the pre-test and the post-test groups, indicating that the implementation of new routines had not lead to the workforce being more or less concerned about a child focus interrupting the patient-therapist relationship. Furthermore, *Positive Attitudes* toward incorporating routines to identify and support patients' children had increased. There were also significant differences in terms of *Knowledge and Expectations* between the pre- and post-group. The post-test group scored lower on both variables. We also tested for differences between staff members who reported they had started to run the *Child Talks* intervention and those who had not. The only significant difference was in *Expectations.*

Discussion

One of the main objectives of this project has been to develop procedures to monitor and evaluate the process of change within the participating clinic. Subsequently, a further aim was to unravel what it is that makes the implementation of new clinical routines so challenging. As a whole, this dissertation shows that implementing new routines to identify and support children of mentally ill parents within adult mental health care is feasible despite the fact that it is challenging and time-consuming.

Workforce attitudes and behavior

In article 2, we investigated practitioner behavior in terms of identification and support for children of mentally ill parents. We also examined attitudes towards including a family focus in the treatment of patients who have children. We found that the majority of participants had positive attitudes towards supporting mentally ill parents and their children within the context of adult mental health services. There were no differences in attitudes between the group who said they did identify and the group who said they did not identify. In fact, both groups scored very high on positive attitudes. Even so, less than half of the staff said that they actually identified and provided support for children and parents. It is somewhat paradoxical that staff reported that the identification of children was a task they should handle while also being reluctant to incorporate that task into their own routines. This indicated that the accommodating attitudes had not translated into new practice. This is in line with existing research on the field suggesting that, even though adult mental health care workers believe supporting the children is important, they are reluctant to do so themselves (Falkov, 2012; Maybery & Reupert, 2009; Korhonen et al.,

2008). Implementation strategies to facilitate changes in practice, therefore, have to consist of more than creating positive attitudes toward the new routines. Implementation strategies need to be of a *performance implementation* degree (Fixsen et al., 2005) and should include guidelines, knowledge, training and supervision.

We believe the BAP- study is an illustration of the discrepancy between attitudes and practice; there may be positive attitudes towards providing for the children of mentally ill parents, however, clinical practice will not encompass the inclusion of a child perspective unless the organization and the workforce have been adequately prepared for change. Only when this is properly anchored within the participating organization should mental health care workers be introduced to the new guidelines. This means that, even though the legislation had changed at the time of study 2, providing children of mentally ill parents the right to be identified and offered support, new routines had not been operationalized at the clinic. According to existing implementation literature (Fixsen et al., 2005), to see changes in practitioner behavior as a mere consequence of new legislation would be unlikely, as the process of implementing a child perspective in adult mental health care would have to involve preparation for change. This includes development of new materials and routines for the staff who assess children of patients, introduction of the new interventions to the entire staff, and training of personnel in the participating organizations.

Our findings are in line with Maybery and Reupert (2009), who found that a worker's profession and prior training may also influence his or her attitude about working with

families in a review study. Although positive attitudes were generally found to be high in study 2, nurses were more positive to identifying children as compared to those with a higher education; e.g. psychiatrists and psychologists. The reasons for this may include factors in nursing education that lead to increased openness to a child-focused clinical practice. Additionally, the role nurses play in the treatment process may make them more sensitized to the child as well as parenting perspectives. Furthermore, psychiatrists/psychologists are generally educated to focus on treatment and symptoms of the patients, rather than learning how to involve family members as part of their training. Nurses generally have an education that is more inclusive in terms of the patient context. Alternatively, psychiatrists/psychologists often have management roles in the wards, which may put them in the position of needing to prioritize the demand for more cost-effective and less time-consuming treatment for patients. This means that changes in professional behavior may be seen as directly influencing all implementation outcomes; in terms of unchanged practice related to children, unchanged structures for identifying children and lack of change in relating to consumers – e.g., parents and children. This again may lead to an additional reluctance to extend the treatment scenario to involve children.

Some of the practitioners expressed a notion that the patient-therapist relationship may be disturbed by bringing a child perspective into the treatment of mentally ill parents. This reflects the uncertainty some therapists have that bringing up the subject of children in conversations with a patient may cause the patient to be less open for fear of losing custody of a child (Reupert & Mayberry, 2008). In article 2, we found that those who

reported a high level of knowledge about children were less concerned about this. The same was seen in relation to positive expectations for intervention outcomes; the more positive the expectations, the less concerned workers reported being about the patient-therapist relationship. This may be an important predictor for achieving changes in practice. By focusing attention on positive outcomes for children and increasing the workforce knowledge, organizational cultures may change and facilitate a successful implementation process.

Another important finding in article 2 was that the workers who identified patients' children were significantly different from the workers who did not in terms of knowledge; i.e., knowledge about the consequences for children and knowledge on modified health legislation. This suggests that increased workforce knowledge could lead to more children being identified and supported within adult mental health services. Knowledge may lead to changes in clinical practice in terms of more patients and families being offered the *Child Talks* intervention. In this way, training practitioners in interventions to support parenting, and thereby improving the developmental path of children, may contribute to patients and their children receiving better services. Our findings are in line with existing research that has documented the importance of providing specialized training packages to the workforce in order to create the capacity to change practice (Reupert & Maybery, 2008).

Several studies have documented that a change in practitioner behavior is needed in regards to patients who are parents as well as their children (e.g., van Doesum, 2007;

Aamodt & Aamodt, 2005). Norwegian legislation has been altered to take this perspective into account in the treatment of adults who are also parents. The modified health care legislation has changed the terms such that children now have the official right to be informed and receive adequate follow-up from adult mental health services. Consequently, the modified legislation challenges all Norwegian hospitals to change their practice related to patients who are parents, including their children. The problem lies in achieving a change in practitioner behavior without also introducing new operationalized routines. Study 2 illustrates this. The pre-data reported in article 2 was collected almost a year after the legislation had been changed, however, the workforce had received little input as to how to incorporate the new tasks and, therefore, children of mentally ill patients were not identified and offered support.

Barriers to successful implementation of new routines

The aim of article 3 was to investigate which barriers health care workers encountered in relation to implementing the new practice to identify and support children of mentally ill parents. It is generally agreed that establishing a new practice within existing services is time-consuming; and the reasons for the inertia related to establishing new routines are multi-factorial (Maybery & Reupert, 2006; Falkov, 2012). We identified many factors that hindered the process of change in relationships to patients who are parents. Some of the barriers are workforce-related, while some are related to organizational culture and structure, and others are related to relationships between practitioners and patients. The main barriers were related to both interventions; i.e., to the identification of children and to providing support for parents and children. It is important to systematically assess what

the barriers consist of and to initiate strategies to overcome them. For instance, one main concern among the workforce was the lack of time allocated to the new tasks. The response from the research group has been to provide more training on how to include the tasks in existing structures such as the intake interview. By introducing procedures or manuals that show the practitioners how they may include the new tasks, barriers may be reduced and the goal of changed practitioner behavior may be achieved. The barriers may be seen as indicators that readiness to change has not been successfully established and, hence, the barriers to successful implementation may be overcome by doing more groundwork to prepare the organization and the workforce to change, for example, by offering more training and developing procedures.

According to article 3, the main barriers were also related to organizational issues such as lack of time, lack of resources, lack of training, lack of management support, and lack of economic resources and tools. All of these organizational issues may, in turn, contribute to increased reluctance within the workforce to take on the task. Altogether, these factors may be seen as insufficient organizational readiness. If the workforce is not ready to change, structures and cultures will not change. This may successively lead to no change in professional behavior and, furthermore, to a lack of change in relation to patients who are parents; i.e. if the readiness to change is lacking, the old structures of random support and identification will remain and the new practice will not be successfully implemented. The challenges to achieving change in organizational structures and cultures may be overcome by taking a step back and doing more work to enhance readiness for change. A possible solution may be to identify which steps may be taken to move the organization

toward a state of readiness. These may be identified by interviewing the staff and management, and by pinpointing important existing arenas where a systematic focus on the new routines may be included. Working simultaneously with management and staff to anchor the new practice within such arenas may improve the overall organizational readiness to change.

When trying to change organizations, it is important to take into consideration the aspect of informal leaders and workplace cultures. If the role of informal leaders is underestimated, change may be difficult. If the informal leaders are against the innovation, and do not see it as advantageous (Greenhalgh et al., 2004), this may be one explanation for why the progression from initial to full implementation/operation is moving slowly. In study 3, we identified several staff-related challenges such as lack of interest and commitment and lack of knowledge and experience, which would consequently result in a reluctance to incorporate the new routines into practice.

The provision of adequate support may also be hindered by contextual factors such as geographical conditions. The implementation of new routines is at the mercy of the terms laid out by the overall societal context. In this particular project, the geographical context of rural Norway adds a dimension to the challenges of implementation (see article 3). Although the management and workforce are aware of the new obligations presented by the modified legislation, the context of rural Norway complicates the actual feasibility of the intended innovation in terms of providing support for the children. An infinite amount of resources and efforts at the organizational level will not necessarily lead to a change in

practice unless the contextual dimension is taken into account. Specifically, the challenges related to geographical distances and organization of health services in Norway were identified as central contextual barriers in study 3. The solution may be to provide support for children without necessarily inviting them to come to the hospital. Telecommunication and/or collaboration between the hospital and community services to offer the *Child Talks* intervention are options that can be explored. However, poor collaboration between the hospital and local community-based services was seen as a very important consequence of organizational, as well as geographical, challenges in study 3. As of today, the interaction between state-run hospitals and the local authorities in regards to health care services is inadequate (Hanssen, 2008). The realization of this inadequacy resulted in a recently passed reform on the collaboration of health care services in Norway (The Coordination Reform). The implementation of this reform was initiated in January 2012, and implies that the Norwegian authorities have committed to starting the process of strengthening the capacity of local communities and will gradually facilitate the acceptance of greater responsibilities on the part of local communities. However, the Coordination Reform is not yet fully operative and, therefore, the collaboration between state-run hospitals and the local communities that constitute their uptake-area is weak in many areas of mental health care services. Increased collaboration implies new behaviors and new practices that would also have to be properly implemented in order to become fully operational. If adult mental health services regard the Coordination Reform as a justification for leaving the task of supporting children to local communities, the reform may only serve as a pretext for doing nothing to support children with adult mental health services.

Implementation of new routines to change clinical practice

In article 4, we aimed to evaluate the process and outcomes of implementing new routines and interventions within adult mental health services to identify and support children of mentally ill parents. The results show a slight change in professional behavior since the implementation of the interventions in the BAP-study was initiated. In study 4, we were able to detect an increase in self-reported identification as well as a small increase in positive expectations, knowledge and positive attitudes among the mental health professionals. However, the study also showed that the provision of support for these children had not increased. Although obligated by law to provide follow-up, the services still have a long way to go before this is fully incorporated into clinical practice. One explanation may be that it is too early to measure change in this respect. According to Fixsen and colleagues (2005), the evaluation of newly implemented programs may result in poor outcomes, not because the program is ineffective but because the results were assessed before the program had been completely implemented. Based on this theory, the lack of increased support for children of mentally ill parents may have been prematurely evaluated. There are several indications that this part of the implementation strategy was not yet fully operational; e.g., self-report data showing a very low usage of *Child Talks*. This may imply that the changes in professional behavior linked to *Child Talks* need more groundwork before they may be detected in evaluation studies or that the post-measures should have been conducted at a later point.

Merely informing workers of anew practice does not necessarily lead to a change in behavior. Management must be fully on board with the strategy. Furthermore, personnel should be monitored in relation to how well they follow the new legislation. Another solution may be to foster key personnel, *champions*, within the clinic. These *champions* (individuals or groups of individuals representing a program) can then actively work to implement the new practice. *Champions* can, furthermore, vigorously work with the clinic to reveal barriers that need to be overcome and to uncover eventual solutions for such barrier, thereby helping the clinic to stay on track. By enabling the *champions* to conduct the training of ward personnel, and by providing them with a manual and educational material, on-going training may be easier to accomplish. However, by handing it over to the organization, we lose control how the training is delivered to some extent. This is an important criterion for success and requires maintaining an open dialogue with the *champions*. Since the evaluation of the implementation process in study 4 showed that the changes in practice are progressing very slowly, we have initiated a process of involving *champions* to a larger extent. Evaluations at a later stage of the implementation process will show whether or not this turns out to be effective.

A broader perspective on children of mentally ill parents

In article 1, we described the overall project of which the studies in this dissertation are a part. Implementation strategies require long-term perspectives. To get the full picture of the changes taking place within the clinic, additional aspects must be investigated. In this respect, the studies in this dissertation are part of a larger implementation strategy that involves a rather complex design to achieve successful implementation outcomes.

The aim of article 1 was to develop a comprehensive methodology to facilitate successful implementation of the new practice. The importance of regarding implementation work as a process, rather than an event, was subsequently brought to light. This, in turn, may mean that the initial project protocol that study 1 is based on may be subject to revision.

One of the aspects that is likely to be altered is the time perspective. We believe the project will need to run for longer than initially planned in the protocol. This is due to the discovery in study 4 that additional groundwork is needed in order to create readiness to change in the clinic. Another issue we need to address is the question of management involvement. Perhaps management needs to be more closely connected to the implementation process. One solution may be to invite leaders and key personnel to participate in extended work group meetings, and thereby have them play a more active role in cultivating readiness to change. Another solution may be to make sure that identification and support for children is embedded in the organization's overall mission.

A final aspect to keep in mind is the modified view of children in society as a whole, where children now have the formal right to be recognized and visible in processes that are relevant to their lives (Skivenes & Strandbu, 2006). We believe that the child perspective and the concept of child participation are concepts that have not yet been incorporated into adult mental health services because there has been no tradition to keep in mind a child focus. This implies that there is a gap between what is expected by the Norwegian Ministry of Health and Care Services from the new legislation and the culture

and tradition that already exist within adult mental health services. Long-term implementation projects such as the BAP-study have the potential to make a difference in contributing to a changed clinical practice, where a focus on children of mentally ill patients is incorporated. The BAP-study may, therefore, contribute in preventing the transmission of mental health problems from one generation to the next.

Strengths and limitations

An important limitation to this study is the relatively modest response rate (50% at pre-test and 40% at post-test). A 2009 meta-analysis conducted on survey response rates (van Horn et al., 2009) showed an average response rate of 49, 6%. In this context, a response rate of 50 % is common and not unexpected. However, this may bias the results if the decision to participate is related to worker attitudes; i.e. those who were already positive to involving the children of their patients were more likely to participate. If non-responders primarily consisted of workers who were negative to involving children, we may have overestimated how positive the workforce is to including a family focus in the treatment of mentally ill parents. According to Barr and colleagues (2008), non-response is common in organizational research and it is generally thought that research participants differ systematically from those who do not choose to participate in studies. This, of course, implies that the generalizability of survey findings may be influenced by a sample that is skewed. The majority of the respondents were women, which may also have led to biased results. We, therefore, conducted an analysis of the total workforce in terms of gender. Of the total mental health care workforce, the percentage of men amounted to

29 %, which was approximately the same as in our samples (24 % at pre-test and 27 % at post-test).

Another explanation for non-responders is linked to work overload. Workers who experience an overload of tasks and responsibilities are more likely to fail in the completion of web-based surveys (Barr et al., 2008). However, we did not measure this aspect in our study. Furthermore, due to anonymity issues, we do not know if the group that answered the questionnaire at pre-test is the same group that answered at post-test. Additionally, few leaders responded, which means that we lack input from their perspective on the matter.

The studies relied solely on self-report measures for attitudes, knowledge, and current work practice. Future studies may also include more extensive objective measures; e.g., journal data for assessing the number of children of mentally ill patients. To make up for this limitation, we have initiated a register data study for which we have been granted access to anonymous data extracted from the electronic patient journals. This study will be a cross-sectional study of the information on current practice that is entered into patient journals.

Another limitation to this study is the lack of data describing the new routines in full operation. In terms of measuring whether the children are better off as a result of the interventions implemented through the BAP-study, there is still a long way to go. To assess whether the interventions in the BAP-study have contributed to a positive outcome

for children, the study is designed to assess changes in parental concerns and sense of competence. However, due to the slow implementation progress, we are not yet in a position to evaluate the outcomes for the patients' children. Furthermore, it is too early in the process to say anything about maintenance and thereby too early to evaluate the sustainability of the new practice.

The design of this study is a pre-test – post-test study, with no control or comparison group. Methodologically speaking, a control group would have strengthened the design of the study. We could have planned the study in a way that included a control group from the beginning. However, there are few similar hospitals that would be relevant to such a study in Northern Norway. The most applicable candidate was already offering activities for families affected by mental illness and would, therefore, not provide realistic control conditions. Additionally, due to the legislation amendments, it would be difficult to find a clinic that had not already initiated the process of working with identification and support for children of mentally ill parents to some extent. Furthermore, if we had recruited a control group from the beginning, it would be hard to say if detectable differences between the participating clinic and the control group would be due to the BAP-study to other factors.

Given the time perspective, it is likely that the workforce will move on to other tasks and that the focus on the children of patients may lessen. An important weakness in this project has been the difficulty of establishing permanent arenas for collaboration between the project group and the staff and the fact that the implementation of the new practice

may have been less prioritized as a result. Perhaps workforce booster sessions focusing on the content of the new practice could contribute to quickening the pace of the implementation process.

One of the strengths of this particular project is that, in its entirety, it surpasses the investigation of current practice and introduction of new routines. The BAP-study has a long-term strategy that encompasses more than just the aspects of research. The purpose of the project is not just to monitor the implementation process, but to support the clinic in its endeavor to successfully change practice as well.

Moreover, the project encompasses a strategy to achieve behavior change that exceeds creating the mere intention to change clinic practice. Studies have shown that intentions in themselves do not determine behavior (Webb & Sheeran, 2006). We believe that a major strength of this study is the provision of content for the new practice rather than a mere justification for why practice should be modified, which is in line with relevant implementation research (e.g., Fixsen et al., 2005).

A third strength is the interventions that we have included in the overall project. The interventions are well described, successfully tested in other settings and liked by the staff. Furthermore, they are easy to carry out and may be included in clinical practice without having to allocate unrealistic resources.

Conclusion

The long-term implementation strategy of the BAP-study seems to be contributing to slight changes in clinical practice in terms of increased identification of mentally ill patients and their children. The changes are, nevertheless, taking place very slowly. The reasons for the changes taking place are likely linked to a systematic long-term implementation strategy where core components of implementation are taken into account and where the degree of implementation performance has been chosen.

In terms of support for the families affected by parental mental illness, the changes are not yet significant. Even though the implementation is progressing very slowly, evaluation of newly implemented programs often do not reveal changes if the project is prematurely evaluated. Continued work on readiness to change may speed up the process, and the work of supporting families may be measured at a later point.

In terms of implementation work, in general, it is important to accept the basic premise that innovations takes time.

Clinical implications of the results

In the continuation of the BAP-study, there are several steps to take in order to encourage the process of implementing new practice. Firstly, it might be fruitful to initiate meetings with management and to involve the managers in the process of fostering readiness to change. Allocation of staff resources, time and arenas are factors in which management

needs to actively be involved in order to encourage the implementation process. Secondly, we believe that it may be time for booster sessions in terms of training and courses. We also believe that the staff responsible for internal courses may need additional training. In the training of trainers, it might be a good idea to include training on how to supervise colleagues in carrying out the interventions. Another idea may be to create arenas (or take advantage of existing arenas) to discuss actual cases where patients are parents. Finally, it might be a good idea to turn to the education of mental health workers (e.g. nurses, psychologists, doctors) in trying to stimulate the inclusion of the child and family perspectives in curriculums.

Future directions for research

The future of the BAP-study should focus on continuing the work to change clinical practice as well as maintaining and evaluating the sustainability of such changes. Furthermore, an evaluation of the effectiveness of the interventions should be conducted. The work to consolidate the new practice will continue. At this time, the implementation outcomes in this dissertation are to be regarded as preliminary results.

The long-term goal of the BAP-study is to perform efficacy and effectiveness studies of preventive interventions for children of mentally ill parents. A prerequisite for this is that the interventions be put to wider use and that the relevant changes in clinical practice to identify and offer children adequate support be adequately implemented. This kind of evaluation will provide evidence as to whether these interventions are cost-effective and

have proven the potential to prevent child maltreatment as well as socio-emotional and behavioral problems in children.

As of today, psycho-education is a core element in several preventive interventions for families affected by parental mental illness. There is an assumption that this has a preventive effect, however, studies documenting this assumption have yet to be done. Future studies should compare the effects of various approaches and interventions in order to identify effective components in the prevention of trans-generational transmission of mental illness. If the new practice is not found to be effective in terms of preventing socio-emotional and behavioral problems in children, interventions should be differently rigged. Preventing the transmission of mental illness from one generation to the next is a very important investment in the future. According to Nobel prize-winning economist, James Heckman, investment in early intervention is a sound investment in the productivity and safety of our society (Heckman & Masterov, 2004). Treatment is much more costly and challenging than prevention, and less likely to have an effect. This makes it safe to say that a focus on the children of mentally ill parents constitutes a very worthwhile focus on the future.

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Article 1

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Article 2

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Article 3

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Article 4

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