

PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Evaluating Workforce Developments to Support Children of Mentally Ill Parents: Implementing new interventions in the Adult Mental Health Care in Northern Norway
AUTHORS	Charlotte Reedtz, Camilla Lauritzen and Karin TM van Doesum

VERSION 1 - REVIEW

REVIEWER	<p>Brenda Gladstone, PhD Project Investigator Child Health Evaluative Sciences SickKids, Adjunct Lecturer Lawrence S. Bloomberg Faculty of Nursing, University of Toronto</p> <p>I have no competing interests to declare.</p>
REVIEW RETURNED	23/01/2012

THE STUDY	<p>Is the research question clearly defined?</p> <ul style="list-style-type: none"> • As stated the overall aim of the study is to assess the process of implementing two interventions/practices related to COPMI and parent's experiences of them; to this end the authors include a study objective and research questions; some clarity here would be helpful. <ul style="list-style-type: none"> o The second part of the objective states that the study will evaluate the impact of the implemented intervention on parental competence and parental concerns (is this the same as parent 'experiences'?; also, my understanding is that these two constructs are the basis for two measures/tools used as 'proxy' accounts for assessing/screening the needs of the children in this study rather than to evaluate parental concern/competence in and of themselves; if I have misunderstood this then perhaps some clarity would be helpful to the reader o Regarding the process evaluation: question # 1, pg. 7 – are the investigators interested in establishing prevalence only by identifying the numbers of children? Is it worth considering identification in terms of other variables such as gender, ages of children, presence of siblings, family context [and I believe there is reference to collecting demographic information but without more detailed information this is difficult to determine) and more importantly to think about how these variables matter in terms of study objectives? For e.g. in an analysis of parents' reports on the intervention some of these factors might be important, but I am not clear if this is significant regarding the purpose of this study design; question # 2 – this seems quite ambitious in terms of the four areas of 'change' they are looking for at time 2 and time 3 in terms of health
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professionals' 'knowledge', 'attitude', 'collaborative routine' and 'clinical practices'; it would help perhaps to have a bit more detail on what these concepts mean in terms of how they hope to establish change by using online survey questionnaires ; question #3 – more might be said about why it is important to this study to establish whether or not the intervention was delivered according to the protocol – and if not, what would that mean for learning from this study?; question # 4 – this question seems to be part of question # 2 in that worker expectations and beliefs about effectiveness may be tied to concepts about knowledge, attitude and how workers think about collaborations and practice

- o Regarding the 'evaluation of the interventions impact on parents' – question #1 is awkwardly phrased, do they mean to ask more simply – are the parents satisfied with the intervention? Is satisfaction the same as asking about their experiences?; questions # 2 and 3 – when I first read these questions I wondered where the constructs concerning parental 'competence' and 'concerns' arose and realized later in the protocol that these are part of the measures used in the study – however they appear to be implemented as part of the 'assessment phase' of the study, which I find a bit confusing in this design, moreover, they don't seem to be part of the introductory background to the study and I am not sure then if and why they are so central to this design

Is the overall study design appropriate and adequate to answer the research question?

- I am confused regarding the two scales being implemented as part of evaluating the impact of the interventions on parents – on pg. 8 they are described as obligatory because they are part of a quality assurance evaluation [which I assume is separate from this study?] and on pg. 9 the rationale given for inclusion is that this information 'correctly describes the emotional, social and behavioural development of their children'; also, I am not convinced that the two measures [PEDS and PSOC] will address the objective of the study as I have understood it; I am not familiar with these tools, are they developed for parents with mental illnesses or the general population? How do they address the situation for parents who are experiencing mental illnesses, and their children, more detail might help me in response to these questions; for e.g. there is conflicting research that suggests some, although not all, parents with mental illnesses may judge their children's social and emotional life and 'behaviours' more negatively (see for e.g. Somers, V. (2007) Schizophrenia: The impact of parental illness on children. British Journal of Social Work, 37:1319-1334), which would contrast to that suggesting parental concerns are an accurate way to measure children's emotional, social and behavioural related needs; it also seems to me that most parent's satisfaction with their parenting role would be negatively affected by children's 'externalizing' behaviours, in which ways might this be the same or different for those parents who may be struggling with psychiatric symptoms at a particular time and/or many of the other issues that family's face – this speaks again to my point that these tools and the assumptions underpinning these propositions may not be appropriate for this population because they do not account for the psychosocial context of these family's situations

- Are the authors suggesting that a change in parents 'concerns' and 'competence' will suggest that the Child Talks intervention has in fact been successful and more so, that the child in fact will 'do better'? I was not clear but inferred this from the study design; if so, I

do have some concerns and would at the very least hope to have some discussion of the potential limitations of this design;

- o Although I realize the study is focused on practice change and user satisfaction with the intervention from parents' perspectives I do have concerns that the study does not include children's perspectives on the intervention as this is likely to have implications for service and support provision –the children are included in the Child Talks intervention [although there is not enough detail for me to understand how it works exactly] and as I have demonstrated [Gladstone, B. (2010). "All in the same boat": An analysis of a support group for children of parents with mental illnesses. Doctoral Dissertation, University of Toronto, Toronto, Canada) along with other researchers (see for e.g. a number of studies in a review of children's perspectives in Gladstone, B.M., Boydell, K.M., Seeman, M. and McKeever, P. Children's experiences of parental mental illness: A literature review. *Early Intervention in Psychiatry*. 5:271-289), this may have important implications for practice because children often evaluate services and support in ways that are differentiated from that of adults, including clinicians and parents

Are the participants adequately described, their conditions defined, and the inclusion and exclusion criteria described?

- I have some concerns about grouping parents with mental illnesses and those with substance abuse disorders together in this study and what the implications for the study results might be in terms of understanding service and support needs; at the least it would be helpful to have the authors comment on this as perhaps the new regulatory guidelines in Norway account for this grouping in a particular way.
- The mental health workers that form the first group of participants come from a range of disciplinary and practice professions, including psychiatry, nursing, psychology, social work – how would this impact their knowledge, beliefs, collaboration routines and clinical practices [for e.g. on pg. 10 the authors make reference to topics about knowledge and attitudes about responsibility for COPMI, which would vary across these workforce professions] and do the authors intend to perform an analysis that might reflect these potential differences within the workforce?
- Similarly will patients who are parents be differentiated in terms of analysis regarding for e.g., gender of the ill parent, diagnosis, family context [one parent family etc.]; some mention is made about collecting demographic variables about the patient and the child but it there isn't enough detail to think about how for example, diagnosis and psychiatric history might be used in the analysis of user satisfaction [see pg. 11]?; also, will all age ranges of children be represented and if so, wouldn't parenting behaviours influence the 'socio-emotional and behavioural problems' in these individuals differently given the structurally differentiated positions of children in society? What kinds of questions will be asked in the 'user satisfaction' questionnaire? [see pg. 12]?; how will responses be differentiated between the study intervention, Child Talks, and 'broader services they have been offered', is there an intention to compare these supports/services? Are there any 'open-ended' questions that will allow participants to elaborate on their perspectives of satisfaction?

Are the patients representative of actual patients the evidence might affect?

• Yes; my one concern as stated earlier is the combination of parents with mental illness and those with substance use disorders.

• The only other comment I would like to make here is that although the study appears to try to address children's perspectives in the reference on page 13 to 'including the children through questions about their understanding and experiences of the family situation, and the children's view of what may improve their situation' I found this too vague in terms of assessing children's participation in the intervention Child Talks; is this part of the study data or 'just' a description of the intervention itself and if so how will this data be analyzed?; if not, there is the problem here of perpetuating the broad and enduring issue in this field that focuses only or primarily on the 'patient' as the parent rather than the child and his/her support needs or the family as a whole; it appears to me that children's 'needs' are assessed almost solely from the perspective of the workforce via the Family Assessment form and/or the parent as patient in Child Talks, – and particularly as other studies have found that child/adult perspectives may not always align with those of adults [see citations noted previously for example]

Are the methods adequately described?

• See comments in previous sections

• Reference for implementation training is made to 'Adults for Children' – I would be interested in knowing more about this group, particularly because they seem integral to whether or not the intervention is delivered according to protocol based on the training they are providing - pg 11 indicates that workforce participants will evaluate the training/supervision in relation to question # 4 in the first phase of the study – it would be important to give some indication of this earlier in the protocol as it might help explain the purpose for this question; however, I wonder if overall the design of the study is too ambitious, or would some clarification of questions related to the study design and questions help to mitigate this impression?

• Which other 'services' or 'additional support' might children who are identified in the assessment phase might be offered in addition to Child Talks and how would this impact the findings of the study?

• How is the Australian online resource questionnaire adapted to the Norwegian context? I think the paper should include more detail on the kinds of criteria or indicators of clinical practice change are being used rather than relying on reference to this resource. And how will these be measured to indicate whether or not they are sustained at the one year follow up?

• What does the 'logbook from Child Talks' consist of?; how does this constitute data for this part of the study? More detail about this would be helpful – and more broadly this should include information about Child Talks itself as an intervention – what is the content, format of the program, which is only briefly summarized here in terms of a discussion with the patient and his/her partner and children at 3 points in time; moreover, if new topics/concerns, opportunities/needs for support were to arise during the intervention over and above what may be anticipated by Child Talks, would that constitute a breach of protocol or is there space here to consider innovation to the intervention itself?; the problem of 'program fidelity' can be understood quite differently as for example in a study I conducted involving a critical discourse analysis of the program content of a psychoeducational program for COPMI (Gladstone,(2010) "All in the same boat": An analysis of a support group for children of parents with mental illnesses, Doctoral Dissertation, University of Toronto, Toronto, Canada).

	<ul style="list-style-type: none"> • There is no detail about the user satisfaction scale and how the analysis will be conducted. <p>Is the main outcome measure clear?</p> <ul style="list-style-type: none"> • No I believe that there are a number of points of clarification needed; in addition to comments threaded throughout my previous comments in this regard I would suggest the authors might find a recent paper of note in which a differentiation is made between how we understand 'screening' and 'assessment' in terms of evaluating referral and assessment practices in programs for children as they anticipate the scientific and practical implications of their project as it is proposed here [see pg. 15]: specifically see pg. 505 in Steer, S., Reupert, A. & Maybery, D. (2011). Programs for children of parents who have a mental illness: Referral and assessment practices. "One size fits all"? Australian Social Work, 64:4, 502-514. <p>Are the abstract/summary/key messages/limitations accurate?</p> <ul style="list-style-type: none"> • I found the abstract hard to read; more detail about actual methods would be helpful, or perhaps a different organization of the summarized material; for e.g. the analysis section seems to me to be more about data collection; more detail about the interventions [Family Assessment, Child Talks] would be less confusing and more compelling for the reader • I do not have a sense of what the authors might anticipate to be the 'limitations' or 'considerations' of this study design, from either the methodological and/or substantive approaches taken in this study as it is currently described <p>Are the statistical methods described? Are they appropriate?</p> <ul style="list-style-type: none"> • This is not my expertise. <p>Is the standard of written English acceptable for publication?</p> <p>Yes.</p> <p>Are the references up to date and relevant? (If not, please provide details of significant omissions below)</p> <ul style="list-style-type: none"> • I have chosen to add some references where they might be helpful to review the points I am making here; I am not necessarily suggesting that these are significant omissions.
<p>REPORTING & ETHICS</p>	<p>I am surprised by the statement in the protocol that the study is regarded as a 'quality evaluation project aimed at improving diagnostic and therapeutic practices' rather than as a research study in the more traditional sense that would require a more standard [in my experience] ethical review. I am not familiar with the role and responsibility of a 'data protection officer' who approved the protocol but as the title suggests I have concerns about what it may mean to protect 'data' and how this might relate to the protection of human subjects as is the purview of most REB processes. For example, in this study mental health workers participate in the study assessments as part of a formal agreement between the researchers and the management in their place of work, but I am not clear whether or not they can opt out of participation and the language used also suggests that they are 'encouraged' [but not obligated?] to answer the questionnaires [p. 8]. The scales that the parent participants are asked to complete are obligatory as part of a</p>

	<p>quality assurance evaluation of clinical practice but also part of the study design so I assume participants would be obligated to complete these, but this should be made clear and subject to review. Parents are recruited via the mental health worker who assesses the 'patient'; would this be an individual from whom they would also receive care and if so are there any ethical concerns with this relationship or guarantees that will be made with regard to consent/confidentiality procedures? There is a brief mention of the intervention including children through questions about their understanding and experiences of their family situation and view of what may improve it - are there plans to include this as study data beyond what the intervention itself entails and if so will the children be involved in consent/assent procedures along with their parents?</p>
GENERAL COMMENTS	<p>I would like to thank the authors for the opportunity to review their study protocol, which is part of a promising and significant area of study that has not been widely studied and is under-funded in most contexts. I hope the authors find my comments helpful.</p>

VERSION 1 – AUTHOR RESPONSE

Comments from the reviewer:

Is the research question clearly defined?

- As stated the overall aim of the study is to assess the process of implementing two interventions/practices related to COPMI and parent's experiences of them; to this end the authors include a study objective and research questions; some clarity here would be helpful.
 - o The second part of the objective states that the study will evaluate the impact of the implemented intervention on parental competence and parental concerns (is this the same as parent 'experiences'?; also, my understanding is that these two constructs are the basis for two measures/tools used as 'proxy' accounts for assessing/screening the needs of the children in this study rather than to evaluate parental concern/competence in and of themselves; if I have misunderstood this then perhaps some clarity would be helpful to the reader

We are measuring parental concern/competence to get information about the needs of the children, as well as to evaluate parental concern/competence "in and of themselves". Parental competence and parental concerns are measured by PSOC and PEDS. Parental experiences are measured by a user satisfaction assessment after the intervention Child Talks. In this user satisfaction assessment, parental experiences are measured specifically, as well new measures by use of the PSOC and PEDS. This is clarified in the text, p10.

- o Regarding the process evaluation: question # 1, pg. 7 – are the investigators interested in establishing prevalence only by identifying the numbers of children?

Is it worth considering identification in terms of other variables such as gender, ages of children, presence of siblings, family context [and I believe there is reference to collecting demographic information but without more detailed information this is difficult to determine) and more importantly to think about how these variables matter in terms of study objectives?

For e.g. in an analysis of parents' reports on the intervention some of these factors might be important, but I am not clear if this is significant regarding the purpose of this study design; Primarily, we are interested in implementing routines to identify children. The current situation in adult mental health care in Norway is that children are not identified at all (we have collected data which confirms this), and hence the most important issue is to establish practices which ensures that children are taken into account. However, we are also collecting data on age, gender, parental custody, who takes care of the children when mom or dad is receiving treatment, other carers, and which information the child has received about the situation of the parent/s. This is clarified in the text

on p 12.

question # 2 – this seems quite ambitious in terms of the four areas of ‘change’ they are looking for at time 2 and time 3 in terms of health professionals’ ‘knowledge’, ‘attitude’, ‘collaborative routine’ and ‘clinical practices’; it would help perhaps to have a bit more detail on what these concepts mean in terms of how they hope to establish change by using online survey questionnaires;

We evaluate if the two interventions will contribute to changes in health professionals’ ‘knowledge’, ‘attitude’, ‘collaborative routine’ and ‘clinical practices’ in a pre-post design. Hence, changes are introduced by implementing the interventions, not the online survey. This is now clarified on p 10 in the manuscript, and this is also originally outlined in the text on page 12 where the questionnaire is described.

question #3 – more might be said about why it is important to this study to establish whether or not the intervention was delivered according to the protocol – and if not, what would that mean for learning from this study?;

We have included a new paragraph on this issue to clarify this on p 11. We are evaluating the training, the content of each session, as well as how many sessions health professionals are offering to their patients. See also last paragraph on p 11, where this measure is explained.

question # 4 – this question seems to be part of question # 2 in that worker expectations and beliefs about effectiveness may be tied to concepts about knowledge, attitude and how workers think about collaborations and practice

We agree on this, and have excluded research question 4.

o Regarding the ‘evaluation of the interventions impact on parents’ – question #1 is awkwardly phrased, do they mean to ask more simply – are the parents satisfied with the intervention? Is satisfaction the same as asking about their experiences?;

We agree on this and have changed the phrasing accordingly.

questions # 2 and 3 – when I first read these questions I wondered where the constructs concerning parental ‘competence’ and ‘concerns’ arose and realized later in the protocol that these are part of the measures used in the study – however they appear to be implemented as part of the ‘assessment phase’ of the study, which I find a bit confusing in this design, moreover, they don’t seem to be part of the introductory background to the study and I am not sure then if and why they are so central to this design

We agree on this and have clarified this in the abstract, as well as by including a new paragraph explaining the rationale for this in the introduction p 7.

Is the overall study design appropriate and adequate to answer the research question?

- I am confused regarding the two scales being implemented as part of evaluating the impact of the interventions on parents – on pg. 8 they are described as obligatory because they are part of a quality assurance evaluation [which I assume is separate from this study?]

We agree that the phrasing was confusing, and have changed the text to clarify this issue on p 9. and on pg. 9 the rationale given for inclusion is that this information ‘correctly describes the emotional, social and behavioral development of their children’;

We have addressed this by including a new paragraph explaining the rationale for this in the introduction p 7 (mentioned above), in addition to the two references we have regarding this in the manuscript.

also, I am not convinced that the two measures [PEDS and PSOC] will address the objective of the study as I have understood it; I am not familiar with these tools, are they developed for parents with mental illnesses or the general population? How do they address the situation for parents who are experiencing mental illnesses, and their children, more detail might help me in response to these

questions; for e.g. there is conflicting research that suggests some, although not all, parents with mental illnesses may judge their children's social and emotional life and 'behaviors' more negatively (see for e.g. Somers, V. (2007) Schizophrenia: The impact of parental illness on children. *British Journal of Social Work*, 37:1319-1334), which would contrast to that suggesting parental concerns are an accurate way to measure children's emotional, social and behavioral related needs; it also seems to me that most parent's satisfaction with their parenting role would be negatively affected by children's 'externalizing' behaviors, in which ways might this be the same or different for those parents who may be struggling with psychiatric symptoms at a particular time and/or many of the other issues that family's face – this speaks again to my point that these tools and the assumptions underpinning these propositions may not be appropriate for this population because they do not account for the psychosocial context of these family's situations • Are the authors suggesting that a change in parents 'concerns' and 'competence' will suggest that the Child Talks intervention has in fact been successful and more so, that the child in fact will 'do better'? I was not clear but inferred this from the study design; if so, I do have some concerns and would at the very least hope to have some discussion of the potential limitations of this design;

PSOC and PEDS are developed for the general population like almost all measures for parenting and child behavior checklists. Because we have information on the scores of the normal population we can compare them to the scores of this group of parents. We of course take in account that parents with mental illness can measure their children's behavior in a different way than the normal population. Regarding the reviewer's comment on how mentally ill patients "may judge their children's social and emotional life and 'behaviors' more negatively", our response is that this research project is conducted in the general psychiatric clinic, as opposed to the clinic for substance abuse and specific psychiatric disorders (which includes serious disorders like Schizophrenia). Hence, the patients included in this study will not fit the group the reviewer refers to. We have described the participating clinic explicitly on p 3. We also believe that the "psychosocial context" of the participating families' life situation is more or less comparable to the general population. The difference would be the short periods where a parent is admitted to a ward at the hospital, but most patients in this study will only receive outpatient treatment. We do believe that parental concerns and parents sense of competence gives valuable information about the life situation of the child, and that assessment of these variables might indicate which children should be referred to additional services for additional support/treatment. We have addressed this by including a new paragraph explaining the rationale for this in the introduction p 7 (mentioned above).

We agree that only using parents perceptions on child development and well-being is a limitation, and we have included this in the abstracts and in a new paragraph on p 16 to address this.

o Although I realize the study is focused on practice change and user satisfaction with the intervention from parents' perspectives I do have concerns that the study does not include children's perspectives on the intervention as this is likely to have implications for service and support provision –the children are included in the Child Talks intervention [although there is not enough detail for me to understand how it works exactly] and as I have demonstrated [Gladstone, B. (2010). "All in the same boat": An analysis of a support group for children of parents with mental illnesses. Doctoral Dissertation, University of Toronto, Toronto, Canada) along with other researchers (see for e.g. a number of studies in a review of children's perspectives in Gladstone, B.M., Boydell, K.M., Seeman, M. and McKeever, P. Children's experiences of parental mental illness: A literature review. *Early Intervention in Psychiatry*. 5:271-289), this may have important implications for practice because children often evaluate services and support in ways that are differentiated from that of adults, including clinicians and parents

In general, we do agree with this point. However, and as we state in the introduction p 5, "... before researchers are in a position to evaluate the different interventions to prevent the trans generational transference of mental health problems, these interventions have to be put into wider use. In order to conduct research to evaluate the health promoting and preventing effects of interventions in the COPMI field, it is a prerequisite that relevant changes in clinical practice to identify and offer children

adequate support have been implemented.” Our project intends to set the stage for the use of other interventions, and research on new efforts may focus also on children’s perspectives. As a first step it seems ambitious enough to implement interventions to identify and offer a minimal standard of support for the children and parents.

The second, but related point we want to make, is that since adult and child mental health services are separated in different organizations in Norway, we cannot ask mental health workers to assess the children directly. They are not legally in a position to perform such assessments, they would have nowhere to put the information about the child (other than in the journal of the parent), and they do not have the formal competence to work directly with the children. Furthermore, since this is an implementation project evaluating changes in clinical practice in adult mental health care, researchers from outside the hospital do not have access to patients directly, and cannot gather such data.

Are the participants adequately described, their conditions defined, and the inclusion and exclusion criteria described?

- I have some concerns about grouping parents with mental illnesses and those with substance abuse disorders together in this study and what the implications for the study results might be in terms of understanding service and support needs; at the least it would be helpful to have the authors comment on this as perhaps the new regulatory guidelines in Norway account for this grouping in a particular way.

Reference to the group with substance abuse disorders should have been excluded, and this mistake is corrected on several lines on p 3, 6, 11-12 and 16.

- The mental health workers that form the first group of participants come from a range of disciplinary and practice professions, including psychiatry, nursing, psychology, social work – how would this impact their knowledge, beliefs, collaboration routines and clinical practices [for e.g. on pg. 10 the authors make reference to topics about knowledge and attitudes about responsibility for COPMI, which would vary across these workforce professions] and do the authors intend to perform an analysis that might reflect these potential differences within the workforce?

Yes, we have already analyzed data from the pre-measures of health professionals. Differences between health professionals will be reported in our publication on all pre-measures related to the health professionals’ ‘knowledge’, ‘attitude’, ‘collaborative routine’ and ‘clinical practices’.

- Similarly will patients who are parents be differentiated in terms of analysis regarding for e.g., gender of the ill parent, diagnosis, family context [lone parent family etc.]; some mention is made about collecting demographic variables about the patient and the child but it there isn’t enough detail to think about how for example, diagnosis and psychiatric history might be used in the analysis of user satisfaction [see pg. 11]?

The text has been changed on p 12 to clarify which demographic variables we are measuring for both children and parents. As described in the manuscript, we are collecting data to describe and explore all participants and the relationship between different demographic variables and outcomes.

also, will all age ranges of children be represented

Yes, all identified children of patients will be included in the analysis.

and if so, wouldn’t parenting behaviours influence the ‘socio-emotional and behavioural problems’ in these individuals differently given the structurally differentiated positions of children in society?

It is unclear to us which point the reviewer wants to make here ...

What kinds of questions will be asked in the ‘user satisfaction’ questionnaire? [see pg. 12]?: how will responses be differentiated between the study intervention, Child Talks, and ‘broader services they have been offered’, is there an intention to compare these supports/services?

There is no intention to compare, because only the patients who are offered the Child Talks intervention get this user satisfaction survey. Regular practice in the hospital does not include any interventions or evaluations related to a parenting or child perspective. We think it will be possible to compare specific interventions with treatment as usual sometime in the future, but as we have outlined in the manuscript, one needs to implement new interventions to make such comparisons and further effect evaluations possible.

Are there any 'open-ended' questions that will allow participants to elaborate on their perspectives of satisfaction?

Yes, there is an open ended question at the end of this questionnaire. We will analyze this too.

Are the patients representative of actual patients the evidence might affect?

- Yes; my one concern as stated earlier is the combination of parents with mental illness and those with substance use disorders.

We agree with this point, and have excluded all references to the latter group.

- The only other comment I would like to make here is that although the study appears to try to address children's perspectives in the reference on page 13 to 'including the children through questions about their understanding and experiences of the family situation, and the children's view of what may improve their situation' I found this too vague in terms of assessing children's participation in the intervention Child Talks; is this part of the study data or 'just' a description of the intervention itself and if so how will this data be analyzed?;

This is only a description of the intervention itself, and will not be analyzed.

if not, there is the problem here of perpetuating the broad and enduring issue in this field that focuses only or primarily on the 'patient' as the parent rather than the child and his/her support needs or the family as a whole; it appears to me that children's 'needs' are assessed almost solely from the perspective of the workforce via the Family Assessment form and/or the parent as patient in Child Talks, – and particularly as other studies have found that child/adult perspectives may not always align with those of adults [see citations noted previously for example]

We agree to the general fact that there might be large discrepancies between a parent/adult perspective, and a child perspective. However, the aim of this study is to implement attention for children in the adult mental health care and not to assess the needs of the children or the effects of the intervention on children. We first need to identify all children to be able to reach those in need of additional support in their communities. Until now children of patients in adult mental health care are not identified. They have been invisible. In future research these issues need attention. This is not yet available in this part of Norway, hence the goal of the interventions; to identify those in need of further assessment and support and referring them to appropriate services for children.

Are the methods adequately described?

- Reference for implementation training is made to 'Adults for Children' – I would be interested in knowing more about this group, particularly because they seem integral to whether or not the intervention is delivered according to protocol based on the training they are providing - pg 11 indicates that workforce participants will evaluate the training/supervision in relation to question # 4 in the first phase of the study – it would be important to give some indication of this earlier in the protocol as it might help explain the purpose for this question; however, I wonder if overall the design of the study is too ambitious, or would some clarification of questions related to the study design and questions help to mitigate this impression?

We assume the reviewers comment is related to study question #3, not #4. We find it natural to describe Adults for Children and their training/supervision program, when we present the empirical data from this part of the project. We plan to publish several empirical articles from the project when the data has been collected.

We agree that the study is ambitious, and we have had several challenges during the year we have been collecting data. However we don't find the study too ambitious. We find it natural to describe the issue of "Evaluating the content of the logbook from Child Talks" (p 12) and "intervention integrity" (p 14) in the methods section, as the research question related to these issues are standard and best fit into this section.

- Which other 'services' or 'additional support' might children who are identified in the assessment phase might be offered in addition to Child Talks and how would this impact the findings of the study? Children will not get any other 'services' or 'additional support' in addition to Child Talks within adult mental health care. The Family Assessment and Child Talks are "as good as it gets" within these services. However, and this is the main point about these two new interventions; they may help identify families and children in need of other 'services' or 'additional support', and may help the workforce to refer families to adequate services in their community. The rationale for this is outlined in the introduction pp 5-6, and the manuscript has been changed on p 7 to clarify this point. Furthermore, this is clarified in a paragraph on limitations on p 16.

- How is the Australian online resource questionnaire adapted to the Norwegian context? I think the paper should include more detail on the kinds of criteria or indicators of clinical practice change are being used rather than relying on reference to this resource. And how will these be measured to indicate whether or not they are sustained at the one year follow up? The Australian online resource questionnaire is adapted in the way that most questions are used, but are reframed to fit the Norwegian clinical context and welfare state (public services for all). The evaluation of change is not related to specific items, criteria or indicators in the questionnaire, but to the pre-post-one year follow up design.

- What does the 'logbook from Child Talks' consist of?; The logbook is represented in the electronic patient journal in the participating wards in the hospital. It is brief, and described on p 12 in the measures section. We think the description is detailed enough for the reader.

how does this constitute data for this part of the study?

See previous comments and changes on this issue (intervention integrity).

More detail about this would be helpful – and more broadly this should include information about Child Talks itself as an intervention – what is the content, format of the program, which is only briefly summarized here in terms of a discussion with the patient and his/her partner and children at 3 points in time;

The Child Talk intervention is described in 16 lines, almost a full page pp 12-13, and we find this detailed enough for the reader.

moreover, if new topics/concerns, opportunities/needs for support were to arise during the intervention over and above what may be anticipated by Child Talks, would that constitute a breach of protocol or is there space here to consider innovation to the intervention itself?;

No, new topics would not be a breach of protocol, but will be reported in the logbook. The need for more sessions is to be dealt with in such a way that the family is referred for additional support within adequate community services. Innovations that require more sessions within the adult mental health care are not possible within this framework.

the problem of 'program fidelity' can be understood quite differently as for example in a study I conducted involving a critical discourse analysis of the program content of a psychoeducational program for COPMI (Gladstone,(2010) "All in the same boat": An analysis of a support group for children of parents with mental illnesses, Doctoral Dissertation, University of Toronto, Toronto, Canada).

- There is no detail about the user satisfaction scale and how the analysis will be conducted.

We have added more information about this scale on p 13. There is a full paragraph on the analysis

related to the pre-post measures of PSOC and PEDS, which is included in the user satisfaction scale on pp 10-11.

Is the main outcome measure clear?

- No I believe that there are a number of points of clarification needed;

We have changed the manuscript and/or reflected on these issues previously.

in addition to comments threaded throughout my previous comments in this regard I would suggest the authors might find a recent paper of note in which a differentiation is made between how we understand 'screening' and 'assessment' in terms of evaluating referral and assessment practices in programs for children as they anticipate the scientific and practical implications of their project as it is proposed here [see pg. 15]: specifically see pg. 505 in Steer, S., Reupert, A. & Maybery, D. (2011). Programs for children of parents who have a mental illness: Referral and assessment practices. "One size fits all"? Australian Social Work, 64:4, 502-514.

We have changed the phrase "screening" on p 16, as we only meant the Family Assessment intervention. We only refer to and discuss assessment practices, and not in "programs for children", as stated by the reviewer, but as part of adult services. The context of the project is that adult mental health care services very seldom refer children of their patients to adequate child services, whereas the new laws require them to do so.

Are the abstract/summary/key messages/limitations accurate?

- I found the abstract hard to read; more detail about actual methods would be helpful, or perhaps a different organization of the summarized material; for e.g. the analysis section seems to me to be more about data collection; more detail about the interventions [Family Assessment, Child Talks] would be less confusing and more compelling for the reader

We agree on this, and have added a few sentences describing the interventions.

- I do not have a sense of what the authors might anticipate to be the 'limitations' or 'considerations' of this study design, from either the methodological and/or substantive approaches taken in this study as it is currently described

We have added a central limitation to the discussion section, and included this in the abstract.

Are the statistical methods described? Are they appropriate?

- This is not my expertise.

Is the standard of written English acceptable for publication?

Yes.

Are the references up to date and relevant? (If not, please provide details of significant omissions below)

- I have chosen to add some references where they might be helpful to review the points I am making here; I am not necessarily suggesting that these are significant omissions.

We have changed the text in the manuscript or presented the rationale for our choices throughout the response to the reviewer's comments.

I am surprised by the statement in the protocol that the study is regarded as a 'quality evaluation project aimed at improving diagnostic and therapeutic practices' rather than as a research study in the more traditional sense that would require a more standard [in my experience] ethical review. I am not familiar with the role and responsibility of a 'data protection officer' who approved the protocol but as the title suggests I have concerns about what it may mean to protect 'data' and how this might

relate to the protection of human subjects as is the purview of most REB processes. For example, in this study mental health workers participate in the study assessments as part of a formal agreement between the researchers and the management in their place of work, but I am not clear whether or not they can opt out of participation and the language used also suggests that they are 'encouraged' [but not obligated?] to answer the questionnaires [p. 8]. The scales that the parent participants are asked to complete are obligatory as part of a quality assurance evaluation of clinical practice but also part of the study design so I assume participants would be obligated to complete these, but this should be made clear and subject to review. Parents are recruited via the mental health worker who assesses the 'patient'; would this be an individual from whom they would also receive care and if so are there any ethical concerns with this relationship or guarantees that will be made with regard to consent/confidentiality procedures? There is a brief mention of the intervention including children through questions about their understanding and experiences of their family situation and view of what may improve it - are there plans to include this as study data beyond what the intervention itself entails and if so will the children be involved in consent/assent procedures along with their parents? We do appreciate this comment, but would like to inform the reviewer that we had submitted a confirmation letter from Regional Ethics Committee (REK) to BMJ Open on this issue. REK has reviewed the ethical aspects of the project, and has discussed these in relation to Norwegian research legislation in their response to the research group. This is their response to the research group:

“The regional ethics committee (REK) can confirm that project, which is categorized as quality assurance project , is not required to be submitted before the committee. Projects to be submitted to the Committee are projects concerning "medical and health research on human beings, human biological material or medical information", cf. § 2. "Medical and health research" are defined in Health Research Act § 4 a) as "operations performed using scientific methodology to obtain new knowledge about health and disease". It is therefore the purpose of the study that determines whether a project should be submitted to REK.

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

I would like to thank the authors for the opportunity to review their study protocol, which is part of a promising and significant area of study that has not been widely studied and is under-funded in most contexts. I hope the authors find my comments helpful.

We appreciate all comments and questions from the reviewer. We hope that the changes we have made contribute to improve and clarify the manuscript according to the reviewer’s comments. We believe that some of the questions from the reviewer may be related to the specific way adult and child services are organized in Norway, and how the responsibilities for adult patients and children are dealt with in separate organizations. We hope this has been clarified in a satisfactory way in our response.

VERSION 2 – REVIEW

REVIEWER	Brenda Gladstone, PhD Project Investigator Child Health Evaluative Sciences SickKids, Adjunct Lecturer Lawrence S. Bloomberg Faculty of Nursing, University of Toronto
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	I have no competing interests to declare.
REVIEW RETURNED	06/03/2012

THE STUDY	<p>Is the overall design appropriate and adequate to answer the research question; are the participants adequately described, their conditions defined, and the inclusion and exclusion criteria described? are the patients representative of actual patients the evidence might affect [my comments overlap with these three questions]?</p> <p>1. With respect to the measurement tools while I appreciate the clarity given with respect to the patient population that will be seen in this clinic [seemingly those who will not be diagnosed with a more severe illness like schizophrenia, according to the author letter of response] and the reasons for using particular measurement tools due to a corresponding lack of such measures for this group of parents, I wonder if it would be helpful to include a general description of the types of diagnoses these parents are likely to have, to give the reader a better understanding of this particular patient population [although I assume that even brief hospitalization might indicate some type of severity]; moreover, this may also help to explain the authors' contention that the 'psychosocial context' of participating families' life situations as being similar to the general population in Norway, which should be clarified in the paper – however it is a point of view that I find it difficult to share, given the accumulated literature suggesting that risk to children and families more broadly is based on the psycho/social context and experiences they encounter rather than the parents' medical diagnoses; I realize of course too that one of the difficulties in this field is the fact that different health care systems in different countries will have a social and political impact on how families experience parental mental illness. [See also my comments in the next section]</p> <p>2. I believe the authors have begun to address a potential limitation of this design in response to my concerns about whose evidence is considered significant in determining the 'life situation of the child' and their respective needs [on page 7] in both the abstract and more explicitly in the final section on 'scientific and practical implications' p. 16 –</p> <ul style="list-style-type: none"> • however, I would have to disagree with the statement that it is widely accepted that the 'quality of parenting a child receives is 'the most potent and most modifiable' in terms of risk to children – children and parents have claimed many other social variables and interactions with others that have an impact on them across familial, educational and health and social care systems –see for example a number of studies in which children and parents [and some professionals] describe the problems of day-to-day life and its' associated risks: Gladstone, B.M., Boydell, K.M., Seeman, M. and McKeever, P. Children's experiences of parental mental illness: A literature review. Early Intervention in Psychiatry. 5:271-289; while parental behaviours are significant influences, in addition to how parents think about themselves, their role, the role of children in the family and so forth, I think the authors should state this influence with less assuredness – to my mind there is evidence to suggest that many more factors need to be considered in the relationship between children [of varying ages, social location etc.], parents, and the wider community in which 'risk' is played out – that should be considered in tandem with an exclusive focus on parenting skills and parent interaction in terms of risk [p. 4]; moreover, the literature suggesting a decrease in perceived competence in children who are 'at risk'[p. 4] should be considered in light of others who suggest the
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	<p>importance of understanding/measuring children's competence as a social accomplishment to examine risk differently [see for e.g., Gladstone, Boydell & McKeever (2006), Recasting research into children's experiences of parental mental illness: Beyond risk and resilience, <i>Social Science & Medicine</i>, 62: 2540-50 – this is particularly important in light of the argument to develop interventions that focus on the 'malleability of psychological and social risk'</p> <ul style="list-style-type: none"> • Could the authors clarify who they are referring to when they suggest that there may be 'other informants' [on pg. 16] whose perceptions would be important to consider ; also I was not very clear on the explanation that followed regarding 'correlations between self-report measures of parent and that of observers' – which other observers? My point was not that parents' proxy accounts are 'wrong' or that they somehow need to be tested for accuracy, but rather that children's views [and indeed that of others involved in the situation who have an influence on their health and social well being such as the 'well' parent, extended family, peers, teachers and so forth] may be different or conflicting with that of the parent or the mental health professional and that these should be taken into consideration in developing evidence; but of course no study can do everything, and an important limitation or point for future consideration would be to take more than the parents' view into account [in addition to these accounts but not instead of...] • I am still a bit confused as to whether or not the study is assessing children's needs; for e.g. in the authors' letter of response they say that aim of the study is not to assess the needs of children but to 'implement attention for them in the adult mental health care' – but on pg. 7 in the paper they are saying that their needs will be assessed indirectly and they give reasons for this situation that are common in many countries given the separation between adult and paediatric services and so forth; I wonder if there needs to be some clarity in the writing to say that the assessment is only that the children have needs and will be referred on, but not that this study is about assessing what those specific needs are – if I have understood this correctly – this might clear up any confusion on the part of a reader such as myself • In the author letter of response I thought the comments that this project 'sets the stage' for future endeavours [i.e. for use of other interventions, and research on new efforts may focus also on children's perspectives....'] might be helpful to consider including directly in the concluding section of the paper
REPORTING & ETHICS	<ul style="list-style-type: none"> • Ethical concerns – mental health workers are encouraged to answer web-based questionnaires – how will they be encouraged, and can they refuse? [p. 9]; patients will be assessed by workers using the assessment form to determine if they should receive the Child Talks intervention – I assume those in an acute phase of illness, who have been hospitalized at the time of the study, will not be expected to participate; and for those who are, will they be able to refuse and will they feel the pressure to say yes because they are asked by their worker to attend?; is there any concern about asking parents about their 'competence' and 'concern' if they are experiencing mental health difficulties at the time of the study?

VERSION 2 – AUTHOR RESPONSE

Comments from the reviewer:

1. With respect to the measurement tools while I appreciate the clarity given with respect to the

patient population that will be seen in this clinic [seemingly those who will not be diagnosed with a more severe illness like schizophrenia, according to the author letter of response] and the reasons for using particular measurement tools due to a corresponding lack of such measures for this group of parents, I wonder if it would be helpful to include a general description of the types of diagnoses these parents are likely to have, to give the reader a better understanding of this particular patient population [although I assume that even brief hospitalization might indicate some type of severity];

We agree that it is helpful to include a general description of the diagnoses these parents are likely to have. According to this we have included a new line on page 8. We do not think this needs further clarification in the paper, as the reviewer suggests in the paragraph below.

moreover, this may also help to explain the authors' contention that the 'psychosocial context' of participating families' life situations as being similar to the general population in Norway, which should be clarified in the paper – however it is a point of view that I find it difficult to share, given the accumulated literature suggesting that risk to children and families more broadly is based on the psycho/social context and experiences they encounter rather than the parents' medical diagnoses; I realize of course too that one of the difficulties in this field is the fact that different health care systems in different countries will have a social and political impact on how families experience parental mental illness. [See also my comments in the next section]

We find the issues the reviewer raises in the above paragraph very interesting. Our general perspective is that the psycho-social risk factors for developing mental health problems are the same for the universal population as for this sample. According to this perspective, the literature suggests that it is the quantity, and not the quality of risk factors which determines the developmental path for children. Rutter's concept "additive effects" is a key concept on this issue, and points to the exponential risk related to accumulated risk factors which coincides in time. This perspective implies that mental health problems may also be understood as a public health issue, as opposed to the view that mental health problems only affect a marginal group of the universal population.

2. I believe the authors have begun to address a potential limitation of this design in response to my concerns about whose evidence is considered significant in determining the 'life situation of the child' and their respective needs [on page 7] in both the abstract and more explicitly in the final section on 'scientific and practical implications' p. 16 – •

however, I would have to disagree with the statement that it is widely accepted that the 'quality of parenting a child receives is "the most potent and most modifiable" in terms of risk to children – children and parents have claimed many other social variables and interactions with others that have an impact on them across familial, educational and health and social care systems –see for example a number of studies in which children and parents [and some professionals] describe the problems of day-to-day life and its' associated risks: Gladstone, B.M., Boydell, K.M., Seeman, M. and McKeever, P. Children's experiences of parental mental illness: A literature review. *Early Intervention in Psychiatry*. 5:271-289; while parental behaviours are significant influences, in addition to how parents think about themselves, their role, the role of children in the family and so forth, I think the authors should state this influence with less assuredness – to my mind there is evidence to suggest that many more factors need to be considered in the relationship between children [of varying ages, social location etc.], parents, and the wider community in which 'risk' is played out – that should be considered in tandem with an exclusive focus on parenting skills and parent interaction in terms of risk [p. 4]; moreover, the literature suggesting a decrease in perceived competence in children who are 'at risk'[p. 4] should be considered in light of others who suggest the importance of understanding/measuring children's competence as a social accomplishment to examine risk differently [see for e.g., Gladstone, Boydell & McKeever (2006), Recasting research into children's experiences of parental mental illness: Beyond risk and resilience, *Social Science & Medicine*, 62:

2540-50 – this is particularly important in light of the argument to develop interventions that focus on the ‘malleability of psychological and social risk’

We are not arguing that “other social variables and interactions” do not “have an impact on them across familial, educational and health and social care systems”. However our focus is that parenting is an important, and a highly modifiable factor. The paragraph “It is widely accepted that parenting behaviors influence the development of socio-emotional and behavioral problems in children, and the quality of parenting a child receives is considered to be the most potent but also the most modifiable risk factor contributing to the development of behavioral and emotional problems in children” is supported by references number 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 40 and 41. Hence, parenting is a major focus in the project.

Could the authors clarify who they are referring to when they suggest that there may be 'other informants' [on pg. 16] whose perceptions would be important to consider ;
Other informants may be preschool teachers (more than 80 % of Norwegian children aged 0-6 years, attend preschools), school teachers, public health nurses, relatives and adults in the family's social network. We have included examples of other informants in the text on p. 16.

also I was not very clear on the explanation that followed regarding ‘correlations between self-report measures of parent and that of observers’ – which other observers?

See response above.

My point was not that parents' proxy accounts are ‘wrong’ or that they somehow need to be tested for accuracy, but rather that children's views [and indeed that of others involved in the situation who have an influence on their health and social well being such as the ‘well’ parent, extended family, peers, teachers and so forth] may be different or conflicting with that of the parent or the mental health professional and that these should be taken into consideration in developing evidence; but of course no study can do everything, and an important limitation or point for future consideration would be to take more than the parents' view into account [in addition to these accounts but not instead of...] We agreed on this in the last review, and the manuscript was changed accordingly. Hence the sentence: “Direct measures of child development and observations of parent-child interactions are needed to further increase the confidence in the results.”

I am still a bit confused as to whether or not the study is assessing children's needs; for e.g. in the authors' letter of response they say that aim of the study is not to assess the needs of children but to ‘implement attention for them in the adult mental health care’ – but on pg. 7 in the paper they are saying that their needs will be assessed indirectly and they give reasons for this situation that are common in many countries given the separation between adult and paediatric services and so forth; I wonder if there needs to be some clarity in the writing to say that the assessment is only that the children have needs and will be referred on, but not that this study is about assessing what those specific needs are – if I have understood this correctly – this might clear up any confusion on the part of a reader such as myself

We agree on this, and have included a sentence to clarify on p. 7.

In the author letter of response I thought the comments that this project 'sets the stage' for future endeavours [i.e. for use of other interventions, and research on new efforts may focus also on children's perspectives....] might be helpful to consider including directly in the concluding section of the paper

This is what we already meant to express in the conclusion. However, and according to the reviewers comment we have changed the phrasing in the last paragraph to emphasize this point.

Ethical concerns – mental health workers are encouraged to answer web-based questionnaires – how will they be encouraged, and can they refuse?

Yes, they can refuse. However they are encouraged to participate from the management at the

hospital.

[p. 9]; patients will be assessed by workers using the assessment form to determine if they should receive the Child Talks intervention – I assume those in an acute phase of illness, who have been hospitalized at the time of the study, will not be expected to participate;

All patients will be offered support related to dealing with their children. However, the timing may vary according to the severity of their symptoms.

and for those who are, will they be able to refuse and will they feel the pressure to say yes because they are asked by their worker to attend?;

Patients will not be pressured to participate. The service will be presented as a “standard service” for all patients.

is there any concern about asking parents about their ‘competence’ and ‘concern’ if they are experiencing mental health difficulties at the time of the study?

No, ethical consideration related to NOT offer support is considered more important. Providing support for adults with mental illness who are also parents is more likely to be successful if the treatment includes consideration of their role as parents (Biebel, Nicholson, Williams & Hinden, 2004). This is also emphasized in several research reports. In a study in the USA mothers with mental illness identified motherhood as a primary factor for treatment, and reported that not being able to parent their children compromised their well-being and impeded their progress toward recovery (Biebel, Nicholson, Williams & Hinden, 2004).

We appreciate all comments and questions from the reviewer. We hope that the changes we have made contribute to improve and clarify the manuscript according to the reviewer’s comments.